

Assessing teenagers' knowledge, attitudes and perceptions towards teenage pregnancy. The case of a Durban High School

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COLLEGE OF HUMANITIES

I **Prestage Murima** declare that

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DEDICATIONS

For my parents who have toiled so that I can be a better individual, this is for you. Mama for all the times your passport has been stamped crossing borders. Daddy for all the extra shifts, long and tiring journeys you made across Zimbabwe, *Save ndokudai*. For Paul, this is for not walking away seven years ago. For Pauline and Yolanda you can, because you are!

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To the best of my ability, I have tried to make this thesis as accurate as is possible but I am sure somewhere there are errors. All who have helped me ought not to be blamed for them. All errors are mine to bear.

ABSTRACT

Teenage childbearing is a global social and health concern. South Africa is not spared from the problems of teenage pregnancy be they related to health or to the social sphere. Researchers have been entreated to investigate teenagers' sexual behaviour and the determinants to their behaviour especially in light of HIV/AIDS and other sexually related diseases. Various programmes and interventions have been developed and implemented in an effort to manage prevalence rates and address the challenges of teenage pregnancy. In spite of these concerted efforts, pregnancy rates continue to increase.

These efforts have been hampered by the absence of the voice of teenagers in research as interventions implemented do not adequately capture the complexity of teenage pregnancy. Research has also divorced teenagers from the environment within which teenage pregnancy takes place and as a result come up with interventions that are not pro teenagers. The absence of teenagers' input in these interventions results in little uptake of interventions as teenagers feel no ownership or entitlement to these intervention. This study therefore seeks to bridge the gap by addressing teenage pregnancy from the perspective of teenagers themselves and locates teenage pregnancy within the lived experiences of teenagers. Guided by the Social Ecology Model and The Health Belief Model, this study seeks to analyse teenagers' knowledge, attitudes and perceptions towards teenage pregnancy.

This study is qualitative in nature and is situated within the interpretive paradigm that enables the researcher to explore people's lived experiences. Using the case study approach, the study employs focus group discussions to elicit information from participants on their knowledge, attitudes and perceptions towards teenage pregnancy.

The study concludes that knowledge; attitudes and perceptions are influenced and affected by various factors such as peer pressure, lack of adequate information and gender dynamics. To address teenage pregnancy challenges, there is a need for addressing the structural factors that influence teenagers' knowledge, attitudes and perceptions. Knowledge on safe sex and contraception abounds though this knowledge does not translate to positive health affirming behaviour. This gap is attributed to the structural factors that influence and affect health behaviour. As such these factors, such as entrenched poverty and lack of proper sexual health communication need to be addressed if teenage pregnancy is to be managed.

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ACRONYMS

AIDS Acquired Immune Deficiency Syndrome

CSG Child Support Grant

DoE Department of Education

DoH Department of Health

DSD Department of Social Development

HIV Human Immunodeficiency Virus

HSRC Human Science Research Council

KAP Knowledge Attitudes and perception

KZN KwaZulu Natal

MCP Multiple and Concurrent Partners

NAFCI National Adolescent Friendly Clinic Initiative

SASSA South African Social Security Agency

STIs Sexually Transmitted Infections

TB Tuberculosis

UNICEF United Nations International Children's Emergency Fund

WHO World Health Organisation

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CHAPTER 1 - INTRODUCTION

Alcohol and drug abuse, juvenile delinquency, teenage pregnancy, the risk of contracting and transmitting Sexually Transmitted Infections (STIs), HIV and unemployment are some of the challenges besetting South African youth today. These challenges make up the fabric of South Africa's social reality, chief among them being adolescent sexual health.

Teenage pregnancy has been a global health issue for more than three decades. Concern over teenage sexual behaviour ranges from immaturity of teenagers to deal with parenthood and social problems with which teenage pregnancy comes. Nearly 16 million of 15-19 year old girls give birth each year, and most are found in developing countries (World Health Organisation, 2012).

In South Africa, teenage pregnancy remains a topical issue as government and other civic organisations seek to control and manage teenage pregnancy rates. The table below shows the national pregnancy rates from 2008 to 2011.

2008	2009	2010	2011
45 000	80 000	89 000	94 875

Table 1. National pregnancy rates, 2008-11 Source: SANAC (2012)

In KwaZulu-Natal, 17 000 learners were pregnant in 2010 while in 2011, the number dropped to 12 971. Despite the drop in pregnancy prevalence rates, teenage pregnancy remains unacceptably high in KZN. Of these 12 971, 508 were primary school learners (Department of Education, 2011). These figures are representative of the girls who attend school and did visit the antenatal clinics. These statistics are exclusive of non-school going teenagers and those that did not attend antenatal clinics.

The 2012-2016 national strategic plan for HIV, STIs and TB sets the integration of teenagers' sexual health as core to the management and prevention of HIV and AIDS, STIs and unplanned and unwanted teenage pregnancy (Department of Health, 2011). The government acknowledges that teenage sexuality needs special attention and an investment in teenage

sexual health contributes to the national goal of enhancing reproductive health (Macleod & Tracey, 2010). The desire to manage teenage pregnancy stems from the consequences of early parenthood on the teenager and on society, and the threat that early child bearing has on efforts to achieve gender parity in schools and girl child empowerment. In addition, the risk of HIV and AIDS infection in teenagers has brought a new dimension to the desire to manage teenage pregnancy. In South Africa 1 in 5 pregnant teenagers is HIV positive (UNAIDS, 2012).

In an effort to manage the rates of teenage pregnancy, the government and other relevant stakeholders have come up with different interventions. The Department of Education's (2007) '*Measures for the Prevention and Management of Learner Pregnancy*' is a framework that seeks to prevent and manage early pregnancy in schools. Government has also introduced Life Orientation as a compulsory subject in schools. Life Orientation furnishes learners with life skills training; however, the success of Life Orientation is hindered by educators' inability to express life skills and their inability to discuss sex without being judgemental (Macleod & Tracey, 2010). In addition, *Soul City* and *Soul Buddies* (an off shoot of *Soul City*) run multimedia health awareness campaigns designed to educate South Africans on various health issues (Tomaselli & Chasi, 2011). DramAidE is another intervention that assists teachers to explore sensitive issues through drama and peer education (ibid). In spite of having a much publicised and well-coordinated sex education programme, teenage pregnancy in South Africa remains unacceptably high (Manzini, 2001).

FRAMING THE RESEARCH PROBLEM

This study explores teenagers' knowledge, attitudes and perceptions towards teenage pregnancy. In order to understand behaviour, knowledge, attitudes and perceptions towards a certain phenomenon need to be analysed within the context that these originate and are produced. As such it is important to unpack the terms that frame this study.

Knowledge

Knowledge is defined as "the facts, feelings or experiences known by a person or group of people; awareness, consciousness, or familiarity gained by experience or learning; specific information about a subject" (*Collins English Dictionary*, 1991:860). Knowledge is gained from peers, institutions of socialisation such as the school, family and church, the media such as newspapers, magazines, radio, films, television and the Internet. Knowledge is very

important as it is the basis upon which decisions are made. It is also essential as it helps shape an individual's reality. Sexual health knowledge is vital not only to adults but to teenagers as well. In the absence of adequate and factual knowledge teenagers are bound to make unsound decisions that have a negative bearing on their lives.

There are different types of knowledge; conceptual, procedural, declarative, strategic and descriptive. These types of knowledge are dependent on whether the knowledge is factual or mythical (Byners, 2001). This study focuses on conceptual, procedural and declarative knowledge.

“Static knowledge about facts, concepts and principles that apply within a certain field is known as conceptual knowledge domain (de Jong & Ferguson-Hessler, 1996). Conceptual knowledge allows an individual to rationalise a phenomenon. Conceptual knowledge is significant for this study as it is important to understand what teenagers know about teenage pregnancy. Such knowledge comprises what the phenomenon is all about (teenage pregnancy), the drivers of and contributory factors to teenage pregnancy, the effects of teenage pregnancy on both individuals and society and prevention and management of the phenomenon.

Procedural knowledge is “knowledge exercised in the performance of a task” (de Jong & Ferguson-Hessler, 1996). This type of knowledge manifests for example when teenagers use contraceptives and condoms to prevent pregnancy and other Sexually Transmitted Infections and making use of health services. Knowledge on its own is not enough to influence behaviour change. "Heightened awareness and knowledge of health risks are important preconditions for self-directed change. Unfortunately, information alone does not necessarily exert much influence on refractory health impairing habits" (Bandura, 1990:1). Attitudes and perceptions then play a role in supporting knowledge in realising behaviour change. "Behaviour change can be attributed to a change in knowledge levels, attitudes and perceptions. A combination of all three results in behaviour change” (Becker, 1990:4). Teenage pregnancy is evidence that procedural knowledge is not being used and opens avenues to identifying the gaps in knowledge that need to be addressed.

Declarative or descriptive knowledge is “knowledge that involves knowing ‘that’ is the case” (de Jong & Ferguson-Hessler, 1996: 12). For instance knowing that Paris is the capital of France and knowing that unprotected sex can lead to unwanted and unplanned pregnancy is descriptive knowledge. In some cases, declarative knowledge does not translate to action, for

example knowledge that smoking is not good for one's health does not stop an individual from smoking. In the same vein, knowledge on the effects of teenage pregnancy may not stop a teenager from engaging in practices that result in pregnancy. Thus, "raising levels of knowledge and correcting misconceptions is necessary as a first strategy by which individuals can begin to protect themselves against diseases" (Coates et al., 1988:6).

Sources of information are crucial in this study as they play a role in informing or misinforming teenagers. An understanding of these sources of information is vital as it exposes areas of attention in teenage sexual health education. It is such gaps in knowledge that this study seeks to identify and address.

Attitudes

An attitude is "a settled way of thinking or feeling about something" (*Oxford Dictionary*, 1999:55). An attitude can also be defined as "an organised predisposition to respond in a favourable or unfavourable manner toward a specified class of objects" (Shaver, 1977:55). Attitudes form a significant determinant of behaviour and form 'biases' to act and behave in a certain way (ibid). Attitudes come in two forms, attitude as a cognitive component and attitude as a behavioural component.

Attitude as a cognitive component comprises of an individual's thoughts and beliefs while attitude as a behavioural component comprises of how the attitude influences action. This study explores these two types of attitudes towards teenage pregnancy. Attitudes develop through experience either direct or indirect and are also influenced by the environment around an individual (de Jong & Ferguson-Hessler, 1996). Social norms, the media, friends, family and culture play a role in the creation of attitudes. The relationship between attitudes and behaviour change is complex; understanding how attitudes influence behaviour can be enhanced by the use of a theoretical framework (ibid). This study makes use of the Social Ecology Model and the Health Belief Model as frameworks to better understand attitudes of teenagers towards teenage pregnancy.

Attitudes have a significant role in changing behaviour towards contraceptive and condom use, breast, cervical and colorectal cancer screening and maintenance of a healthy diet (Cole, Holtgrave & Rios, 1999). For the purposes of this study attitudes are important as they enable the researcher to question teenagers on aspects of teenage pregnancy such contraceptive use, multiple and concurrent partners, transactional and intergenerational sex.

Perceptions

Perception is defined as “the way in which something is regarded, understood or interpreted” (*Oxford Dictionary*, 1999:1049). Through perception, an individual is able to create meaning of the world around them, creating subjective and personal inferences (Quin, 2002). Perception is largely guided by knowledge (de Jong & Ferguson-Hessler, 1996). Through knowledge gained, perceptions enable an individual to choose what is to be interpreted and how it is to be interpreted. For the purposes of this study, perceptions refer to the ways in which teenagers regard, understand and interpret teenage pregnancy within their lived experiences. One of the key research questions that this study explores is how do teenagers perceive pregnancy? Factors that affect and influence teenagers’ perceptions of teenage pregnancy are very important as they may be indicative of gaps in terms of knowledge, knowledge interpretation or even misinformation of facts. Understanding perceptions is vital as perceptions influence uptake of healthy behaviour practices.

PROBLEM STATEMENT

Knowledge, attitudes and perceptions inform behaviour (Ajzen, 1991); sexuality is enmeshed in these three aspects of health behaviour. Teenage pregnancy concern has over the years increased as more efforts have been channelled towards managing teenage pregnancy without any imminent success in sight. Prevalence rates continue to increase despite efforts by government and other stakeholders through campaigns, interventions and the establishment of youth friendly clinics.

This study therefore seeks to unearth teenagers’ knowledge, attitudes and perceptions towards teenage pregnancy. The rationale behind being that an understanding of these components of health behaviour from the teenagers’ perspective may help shed light on teenage pregnancy. This study seeks to broaden the framework through which teenage pregnancy is understood and how future interventions and programmes will be designed and implemented, as a result of exploring teenager’s knowledge, attitudes and perceptions towards teenage pregnancy.

The study draws from the Social Ecology Model and The Health Belief Model. The Health Belief Model is used to understand at an individual level, teenagers’ knowledge, attitudes and perceptions. The Social Ecology Model on the other hand is used to understand knowledge, attitudes and perceptions taking into account the environment that teenagers come from. The

Social Ecology Model helps answer the fourth research question on the factors that influence teenagers' knowledge, attitudes and perceptions.

AIMS OF STUDY

The aim of this study is to understand teenagers' knowledge, attitudes and perceptions of teenage pregnancy and factors that affect them.

Research objectives

The study seeks to:

- Explore teenagers' knowledge, attitudes and perceptions towards teenage pregnancy.
- Explore factors that affect and influence teenagers' knowledge, attitudes and perceptions towards teenage pregnancy.

Research questions

This study intends to answer the following questions:

1. What knowledge do teenagers have with regards to pregnancy?
2. How do they perceive teenage pregnancy?
3. What are their attitudes toward pregnancy?
4. What factors influence the above?

DELIMITATION OF STUDY

The study is based in Durban at a local high school. The principal of the school asked that the school not be mentioned. The study focuses on school-going teenagers specifically Grade 11 and 12 learners. It is a qualitative study aimed at understanding teenagers' knowledge, attitudes and perception towards teenage pregnancy.

SIGNIFICANCE OF STUDY

This study is aimed at exploring teenagers' knowledge, attitudes and perceptions towards teenage pregnancy. Teenagers' dialogues around pregnancy help in establishing how best teenage pregnancy can be managed and controlled from the teenagers' perspective. It is important that teenagers be actively involved in the design and development of interventions that focus on their circumstances. This ensures adoption of messages and practices as they take ownership of the intervention (cf. Parker, 1994). Study findings are expected to shed more light on how teenagers perceive pregnancy thus contributing to wider policy making at community levels. The study also contributes to existing literature on teenage pregnancy. While the study takes the route of exploring knowledge attitudes and perceptions, it deviates from traditional knowledge, attitudes and perception studies in that it does not isolate the individual from the structural factors that influence and affect decision making. This study does not focus on private sexual behaviour but explores teenage sexuality; sexuality affects and implicates the individual and society (Hlabangane, 2012).

Limitations of study

Teenagers out of school were not included in this study as such their opinions are not reflected in this study. This is a limitation for this study as teenagers out of school are an important demographic for teenagers. Probably because teenagers out of school have different needs and as such are affected and influenced by different factors unlike their school going counterparts. An understanding of their needs may inform intervention programs as most interventions are designed for teenagers in school. By virtue of them being an 'under researched' demographic interventions designed for school going teenagers become irrelevant to them.

The study also focuses on urban teenagers, living in the city and excludes the teenagers from the rural areas. By virtue of their geographical locations teenagers' information needs maybe different and thus their knowledge, attitudes and perception towards teenage pregnancy may also be different. The same goes for the factors that influence and affect their knowledge, attitudes and perceptions.

THESIS STRUCTURE

Chapter One outlines the research objectives and the research questions. The chapter also gives an outline of the research problem. It unpacks the key terms, knowledge, attitudes and perceptions as they shape this study.

Teenage pregnancy is discussed in its complex and interwoven form in Chapter Two. The chapter is divided into two sections, consequences of early parenthood and the contributory factors towards teenage pregnancy. Under consequences of early parenthood, the chapter explores the costs of early parenthood on both the teenager and society and explores how these costs are borne by both the girl child and the teenage father. Contributory factors to teenage pregnancy analyse the drivers of teenage pregnancy from contraceptive use, sources of information on sexual health, intergenerational and transactional sex.

Chapter Three discusses the main theories that frame this study and how these theories are ideal in tackling the research problem. This study is informed by the Social Ecology Model, a multi-level model that recognises that the individual and the environment affect and influence each other. The Health Belief Model, an individual level model is used to understand teenagers' knowledge of teenage pregnancy, their perceptions of it and their attitudes towards it. The chapter concludes with a summary of what the entire chapter entails.

The research process of this study is discussed in Chapter Four. It describes the research paradigm within which this study is located, the research design that is employed and why it is suitable for this study and the steps taken to collect data and how this data is analysed. Research techniques employed in this study are discussed in the face of the nature of this research and how applicable these techniques are. Ethical considerations taken into account during the research process are also discussed in this chapter.

Chapter Five analyses the data from the gendered focus group discussions. A descriptive analysis is given, with an emphasis on how the data answers the research questions and ensuring that the research objectives are met.

Chapter Six is the findings and conclusions of the study. A summary of the key findings of the study is given.

CHAPTER 2- LITERATURE REVIEW

INTRODUCTION

Public concern over adolescent sexual health and the resolutions to these concerns has over the past three decades generated political debate and academic inquiry the world over. At the core of adolescent sexual health is the issue of teenage pregnancy. South Africa has not been spared from the challenges teenage pregnancy presents. Inquiry into teenage pregnancy in South Africa began in the 1980s. In an effort to control the prevalence of teenage pregnancy, academics and policy makers alike have developed various strategies and policies targeting teenagers. Yet three decades later, teenage pregnancy still remains a topical issue in South Africa.

Approximately 16 million adolescent girls between 15 and 19 years give birth each year worldwide, and 80% of these girls are found in developing countries (World Health Organisation, 2010). In South Africa, 40% of all births involve girls under the age of 19 years, and 35% of these teenagers, give birth before reaching the age of 19 years (Jewkes, Morrell & Christofides, 2009).

This chapter examines literature on teenage pregnancy, and will assist in providing rationale and context for this study. This literature review will deviate from the traditional knowledge, attitude and perception (KAP) studies that isolate individuals from social, cultural and economic contexts that influence and shape their lives. The weakness of KAP studies is that they do not acknowledge the effect of cultural, economic and societal factors on human behaviour. Knowledge, attitude and perception studies on teenage pregnancy in South Africa have been mainly descriptive and do not make an effort to account for the gap between knowledge, attitude and perception (Jewkes et al., 2001). In an effort to account for these discrepancies, and come up with gaps in teenage pregnancy research, this literature review has been divided into the following sections (i) the consequences of child bearing on teenagers, and (ii) factors contributing to teenage pregnancy.

CONSEQUENCES OF CHILDBEARING ON TEENAGERS

The challenge of unplanned and unwanted pregnancy for a teenager has long-term consequences, not only for the mother, but for society as a whole, with far-reaching implications for economic and social development. “Teenagers who drop out of school due to pregnancy never do well after they return from childbirth” (Mpanza, 2010: 66). This can be attributed to divided loyalties between taking care of the child and continuation of school. Because of its usually unwanted and unplanned nature, teenage pregnancy always poses health and social risks (Edgardh, 2000; Genius & Genius, 2004; Petiffor et al., 2004). These studies confirm that early sexual initiation is a predictor of risky sexual behaviour and is more likely to be non-consensual, unprotected and to be subsequently regretted, resulting in unplanned and unwanted pregnancy.

While the consequences of teenage pregnancy are varied, it is important to acknowledge that teenage pregnancy is a result of a complex set of varied, but interrelated factors. An understanding of these factors will enable a better understanding of the knowledge, attitudes and perceptions of teenagers towards teenage pregnancy.

Disruption of school

Teenage pregnancy has the potential of limiting a learner’s future career prospects. For the pregnant learner, impending motherhood forces her to drop out of school as she is unable to continue studying (Macleod & Tracey, 2010). Learners leave school when their pregnancy has progressed as schools are ‘considerate of their state’ (Swartz & Bhana, 2009). The Department of Education’s (2007) *Measures for the Prevention and Management of Learner Pregnancy* “makes it possible for educators to ‘request’ learners take a leave of absence for up to two years” (Macleod & Tracey, 2010:15). Even with legislation in place, pregnant teenagers are sent away from school earlier than they should (ibid). This is probably due to educators’ perception that pregnant learners are a bad influence on other learners.

Vagueness and ambiguity of the education guideline presents a challenge to educators. For instance, the document puts the responsibility of parenting firmly on the learner, and states that a “period of two years may be necessary for this purpose” (DoE, 2007:5). “No learner shall be should be re-admitted in the same year that they left school due to pregnancy” (DoE, 2007:5),

educators are left to decide how long the learner stays away from school. This ruling may be in conflict with the desires of the young mother who may have sufficient support at home, which enables her to return to school earlier than expected (Swartz & Bhana, 2009).

Young fathers are also affected by pregnancy, albeit differently. Impending fatherhood, cultural and societal expectations may force the young father to leave school and seek employment. This is conditional as it depends on whether the boy accepts responsibility or not (Shefer & Morrell, 2012; Swartz & Bhana, 2009).

The level of disruption caused by pregnancy on learners is debatable as learners drop out of school for various reasons of which teenage pregnancy is but one (Macleod & Tracey, 2010; Preston-Whyte & Zondi, 1992). Manzini's (2001) study of teenage pregnancy in KwaZulu-Natal (KZN) indicates that more than 20.6% of pregnant teenagers had already dropped out of school before falling pregnant. Apart from pregnancy, teenagers may leave school due to frustrations associated with the inexperience of teachers, who often are required to teach in areas they are not proficient in, and a lack of relevance of the curriculum and teaching materials (HSRC, 2007). Among factors within the home that lead to drop-out, learners in the HSRC (2007) study cited the absence of parents at home, financial difficulties and the need to care for siblings or sick family member.

The reasons why teenagers drop out of school are a combination of inter-related factors (Strassburg et al., 2010; Fleisch et al., 2010). As such, Fleisch et al. (2010) note that poverty alone cannot best explain why teenagers drop out of school, because there are other factors such as academic ability of the teenager, teacher-pupil relationship, support from home and school, alcohol and drug abuse and family structure that contribute to school dropout.

The various reasons why teenagers may drop out of school are summarised,

Rather than pregnancy causing girls to drop out, the lack of social and economic opportunities for girls and women and the domestic demands placed on them, coupled with the gender inequities of the education system, may result in unsatisfactory school experiences, poor academic performance, and acquiescence in or endorsement of early motherhood (Lloyd & Mensch, 1995:85).

However, pregnancy ranks among the top contributors to school dropout for girls in South Africa (Panday et al., 2009).

While pregnancy may not be the reason for leaving school, child care is a reason for not returning to school. Young mothers, who have to take care of their babies, and find it difficult to juggle student life and being a mother, ultimately drop out (Manzini, 2001). Various reasons for not returning to school have been explored, among them being a lack of a support structure, financial challenges and access to a Child Support Grant (CSG). Teenagers who do not have support from their families and struggle financially, usually dropout of school so as to provide for the baby and themselves (Swartz & Bhana, 2009). Studies in Brazil and Guatemala indicate that girls are forced to look for jobs to supplement family income and take care of the new family member (Hallman et al., 2005).

Young mothers who have support structures in the form of parents and grandparents have an opportunity of returning to school (Grant & Hallman, 2006; Grant & Hallman, 2008). The presence of an older female in the family enables learners to return to school, while the absence of the same forces them to look for alternative ways of making a living (Matthews et al., 2009). This is the same with teenage fathers who have accepted responsibility and have family that is prepared to support the child (Swartz & Bhana, 2009). The return to school in South Africa is motivated by a desire for a better life. Research evidence suggests that parents of black African teenage mothers usually send the teenager back to school, since she has a higher chance of fetching high bride price in the event that she gets married. In the black African belief system, an educated woman is bound to fetch a higher price than that of an uneducated one (Macleod, 2006; Mkhwanazi, 2010; Morrell, Bhana & Shefer, 2012). By having a baby at an early age, the teenager will have proven her fertility thereby increasing her chances of marriage in future (Kaufman, de Wet & Stadler, 2001). Interestingly, teenagers in Hlabangane's 2012 study in Soweto (South Africa) indicated that falling pregnant before marriage decreases the bride price, as prospective husband's consider the teenage mothers as 'used goods'. Reasons for returning to school after pregnancy may vary for both sexes, but the important part is that the teenager is back in school.

The effects of teenage pregnancy on the teenager vary for the young parents. The differences may lie in the financial circumstances of the teenager's family and on the part of the young father whether or not he accepts responsibility for the pregnancy. The consequences of dropping out of school for teenage girls due to pregnancy cannot be underestimated, "especially

in a continent where the adage when you educate a woman, you educate a nation holds true” (Hubbard, 2009: 223). The main thrust of this study is to understand why teenagers continue falling pregnant in the face of efforts by the South African government in trying to manage teenage pregnancy. In an effort to control and manage teenage pregnancy, the government has provided youth-friendly clinics, life skills programmes in schools and is currently on a much opposed drive to supply condoms in schools. Opposition to distributing condoms in schools comes from parents who fear that by distributing condoms in schools, learners will take this approach as license to indulge in sexual activities. It needs to be noted that sexual behaviour is rarely, if ever, governed by ‘permission’, whether there is tacit or explicit permission teenagers will still be sexually active.

In light of the efforts made by the South African government and a decade of spending on teenage pregnancy management, figures still indicate that teenage pregnancy rates are on the increase nationwide. Disruption of school, as a consequence of teenage pregnancy merits scrutiny in this study, as it will enable an understanding of teenagers’ perceived effect of teenage pregnancy on their lives.

Health risks

Research on health risks associated with early childbirth in teenagers is mainly divided into two main camps. One camp argues that teenagers are at risk of health problems due to their socio-economic status. The other camp, which is scientific, argues that age at first childbirth puts a young woman at risk of health problems as she is not mature enough to give birth, this may be prove fatal to both mother and child (Macleod, 2006). Some young mothers who have assisted births end up having obstetric complications such as haemorrhaging and damage to the womb. There is paucity of research in South Africa in terms of health risks associated with early childbirth (Macleod, 2006).

Age at first child birth contributes to a range of complications, including pregnancy-induced hypertension, anaemia, obstructed and prolonged labour, low birth weight, preterm labour and delivery, infant mortality, and maternal mortality (WHO, 2007). These complications are usually associated with the physical immaturity of teenagers. Limited access to health care services is another contributing factor to the range of complications teenagers face at child birth (Cameron et al., 1996). They state that “complications become more pronounced when the teenager decides to terminate pregnancy” (Cameron et al., 1996:83).

In South Africa, the *Choice on Termination of Pregnancy Act* (No. 92 of 1996) allows minors under the age of 18 years to terminate a pregnancy without the consent of either parents or guardians. Due to health personnel attitudes, teenagers are forced to have unsafe abortions, which may lead to death (Manzini, 2001). The absence of a support structure before and after termination may be the reason why teenagers resort to ‘self-administered terminations’ and this usually leads to irreversible damage to the womb or even death (Petiffor et al., 2005).

Sexually active young fathers face different health challenges from those of the young mother and child. Young fathers often have multiple and concurrent partners (MCPs) and this puts them at great risk of contracting and spreading HIV (Swartz & Bhana, 2009). However, they are quick to mention that impending fatherhood for those that have accepted responsibility is reason for behaviour change. Multiple and concurrent partnerships are one of the main drivers of the spread of HIV (Halperin & Epstein, 2007). Young men put themselves at risk by practicing unprotected sex with multiple partners who themselves may be part of a potential sexual network.

Young African American women who live in conditions of poverty are more prone to pregnancy related problems as they are unable to access pre- and post-natal care (Geronimus, Sanders & Marianne, 1992). This is different for teenage mothers who come from well to do backgrounds and have access to pre and post natal health care services. The difference in the economic status of teenagers has a huge bearing on their pre and post natal behaviour (Geronimus, Sanders & Marianne, 1992). Despite their socio-economic status, teenage mothers hardly ever access pre- and post-natal services (Macleod, 1999). This may be due to the ‘stigma’ associated with teenage pregnancy, and may be attributed to the attitudes of service providers. While studies may cite negative attitudes of staff towards teenagers (Wood & Jewkes, 2006), Ehlers (2003) paints a more positive picture, arguing that youth-friendly services initiated by South Africa’s Department of Health (DoH) have made great strides in addressing the stigma attached to adolescent sexuality.

The Child Support Grant (CSG)

Social grants or assistance can be best described as non-contributory cash transfer programmes set up by the government for the under privileged, aged or vulnerable (Grosh et al., 2008). Social grants are very important as they assist in alleviating poverty, reducing the level of vulnerability of vulnerable groups in society and providing social insurance to the vulnerable groups (Neves et al., 2009).

The CSG was first introduced in South Africa in April 1998 as a poverty alleviation strategy for the poorest children (DSD, SASSA & UNICEF, 2012). Initially restricted to children under the age of 7 years, it was later extended to include 14 year olds in 2003. The CSG pay-out in 2012 was R280 per month per child and is expected to increase to R300 by October 2013.

In South Africa, extensive debate surrounds the relationship between the CSG and teenage pregnancy with the media fuelling the opinion that teenagers fall pregnant to access the CSG (Macleod, 2006). Popular opinion states that the CSG has led to a perverse incentive for teenagers to conceive and go on to spend the money on personal goods (Macleod, 2006). In response to the media outcry, the Department of Social Development (DSD) commissioned research into the matter in 2006. The research concluded that there is no direct relationship between CSG and teenage pregnancy (Kesho Consulting, 2006). Makiwane and Udjo (2006) and Makiwane (2010) also argue that there is no evidence that the CSG leads to an increase in welfare dependency in South Africa, thus divorcing child bearing from the CSG. Furthermore, during the period in which the CSG has been offered, rates of termination of pregnancy have increased (Macleod, 2009). In 1998, when the CSG was introduced, abortion rates were at 4.1%, a decade later abortion rates were at their all-time high of 8.1 %, and in 2011 they were at 6.3%. The high rate of abortion amongst teenagers, in the face of the CSG, is evidence that there is no relationship between the CSG and teenage pregnancy (Macleod, 2009).

Research carried out by Matsidiso Nehemia Naong (2011) concurs with previous research that indicates that there is no link between the CSG and teenage pregnancy. In her study of three of South Africa's provinces (Free State, Mpumalanga and Eastern Cape), Naong's sample of 302 school principals and 225 Grade 12 learners indicated that there is no relationship between the CSG and teenage pregnancy. Instead, the study concluded that poverty, peer pressure and substance abuse contribute to teenage pregnancy. Naong concludes that teenage pregnancy and CSG are divorced and any influence between the two is negligible.

Anecdotal evidence suggests that more and more teenage girls are falling pregnant in an effort to access the CSG so as to complement household earning or in some instances the CSG is the main source of income. In such cases teenage pregnancy ceases to be unplanned and becomes planned and unwanted. In a 2005 study of CSG use in KZN, Case, Hosegood and Lund (2005) showed that 12.1% of pregnant teenagers who had conceived cited CSG as the reason. Tyali

(2012) in his study in Platfontein (South Africa) found that teenagers were deliberately falling pregnant so as to access the CSG, while others indicated that they wanted to be HIV positive so as to access the HIV/AIDS grant.

Research by Kanku and Mash (2010) in Soweto, South Africa, of teenagers' perceptions and understanding of teenage pregnancy, sexuality and abortion concurs with Tyali's (2012) conclusion that teenagers deliberately fall pregnant to access the CSG. Using a sample of 35 teenagers (24 girls and 11 boys), Kanku and Mash discovered that CSG was perceived as means of increasing household income. By having a baby, the teenager then contributes towards the household income through access of CSG. Interestingly, Marsh and Kau's research population indicated that the influence or pressure to bear children in order to access the CSG came from the family. On the other hand, other teenagers viewed CSG as a way of increasing the pocket money for clothes and cell phones.

The CSG has been credited with enabling teenager mothers to return to school. "The CSG is associated with an increase in school attendance and improved child health and nutrition. Thus, the grant can be associated with an improvement in the lives of children whose caregivers receive the CSG on their behalf" (Macleod, 2009:24).

CONTRIBUTING FACTORS TO TEENAGE PREGNANCY

The present study does not examine pregnant teenager's knowledge, attitudes and perceptions towards teenage pregnancy; instead it focuses on non-pregnant teenagers' knowledge attitudes and perceptions towards teenage pregnancy. Having said that, contributing factors to teenage pregnancy merit exploration as these factors shed light on knowledge, attitudes and perceptions towards pregnancy. Understanding how teenagers make meaning of pregnancy through their knowledge, attitudes and perceptions is important in particular if this understanding is viewed through the contributory factors to teenage pregnancy such as family relations, age at sexual debut and economic status.

Reductionist and revisionist approaches to teenage pregnancy ignore other non-sexual factors that contribute to teenage pregnancy. The following contributing factors were apparent in this review of the literature.

Family Relations

Family is an important unit for socialisation as it enables the sharing of beliefs and ideals to construct societal norms. Family relations are an important aspect in teenage pregnancy rates. Teenagers with single parents are prone to risky sexual behaviour, and pregnancy compared to those with both parents (Eaton, Flisher & Aaro, 2003; Hendricks, Swartz & Bhana (2010)). This may be due to shared responsibility of both parents, whereas in single parent families, control is vested in a single parent (see also Muchuruza, 2000). Where the single parent struggles to provide for the girl child, the girl is at greater risk of pregnancy as she has to search for means of survival and usually this is achieved through intergenerational relationships (Muchuruza, 2000). The major reason why teenagers engage in intergenerational relationships with older men and women is that they see them as providers of status symbols such as flashy cell phones and jewellery, while at the same time taking care of their basic needs. Such relationships jeopardise the health of the two people involved as the teenager is unable to negotiate for safe sex because of fear of losing their economic goals (Leclerc-Madlala, 2008). Most documented research on intergenerational relationships is between girls and 'sugar daddies'. These 'sugar daddies' feel that such relationships are transactional, hence there is no need for them to use protection (ibid). Such relationships leave the teenager vulnerable to HIV and AIDS, pregnancy, Sexually Transmitted Infections (STIs) and sexual manipulation.

A study by Bhana (2004) in Cape Town found that 66% of the teenagers reported that family norms enabled them to have people to advise them on how to live a constructive life, while 55% said that availability of family members acted as source of control for their sexual behaviour. This is evidence that family relations play an important part in the behaviour of teenagers and most importantly their sexual behaviour.

The presence of a responsible biological father encourages girls to delay their sexual debut and instils in boys a sense of sexual responsibility. The presence of a male figure in a household and their attitude to sexual behaviour plays an important part in influencing teenagers' sexual behaviour (Blum & Mmari, 2005). They found that girls with father figures who were against premarital sex were less likely to engage in premarital sex and experience unplanned pregnancy, compared to those with father figures who had sexually permissive attitudes and those without fathers. In the same context, Loving's (1993) investigation into the connection between family relationships and teenage pregnancy in Durban (South Africa), established that

warm relationships between fathers and their daughters played an important role in delaying young girls' sexual initiation.

Teenage girls whose mothers were teenage mothers themselves have a greater chance of being teenage mothers (Mfono, 1998). In the United Kingdom and America, the daughter of a teenage mother is one-and-a-half times more likely to become a teenage mother herself than the daughter of an older mother (Arai, 2008). This is due to the fact that these teenagers come from communities where it is 'normal' to be a teenage mother, since almost everyone has been or is a teenage mother (Hlabangane, 2012). The HSRC's (2008) study of perceptions towards teenage pregnancy in Johannesburg, Cape Town and Durban coincides with Hlabangane's conclusions that teenage pregnancy has been normalised in many communities. According to the respondents of the HSRC study, non-pregnant teenagers are viewed as the 'other', and are often asked when they too will be pregnant. Such attitudes make teenage pregnancy a way of life, and teenagers themselves view teenage pregnancy as a reality that forms a part of everyday life rather than an alien occurrence (HSRC, 2008).

This cycle self-perpetuates from one generation to another until it becomes 'acceptable and normal' for teenagers to fall pregnant. The intergenerational cycle is a result of a lack of upward mobility; upward mobility is an individual's ability to rise above their current social or economic position (Hlabangane, 2012). This 'low expectation' on the part of teenagers, perpetuates the intergenerational cycle of teenage pregnancy (Arai, 2008). She attributes this 'low expectation' to structural factors in deprived communities such as schools that fail to give teenagers a reason to feel entitled to anything. Knowledge, attitudes and perceptions of teenagers towards teenage pregnancy may be rooted in the 'lack of upward mobility' that Arai refers to.

In the United Kingdom, Arai (2008) notes that the low expectation argument for teenage pregnancy is a powerful one as evidenced by many British researchers (Garlick et al., 1993; Rosato, 1999; Selman, 1998; Smith, 1993; Wilson, Brown & Richards, 1991). She argues teenage pregnancy is very high amongst teenagers who do not have family support, come from broken homes, are raised by single parents, have difficulty with school and who come from socially disadvantaged backgrounds. Teenagers from such backgrounds have access to contraception and sexual health information, but display a deficiency in their knowledge of

sexual health, proper contraceptive use, are shy to engage in sexual health communication and are wary to access services for sexual health (Arai, 2008).

In a 1999 study in Northumberland, United Kingdom, it was discovered that teenage parents had low educational achievement and low expectations of their future before they became parents (Arai, 2008). These teenagers went on to have low paying jobs where they had to work long hours. In another Scottish study (Smith, 1993 in Arai, 2008) observed that teenagers from deprived backgrounds were six times likely to fall pregnant and then abort than their counterparts from well to do areas. These studies validate Arai (2008) and Hlabangane's (2009) notion of upward mobility and entitlement for more on the part of the teenagers.

In their study of attitudes towards HIV and AIDS and teenage pregnancy in KZN (South Africa), Rutenberg et al. (2003:5) conclude that "for some adolescents, increasing opportunities and aspirations for education and employment, in addition to the perceived risk of HIV and pregnancy, results in not wanting an early pregnancy". Rutenberg et al.'s study, validates Arai's (2008) and Hlabangane's (2009) assertion that teenagers with a low sense of upward mobility are most likely to find themselves as teenage parents while those with a high level of upward mobility are most likely to prevent themselves from early parenthood. This study will seek to unearth these varying dynamics in an effort to understand teenagers' attitudes towards other teenagers who fall pregnant.

Economic status

Pregnancies among teenagers are related to social problems, and this is predominant in developing countries and in particular poverty stricken communities. Risky sexual behaviours among teenagers are more likely to occur in poor families and those with single parents. Girls are forced to become sexually involved in an effort to get material gains due to a lack of resources (Jewkes, Morrell & Christofides, 2009). In South Africa low income families contribute to risky sexual behaviour among young people in both rural and urban areas (Hallman, 2005). The study argues that low income accounts for girls' decision to engage in risky sexual behaviour in trying to make ends meet. Young people from low economic status are most likely not to use condoms. This is attributed to lack of access to health services, reproductive health information and proper support structures from other social institutions (Macleod, 2009; Manzini, 2001)

Teenagers in intergenerational relationships find themselves unable to negotiate safe sex practices in fear of jeopardising their economic goals (Panday et al., 2009; Leclerc–Madlala, 2008). Many young women not only engage in risky sexual activities to meet their basic ‘needs’ such as money, food and clothing, but also to satisfy ‘wants’ such as expensive cell phones, high-class jewellery and rides in luxury cars (Hunter, 2002; Leclerc-Madlala, 2008). Chances of falling pregnant become high when the teenager comes from a home without adult supervision and most likely poor economic standing. Teenagers are at high risk of pregnancy if they come from financially disadvantaged backgrounds, or if they succumb to peer pressure to engage in sexual activities for economic gain ((Mfono, 1998).

Conversely, teenage girls reject the transactional sex talk and state that they are able to make do with what is available without having to engage in intergenerational and transactional relationships with older partners. Sathiparsad and Taylor’s (2011) study of 335 girls and boys in eThekweni Secondary Schools in Durban (South Africa) revealed that girls view themselves as independent and rational thinkers. These girls suggested that they do not think that sex is synonymous with love, and assert their power as individuals by their ability to say no to unprotected sex. This is indicative of girls resisting manipulation and normative submission (ibid). For the purposes of this study, how teenagers perceive economic status as a contributing factor to teenage pregnancy will be explored.

Gender Dynamics

The DoH’s Policy Guidelines for Youth and Adolescent Health (2001) locates gender considerations as fundamental to the health of young people. The policy guidelines identify sexual health and sexual exploitation, sexual abuse, gender-based violence, coercive sex and gang rapes as areas of concern that put young women in particular, at risk of HIV and AIDS and teenage pregnancy.

In their study of young women attending ante-natal clinics in Soweto, Dunkle et al. (2007) discovered that over half of the women aged between 15 and 30 years had been exposed to sexual violence. Another survey, conducted by the Planned Parenthood Association of South Africa (PPASA) in six of South Africa’s provinces, found that 20% of girls reported forced sexual encounters or were sexually assaulted (PPASA, 2003). Similarly, Vundule et al. (2001) found that 33% of girls have their first intercourse as a result of force, including rape. Where

there is unequal power distribution and lack of negotiation skills, pregnancy ceases to be a matter of choice.

Sexual violence alters the power relations in any relationship, and in most cases women are vulnerable and unable to negotiate for safe sex. Teenagers may avoid negotiating contraceptive usage, in particular condoms, for fear not only of violent reactions, but also of emotional rejection, of being labelled unfaithful or HIV positive (Wood, Maforah & Jewkes, 1998). Furthermore, women attempting to use other 'invisible' contraceptive methods, such as the injection, may be accused by their partners of causing 'infertility, 'disabled babies' and vaginal 'wetness', which diminishes male sexual pleasure (ibid). Clearly, men have the upper hand on sexual matters as women are constrained by their subordinate position in gender and social hierarchy, forced and coerced sex and inaccessibility of contraception (Jewkes et al., 2001; Wood & Jewkes, 2006 and Macleod, 1999). Sexual violence is more pronounced between young girls and their older partners, where the relationship is founded on material gain on the part of the teenager (ibid).

In light of contraceptive negotiation, teenagers are coerced into having sexual relations with their partners, leaving them vulnerable, not only to pregnancy, but to HIV. The men have control over sexuality, and as Wood and Jewkes (2006) suggest, some teenagers view coercive sex as an expression of love and an inevitable part of relationships. Sexual violence also increases the chances of repeat pregnancy. In Sweden, condom negotiation is also particularly difficult between teenagers and older partners and between teenagers themselves (Ekstrand, 2008). Ironically, Swedish teenagers agree that contraception is the responsibility of both partners, though some girls want the responsibility to be borne by the boys alone.

Bhana et al. (2008) challenge girls' submissiveness when it comes to sexual intercourse. They put forward that girls are not always the victims of boys' behaviour towards contraceptive use. Girls are also sexual agents, who engage with boys on a sexual level, make decisions and choices consensually and sometimes coercively (Bhana et al., 2008). Bhana et al.'s assertion validates Bhana and Swartz's (2009) conclusion that boys are also victims of girls who refuse to use condoms and even lie to get their own way when it comes to unprotected sex. Clearly, condom negotiation is a contested terrain and merits exploration in this study.

In their study of 335 teenagers in eThekweni secondary schools in Durban (South Africa), Sathiparsad and Taylor (2011) found that boys intentionally impregnated girls so as to 'mark'

these girls as their own and ensure ownership. This 'ownership' ritual is perceived as a method of warding off other boys and probably older men who are viewed as threats since they have more economic power than the teenagers. These boys consider themselves as in control of the decision making relating to when sex take places and what happens afterwards (Sathiparsad & Taylor, 2011). These young men's views on masculinity may be a product of socialisation, where young men are brought up to believe that they are better than their female counterparts, and that a man is always in control. Teenage pregnancy is best understood within the context in which it takes place. This means that for teenage pregnancy to be understood there needs to be an understanding of the background from which these young boys are coming from (Arai, 2008; Wood, Lambert & Jewkes, 2008). One such background is whether they are considered as the 'other' in the discourse around teenage pregnancy.

While South African male teenagers may impregnate girls as a sign of ownership and a sign of masculinity, Australian teenage boys perceive having babies as a sign of strengthening relations. In their study of 350 Australian teenage boys, Corkindale et al. (2009) found that Australian boys perceive having babies as a way of bonding with their partners though they are quick to agree that babies are a big responsibility that needs money, money these teenagers do not have. Corkindale et al.'s study is very interesting as these teenage boys deviate from the 'norm' where girls want to have babies to strengthen relationships and not the other way round.

Much discourse on teenage pregnancy focuses on the girls who bear and suffer the consequences of teenage parenthood. Very little is said about the males who go on with their lives with little or no disruption at all. Disregarding boys and men as part of the problem is retrogressive to the cause of managing teenage pregnancy levels (Masuku, 1998). Some schools in KZN make sure that if the father is a student at the same school, he is sent away together with the pregnant girl and come back when the girl also comes back after giving birth (Mpanza, 2010). While sending the responsible boy away together with the girl may appear to be fair, new social problems are created as the boy is unemployed and may resort to crime to make ends meet. "Sending the father away from school does not solve the problem at hand. It may be 'justice' but it creates new social problems such as youth delinquency" (Mpanza, 2010:15). In their Cape Town study of teenage boys' attitudes towards pregnancy, Swartz and Bhana (2009) conclude that teenage fathers feel a moral responsibility to take care of the new family though they are unable to do so.

Age at first sex/ Sexual debut

Age at first sex has been identified as another contributing factor to teenage pregnancy. For girls, early age at onset of menstrual cycle increases the possibility of pregnancy at an early age and the risk of contracting HIV. The mean age of onset of menstrual cycle in South Africa is 13 years, and the mean age at first sex is 17 years for girls and 16 years for boys (Petiffor et al., 2004). Petiffor et al.'s (2004) survey on HIV and sexual behaviour among young people in South Africa explored sexual behaviour and perceived risk towards HIV infection. The survey concluded that young people are at risk of HIV infection, and possibly teenage pregnancy because they have low self-efficacy and under estimate their risk to HIV and other STIs. It was also found out in the survey that age at sexual debut increases chances of teenage pregnancy.

Age at sexual debut is affected and influenced by various protective and risk factors. A positive relationship with parents and teachers, holding spiritual beliefs and attending school is associated with a decrease in the likelihood of early sexual debut. In contrast, risky sexual behaviour, lack of adequate information on sexual health, low economic status and having sexually active friends is associated with early sexual debut (WHO, 2008).

Early sexual debut is a risk factor for unwanted and unplanned teenage pregnancy. Unequal power relations in the relationships young women find themselves in contributes to early sexual debut (Macleod, 2009). "Timing of adolescent sexual debut is an important factor in the teenage pregnancy discourse as it affords teenagers an opportunity to at least have information on sexual health" (Raffaelli & Crockett, 2003:2). Crockett concludes that at sexual debut, teenagers do not use protection due to lack of sexual health information. Teenagers at first sex do not know the consequences of engaging in sexual activities and are 'saddened' when they have to deal with the results (Swartz & Bhana, 2009).

Peer pressure is a crucial factor in age at first sex. Teenagers with sexually active friends find themselves giving in to pressure to engage in sexual activities. Pressure is increased where the girl comes from an impoverished background, and is driven by the desire to 'change' their circumstances and fit in the circles. Dlamini et al. (2009) conclude that friends influence the decision to engage in sex. Teenage years are a critical period in the exploration and development of gender identity. For this reason, in the context of poverty and limited alternatives, securing and maintaining sexual relations is critical to both girls and boys (Wood & Jewkes, 2009).

Delaying sexual debut has been proposed as a means of curbing unwanted and unplanned pregnancies (Dlamini et al., 2009). However, as indicated earlier, this is complex as teenagers' sexuality is affected by various reasons "ranging from peer group influences which may contribute to acceptance of sexual aggression and the male dominant culture" (Dlamini et al., 2009: iii). Given the desire to manage and reduce teenage pregnancy prevalence, uncovering factors associated with sexual debut delay merits exploration in the study.

Contraception

Teenagers are aware of contraceptives in all their various forms (Rasch et al., 2000; Jewkes et al., 2001; Manzini, 2001; Dunkle et al., 2007; Mfono, 1998; and Macleod, 2011). However, statistics on contraceptive use, teenage pregnancy and HIV infection rates indicate that contraceptive use is erratic (Petiffor et al., 2004). Knowledge is an essential, but not sufficient, element for effective contraceptive usage (Macleod, 2009). As discussed earlier, knowledge also does not translate to health affirming behaviour. This also merits investigation in the study using a broader theory that does not ignore non-sexual factors that may influence teenage pregnancy.

Contraceptive use is a highly contested domain for most adolescents, and as a result preventing an unwanted pregnancy that may result in abortion is not that easy. This is primarily due to factors such as schools, churches, non-governmental organisations, nurses, adolescent girls' mothers and male sexual partners who may play a pivotal role in the decision making process, and may send contradictory messages to adolescents such as contraceptives can 'completely block the tubes' (Warenuis et al., 2006; Woods & Jewkes, 2006).

Emphasis has been placed on condom education since the condom serves a dual purpose as it protects against pregnancy and contraction of STIs. Rutenberg et al.'s (2001) household survey in Durban and Mtunzini (South Africa) assessing young people's understanding of pregnancy risks, found that 8% were aware of the menstrual cycle and the times a woman is most fertile for pregnancy. The research sample comprised of blacks, Indians and whites, the research was conducted in waves and the age groups were as follows, waves 14-18, 14-24 and 14-22. Knowledge increased with age, with the white population having more knowledge than other races. At least 80 % of the sample (both girls and boys) knew that a woman can get pregnant if she has sex only once. Most of the sample (99%) knew of at least one method of family planning, and 72% could name more than two types of contraceptives. The pill, condom and

injectable contraceptives were most frequently cited, and abstinence, non-penetrative sex and withdrawal method were mentioned by less than 6% of the respondents (Rutenberg et al., 2001). Although teenagers might have knowledge on contraceptives, the quality of understanding and level of awareness varies considerably (ibid).

In the United Kingdom, teenage pregnancy and teenagers' attitudes towards contraception are best explained by reference to the effect of sexual attitudes and knowledge on sexual behaviour (Arai, 2008). Even in the developed world, teenage pregnancy is a result of contraception ignorance, service provider attitudes, peer pressure and sexual embarrassment (ibid). She argues that the solution to teenage pregnancy lies with improved sexual health service, greater use of contraception and increased sexual health knowledge. She however cautions that "these factors would not on their own, reduce teenage pregnancy" (Arai, 2008:6). Arai advocates for a more comprehensive and holistic approach to the handling of teenage pregnancy because a "linear solution does nothing at all at dealing with the problem" (Arai, 2008:9).

Maria Ekstrand (2008) studied perception of teenage pregnancy, abortion and contraceptive use among Swedish teenagers and her results correspond with those Arai (2008) got from her study of United Kingdom teenagers. Teenage pregnancy in Sweden is a result of inconsistent use of contraceptives despite the fact that they are readily available (Ekstrand, 2008). Swedish teenagers also have a healthy mistrust of condoms as they are associated with infidelity (ibid). She concludes that teenagers have negative attitudes towards teenage pregnancy as they acknowledge that teenage pregnancy affects future prospects. However, girls have a mistrust of the pill as a contraceptive method as they fear the side effects of the pill. According to Ekstrand, there are still some lingering misconceptions towards contraception as some teenagers believe that they can take breaks from taking contraceptives but still remain protected against pregnancy.

Like in Sweden, misconceptions surrounding contraceptive use still abound in South Africa as evidenced by Oni et al.'s (2005) research on high school students' attitudes, practices and knowledge of contraception in KwaZulu-Natal. At least 21% of the girls in Oni et al.'s study knew that they could fall pregnant after missing their contraceptive pill, while another 12% believed they could not fall pregnant on their first sexual encounter. Clearly, there are some misconceptions, and it is these misconceptions that give rise to unwanted and unplanned pregnancies. Teenagers are exposed to 'sexual myths' such as not falling pregnant the first time

one has sex, having sex standing and withdrawal before ejaculation prevents conception (Richter & Mlambo, 2005). Teenagers believe these myths and have a false sense of security thus indulging in unprotected sex.

Contraceptive use among teenagers

The DoH provides free condoms and a social marketing programme, Society for Health (SFH) provides *Lovers Plus* condoms at a highly subsidised rate (MacPhail & Campbell, 2001). In South Africa, “dedicated condom distribution vans that dispense outside of clinic settings have, however, been discontinued, and it is possible that this has lowered access to the service” (Macleod, 2001: 13). Oral, injectable and emergency contraceptives are also available, free of charge, at government run family planning clinics. At the same time, female condoms (Femidom) are not widely available – an unavailability that, has the potential to lessen the ability of girls to negotiate safe sex as the power is taken away from them by mere unavailability of the femidom. Indeed, access to the femidom seems especially difficult for young women who have to negotiate the negative attitudes of nurses at local clinics, while social norms prevent them from carrying condoms (Macleod, 2011).

Condoms can be sourced from a variety of places, including friends, retail stores, clinics, clubs and schools. This was confirmed by participants in MacPhail and Campbell’s (2001) focus group discussion in Khutsong (South Africa) who reported receiving male condoms from a variety of sources, including friends, schools and retail stores. The research sample comprised of 44 young people in the 13-25 age group. However, the majority made use of the free condoms from the local clinic. Despite the apparently ready availability of condoms, participants still reported having unprotected sex because they had not been able to access condoms. While free condoms are readily available, the lower economic level of young people in general prevents them from purchasing condoms should free condoms not be on hand. Interestingly, teenagers in the HSRC 2008 study on perceptions towards teenage pregnancy said they did not trust the free contraceptives from government and preferred to use the commercial condoms like Durex, Lifestyle and Crown. Of interest in such scenarios is that these teenagers do not have the financial means to afford commercial condoms and yet they do not trust the subsidised condoms provided by government. The cost of condoms is a barrier to access to condom and mistrust of subsidised government condoms is a barrier to condom use, it will be interesting to find out how teenagers perceive this dynamic in the study.

Wood and Jewkes (2006), reporting on South African research conducted in the late 1990s, cite the scolding, stigmatising and harsh treatment of young women at government family planning clinics as a reason for the poor access of these services by young people. The negative attitudes of clinic nurses toward young women were also noted by MacPhail and Campbell (2001) in their study of Khutsong teenagers' attitudes towards HIV and contraception. The stigma attached to youth sexuality may also contribute to young people's unwillingness to access these services. "It is not that contraceptives are not accessible, they are everywhere, but the attitudes of nurses and fear of being seen by community members who might judge these teenagers and report to their respective family members prevent teenagers from accessing contraceptive" (HSRC, 2008: 25). It is these fears and the attitudes of the nurses that essentially make contraceptives inaccessible to teenagers.

However, Ehlers (2003) paints a more positive picture of health service provision by South African clinic nurse staff. In a Pretoria sample of adolescent mothers, Ehlers (2003) found that the majority waited only 30 minutes to receive assistance at a family planning clinic, and 86% experienced nurses as very helpful. Only 6.4% waited two hours or longer, and only 15% reported dissatisfaction at the services they had received. Given that the youth-friendly initiative by the DoH was launched in 1999, it is possible that this initiative has had some positive effects in some areas.

Though contraceptives are available from many sources, Mfono (1998) found that Gauteng teenagers frequenting urban family planning centres had only visited the centres after several sexual encounters. There are barriers against young people freely accessing services, possibly including financial resource constraints, stigmatisation by service providers, difficulty in travelling long distances to reach a clinic, and difficulty in getting to the clinic during school hours.

High teenage pregnancy rates despite the use of contraceptives may be a sign that there may still be unmet contraceptive needs, including intermittent use of contraceptives and interruption in supply (Rasch et al., 2000). The non-availability of and reluctance to use contraceptives are contributing factors towards the increase in teenage pregnancy (Hickley, 1997; Palamuleni, 2002). Reluctance to use contraceptives may be attributed to lack of proper information on contraceptive use, as well as perceptions and attitudes towards contraceptives. Reasons for non-contraceptive use include, religious and cultural beliefs, poor quality of services, including the

negative attitude of service providers, fear of exposure of their bodies, having adults at the same services and inability to negotiate contraceptive use with sexual partners. Furthermore, misconceptions, fear of side effects and stigma associated with the use of contraceptives as adolescents may be labelled as being promiscuous can also be considered as contributing factors for non-contraceptive use (Chonzi, 2000; Paz Soldan, 2004). There are many misconceptions associated with the lack of information regarding sexual reproductive health. Some of these include oral contraceptives and Intrauterine Device (IUD) causes cancer, use of contraceptives before childbearing leads to infertility, and condoms disappearing in the woman's body (Chonzi, 2000).

Swartz and Bhana (2009) in their study on teenage fathers in Cape Town (South Africa) indicated that boys tend to believe information from their girlfriends about contraception use. Girls in turn tend to lie to their boyfriends about their contraceptive use for fear of rejection (Mfono, 1998). The lies that abound in the discussion about contraception among teenagers are a testimony to the complexity of teenage sexuality as these beliefs and 'lies' are a product of other factors.

Conscious non-contraceptive use has been another factor affecting contraceptive use and in particular the condom. The use of condoms is viewed with reluctance as teenagers prefer to have 'skin to skin' or 'meat to meat' sex (Swartz & Bhana, 2009). Unprotected sex increases sexual pleasure and protected sex is equated to 'eating a sweet in its wrapper' (ibid).

In their study of teenagers' attitudes towards HIV, contraceptive use and teenage pregnancy, in Durban, Sathiparsad and Taylor (2011) found that at least 44% of the 335 teenage boys and girls agreed that desire and fun clouded their ability to think rationally when it comes to protection. Sathiparsad and Taylor's study also revealed that 72% of the males and 55% of the females had negative perceptions towards condoms as they interfered with 'pleasure'. Teenagers opt to have unprotected sex regardless of the high risk of HIV infection and pregnancy (Sathiparsad & Taylor, 2011). The gender differences in perceptions towards condoms in Sathiparsad and Taylor's (2011) study are very significant, indicating that boys have more negative attitudes towards the condom more than the girls. Such attitudes may contribute to the gender dynamics of condom use where girls are unable to negotiate safe sex. Attitudes towards the male condom may also stem from the fact that the male condom is

‘readily available’ compared to the female condom. Attitudes towards condom use in general may also stem from trust issues with in teenage relationships.

Trust issues between couples are another factor that significantly affects condom use among teenagers. There is an overarching perception that condoms threaten trust and intimacy between partners (Varga, 2000). Indeed, not using condoms may also be taken as a sign of seriousness and trust within a relationship, while the desire to use one is viewed as a sign of infidelity (Varga, 2000; Swartz & Bhana, 2009; Ekstrand, 2008; Wood & Jewkes, 2009). In essence teenagers find themselves caught between a desire to maintain and hold a relationship by having unprotected sex, while on the other hand there is a genuine desire to protect themselves from STI infection and pregnancy.

Inconsistent contraceptive use among teenagers has been identified as one of the reasons for teenage pregnancy (Varga, 2000; Swartz & Bhana, 2009; Wood & Jewkes, 2009). However, reasons for inconsistent contraceptive use are diverse and complex hence they are not easy to characterise. The ‘ideal’ contraceptive for teenagers is the one that is “safe, provides adequate protection, is reversible, carries minimal side effects, is inexpensive, convenient and can be obtained and used in a private manner” (Arai, 2008:12).

Negative perceptions of teenage pregnancy are most likely to motivate teenagers to use contraception consistently, while the opposite is also true (Varga, 2000; Wood & Jewkes, 2009). That being said, analysing knowledge, attitudes and perceptions towards contraceptive is important as contraceptives play an important role in pregnancy prevention.

Sources of information on sexual behaviour and contraceptive use

Central to tackling existing gaps in teen pregnancies and access to contraceptives is education and information dissemination (Brooke et al., 2006). Teenagers are exposed to information regarding sexuality and contraception through various sources. Sources of information include parents, friends, the media, and institutional sources such as school and church. Since 2002, South Africa has had a publicised and well-coordinated sex education programme, though it still struggles with high teenage pregnancy rates. Parents and caregivers are encouraged to speak openly to their children about sexuality as they are the primary sources of information. However, Macleod (2009) argues that this is an unrealistic expectation as parents are unable to do so because of various reasons, one of them being culture, an issue which will be discussed later on in the chapter.

“Certain issues including pregnancy, premarital sexual intercourse, contraception, sexual harassment and molestation are taboo family subjects in certain cultures in South Africa” (Madu, Kropiunigg & Weckenmann, 2002:88). The curtain of silence drawn over these issues results in anxiety, fear and misconceptions ultimately leading to unplanned and unwanted pregnancies. However, Macleod (2009) paints a rosy picture and notes that there are programmes that have been put in place to ensure that there is frank discussion between parents and teenagers concerning sexuality. These programmes include the Planned Parenthood Association of South Africa and Love Life’s Born Free dialogues.

Teenagers state that they have discussions on sexuality with their parents, though there is no clarity on certain issues and no room for further consultations (MacPhail & Campbell, 2001). Female participants of MacPhail and Campbell’s (2001) Khutsong focus group discussions indicated that they were informed to stay away from boys, and abstain with no emphasis being placed on contraception. The perception that talking about contraceptives gives teenagers the license to engage in sexual activities is cited as one of the reasons elders are reluctant to talk about sexuality. MacPhail and Campbell (2001) further suggest that adult surveillance impinges on contraceptive use and knowledge. Adults pass on information to relevant others about young people’s visits to family planning clinics, and about these young people’s suspected relationships and other indicators of suspected sexual activities (MacPhail & Campbell, 2001). Parents may then reprimand teenagers over their sexual behaviour. Adults’ attitude towards teenagers’ sexual behaviour prevents young people from accessing clinics for contraceptives and sexual health information.

Where young people cannot access information from their parents, they tend to turn to their friends for information. Peer information is regarded as a double edged sword. Some information from peers is well meant and placed as they encourage each other to use contraceptives. On the other hand, peer information is fatal as they are misinformed themselves, and tend to pass on the same (mis)information to their peers. Peers bar young girls who are not sexually active from conversations of a sexual nature, perpetuating the mystification and silence surrounding sex (Wood, Maepa & Jewkes, 1997). They contend that this mounts pressure on the uninitiated to have sex so they can also be included in these ‘circles’. Male partners may take advantage of the information lapse and emphasize notions of female availability and male sexual entitlement (Jewkes et al., 2001).

Mass media, including magazines, radio and television broadcasts, provide useful sexual and contraceptive information to young boys and girls. Rutenberg et al.'s 2001 survey in Durban and Mtunzini showed that 52% of the respondents had received information on contraceptives from the mass media. Oni et al.'s (2005) smaller survey on high school learners' attitudes, knowledge and practices of contraception in Jozini, KwaZulu-Natal (South Africa), suggests that the reception of such messages may be gendered, with 54.2% of male and only 21.5% of female respondents reporting that they had received a television or radio message about contraception.

Institutional sources, such as life skill education in schools has also been somewhat effective in promoting sexual and reproductive health knowledge and perceived condom self-efficacy in South Africa (Magnani et al., 2005). They however note that effectiveness of life skills education is not uniform across board with some areas having not received life skills packages (ibid). This non-uniformity affects teenagers who are coming from areas where sexual health information is already limited, the decrease in sources of information may somewhat increase misconceptions and myths concerning sexual health and in particular pregnancy prevention.

Health care centres are other sources of information on sexuality. However, they have been under the spotlight for their attitude towards young women who visit clinics in search for contraceptives and any other information. "Indeed, access to contraceptives seems especially difficult for young women who have to negotiate the negative attitudes of nurses at local clinics, and social norms prevent them from carrying condoms" (Macleod, 2011:29). However, Mkhwanazi (2010) disputes this, arguing instead that teenagers do not go to clinics with an open mind. In fact, teenagers are the ones who have negative attitudes towards contraception (Mkhwanazi, 2010). It is such attitudes, supposedly, that put teenagers at risk of pregnancy (see Wood & Jewkes, 2006; MacPhail & Campbell, 2001; Macleod, 2011) on negative attitudes of nursing staff. While studies may site negative attitudes of staff towards teenagers, Ehlers (2003) paints a more positive picture, arguing that youth-friendly services initiated by the South Africa's DoH have made great strides in resolving the animosity between health care providers and teenagers.

While services are more plentiful in theory and favourable to girls, there is a dearth in services for young men and failure to provide them with proper health education (Swartz & Bhana, 2009). It is indisputable that health care centres are more women-friendly and are frequented

by more women than men who are going about their health care needs (Quinton, 2002). Such an environment marginalises young men who then opt to rely on friends for information. The mixed messages that young men get from society concerning health and masculinity make them shirk their responsibility when it comes to contraception, and claim it to be the responsibility of the girl (Kiseleca & Sturmer, 1993). It is ironic however to note that it is these same young men who claim that contraception is the responsibility of the woman, who later in life deny women these contraceptives claiming that contraceptives make the ‘vagina wet’ and condom use interferes with sexual pleasure (ibid).

Health seeking behaviour of young men is also affected by beliefs they continue to hold. Traditionally men who seek health services are viewed to be weak and this affects their ability to seek health care services as they strive to keep up appearances (Mfono, 1998). They worry about what other men believe, and how they will be viewed in light of their visits to health care services. It is for these reasons that boys are wary to visit health care centres for help (Swartz & Bhana, 2009). While (Swartz & Bhana, 2009) acknowledge the existence of youth-friendly centres and male sensitive health services, they point out that their effectiveness is in question given the policy debates surrounding them.

In response to calls by earlier researchers for the establishment of youth-friendly services, the National Adolescent Friendly Clinic Initiative (NAFCI) was conceptualised and implemented between 1999 and 2005 (MiET Africa, 2011). At least 350 NAFCI sites had been established in South Africa by 2005 and 13% of these in KwaZulu-Natal (ibid). In an evaluative study of NAFCI services in Limpopo, Baloyi (2006) found that teenagers were making use of these clinics, though rates of teenage pregnancy did not decrease. It is this lack of change in teenage pregnancy rates inspite of the concerted efforts by government and stakeholders that this study seeks to understand through the eyes of teenagers.

Teenage pregnancy, culture and race

In most black African societies, young women of all ages experience pressure to have children and this cultural demand may further contribute to teenage pregnancy (Preston-Whyte, 1991). Importance is placed on fertility and procreation, such that young women may be labelled as ‘barren’ if they do not conceive (ibid). Pregnancy is then viewed as a rite of passage, as the epitome of womanhood and raises social status. It is this desire to gain social status that may encourage teenagers to stop using contraceptives, and end up falling pregnant. Such pregnancies become planned though unwanted. However, this does not remove the gravity of

teenage pregnancy whether wanted or unwanted, planned or unplanned. Some girls may also become pregnant to prove fertility in order to attain the status and acceptance as a woman in a society (Wood & Jewkes, 2006). Pressure to prove fertility is not one sided, boys get the pressure from cultural customs to be fathers at a young age to prove their masculinity.

Culture, mainly through expectations of families and communities, may play a major role in shaping sexual and reproductive behaviour of adolescents. Initiation ceremonies teach girls about responsibilities of adults and mothers, importance of children in a relationship and sexual intercourse, while abstinence is called for until marriage (Munthali & Chimbiri, 2003). Furthermore, these ceremonies reinforce the perceived passive roles that a woman must play in their sexual and marital relationships, obedience and satisfying the sexual desire of a partner (Hickely, 1999).

The collapse of cultural practices, change in cultural values and disintegration of the cultural systems of people also contributes to teenage pregnancy, as teenagers mingle freely (Mashau, 2001). He argues that some of the control measures in the cultural systems ensured that there was no mixing of the sexes yet maintaining a semblance of order.

Hlabangane (2012) rejects the notion that teenage parenthood is a rite of passage to adulthood and it is a social state coveted by young people for the privileges it bestows them as alluded to by Preston-Whyte and Zondi (1992), Varga and Makubalo (1996) and Wood et al. (1997). Instead she argues that culture is a lived experience, a culmination of everyday experiences and that it changes since culture changes. She puts forth that teenagers expressed how their families make them feel 'bad', 'ruined', 'rejected', 'stigmatised' or 'like a failure' for becoming pregnant. Such revelations from the teenagers themselves are an indication that notions of 'culture' and teenage pregnancy have changed over the years.

Teenage pregnancy in South Africa has been labelled a 'black phenomenon or problem' (Macleod & Durrheim, 2002). The reasons behind this claim may be because black people make up the greater portion of the South African population compared to other races. Macleod and Durrheim (2002) assert that pregnancy is labelled a black problem because other races are 'intolerant' of pregnancy, and mainly because blacks are the majority. "Anecdotal evidence suggests that teenage pregnancy (and to some extent premarital sex) is generally very much less acceptable among white and Indian families" (Macleod & Durrheim, 2002:16).

Naong (2011) concurs with Macleod and Durrheim (2002) that teenage pregnancy prevalence is high in black and coloured schools and is very low in Indian and white dominated schools. She attributes the difference to the no tolerance stance taken by Indian and white parents towards teenage pregnancy. She notes that in white families, there is openness when it comes to sex communication and that white teenagers use contraceptives more consistently than do their black and coloured counterparts. She further observes that in Indian families, teenagers are either made to abort or get married when they fall pregnant; hence teenage pregnancy becomes more of a 'black and coloured phenomenon'. Hlabangane (2012) differs from Naong's observation and notes that structural differences and inherited apartheid differences best explain the differences in the teenage pregnancy rates among races in South Africa.

There has been little research done in South Africa as far as teenage pregnancy and race is concerned because among the white and Indian communities, teenage pregnancy is not a 'problem' (Macleod & Durrheim, 2002). This study is concerned with black and coloured teenagers' perceptions and attitudes towards teenage pregnancy.

CONCLUSION

This chapter mainly discusses the documented factors in literature that influence and impact on adolescent sexual behaviour and teenage pregnancy. Unlike the traditional KAP structure of isolating the individual from structural factors that influence and affect teenage pregnancy, this chapter sought to maximise on the structural determinants as possible avenues for exploration in this study. Teenage pregnancy has consequences for teenagers such as health risks and disruption of school. Health risks for the teenage mother include complications, including pregnancy-induced hypertension and anaemia (WHO, 2007). Teenage fathers are at risk of HIV infection and other STIs, especially if they have MCP, which usually is the norm for teenage boys who have MCPs as a sign for masculinity.

Another consequence of teenage pregnancy is school disruption, which disadvantages the girl child more than the boy child. Boys can still continue with their education even if they have accepted responsibility for the pregnancy or not though some have been known to drop out of school so as to fend for the mother and the baby. Girls on the other hand are protected by the Measures for the Prevention and Management of Learner Pregnancy (2007), which essentially allows them to staying school while pregnant. The CSG is a controversial subject with some

proposing that there is no relationship between the grant and teenage pregnancy, while other scholars like Tyali (2012) indicate that there is a link as teenagers do get pregnant to supplement household income and to increase their own pocket money.

The chapter also explores the contributing factors to teenage pregnancy. According to the HSRC (2008) contraceptives like the male condom and injections for the girls are easily accessible, but teenagers fear the attitudes of the nurses at the clinics. The other reason why teenagers are wary to access contraceptives at government clinics is discovery by community members who will in turn tell their parents. While teenagers do not use contraceptives consistently, Panday et al (2009) speculate that the reason behind inconsistent use maybe because teenagers have negative attitudes towards ‘government (supplied) condoms’ and prefer to use commercial condoms like the Durex and Lifestyle, which they usually cannot afford because of their economic status. Male partners have a strong influence in sexual relationships, thus making safe sex negotiation difficult for girls. Because of the gender dynamics inherent in relationships, condoms are stigmatised because of trust issues (Varga, 2000; Swartz & Bhana, 2009; Ekstrand, 2008; Wood & Jewkes, 2009; Arai, 2008). Gender stereotypes also play a role in determining social expectancies and values towards sexual health behaviour for instance, it is acceptable for boys to be sexually active, while girls are expected to be chaste. Sexual health communication is hampered by culture and thus is considered taboo to be discussed between teenagers and parents, leaving teenagers at the mercy of friends who may be misinformed themselves (Madu, Kropiunigg & Weckenmann 2002).

Lastly the chapter discussed race, culture and teenage pregnancy. While teenage pregnancy is considered a ‘black problem’, Macleod and Durrheim (2002) , Naong (2009) and Hlabangane (2009) all agree that inherited apartheid systems that disadvantaged the black races is the reason why teenage pregnancy is termed a black ‘problem’.

CHAPTER 3- THEORETICAL FRAMEWORK

INTRODUCTION

Health behaviour change is infamously difficult to achieve simply because human nature is never easy to predict, even when communities have the information on prevention and care at their disposal (Panter-Brick et al., 2006). This is because human behaviour is influenced and affected by various factors, which cannot be explained using a singular approach. In an attempt to explain health behaviour, numerous models and theories have been developed and designed. These models and theories can be grouped using stages of influence. Individual or intrapersonal health behaviour models include the Health Belief Model (Rosenstock, 1966), the Theory of Reasoned Action (Ajzen & Fishbein, 1980) and the Theory of Planned Behaviour (Ajzen, 1985). The next level consists of interpersonal health models or theories, which include the Social Learning/Cognitive Theory (Bandura, 1977), and finally multi-approach models, such as the Social Ecology Model (McLeroy et al., 1988).

These theories aim to explain and account for the different determinants that affect and influence health behaviour. In a multi-cultural society such as South Africa, health behaviour analysis and determination becomes somewhat difficult as there is a need for culturally sensitive theories and models that result in culturally compelling interventions (Kunda & Tomaselli, 2012; Tomaselli & Chasi, 2011). Teenage pregnancy in its nature, presents problems that cannot be understood at a surface level, but require analysis via a multi-level approach that links human behaviour and the environment, as well as an individual level approach that focuses on the individual's beliefs, knowledge and attitudes.

This chapter explores the models that this study uses to explore teenagers' knowledge, attitudes and perceptions towards teenage pregnancy. The Social Ecology Model is applied to understand teenagers, their environment and how both affect the other in terms of teenage pregnancy knowledge, attitudes and perceptions. The Health Belief Model is used in this study to understand on an individual level, how teenagers perceive teenage pregnancy, their understanding of teenage pregnancy and their attitudes to it.

THE SOCIAL ECOLOGICAL PERSPECTIVE

The ecological perspective places emphasis on the interaction and interdependence between and across the social spectrum. It regards health behaviour as a result of the interaction between people and the environment they are exposed to, hence the understanding of health is incomplete without an appreciation of the environment (National Institute of Health, 2005). The ecological perspective has its roots in Urie Bronfenbrenner's (1979) Social Ecological Theory. Bronfenbrenner used his theory to describe the development of children by studying the external influences that aid or militate against child development. The Social Ecology Model was later adapted from Social Ecological Theory to suit public health communication and intervention design (McLeroy et al., 1988).

Through the lens of the ecological perspective, an opportunity to examine the effects the environment has on social change and organisation is afforded to the researcher, making it easier to plan accordingly should there be a need for intervention. Central to the ecological perspective is the assumption that people are affected by their environment, and they in turn affect it too. "The problems people face or experiences in social functions are a result of the people-environment exchange rather than being a result of individual interaction" (Sallis, Owen & Fisher, 2008: 92). This effect that people and the environment have on each other is called reciprocal causation (*ibid*).

Developed by Albert Bandura in 1986, reciprocal causation also known as reciprocal determinism is a concept stemming from Bandura's Social Cognitive Theory (1986). Bandura argues an individuals' behaviour affects and, is in turn, affected by the social environment and personal factors. Personal factors such as beliefs and expectations influence and affect behaviour change while social environmental factors such as the economic, social and health factors have been known to regulate human behaviour. This connection between the individual and the environment and how they affect and influence each other is then called reciprocal determinism or reciprocal causation.

The last two decades have seen an increase in the interest in ecological models, mainly because of the promise ecological models offer of guiding comprehensive health interventions that help reduce health problems (Sallis, Owen & Fisher, 2008). Ecological models have been credited with the successful improvement of health behaviour such as repeat teenage pregnancy, cancer screening, healthy eating and exercising (Sallis & Owen, 1997; Smedley & Syme, 2000; and

Ranieri & Wiemann, 2008). This experience has prompted the application of ecological models to health and social problems such as diet, violence, bullying, malaria control and cancer screening (Sallis, Owen & Fisher, 2008). This is because the ecological perspective is the response to the gap left by individual level theories and models such as the Health Belief Model, Social Cognitive Theory, the Trans theoretical Model and the Theory of Planned Behaviour (Sallis, Owen & Fisher, 2008; McLeroy et al., 1988; and Glanz, Rimer & Lewis, 2002).

The social ecological perspective is inherently interdisciplinary as it has other disciplines embedded in it such as economics, psychology, sociology, and anthropology (McLeroy et al., 1988). This perspective thus encourages researchers to include the socio-cultural contexts of people's environments so as to come up with comprehensive interventions. It is against this background that this study draws from the social ecology perspective and employs the Social Ecology Model to explore teenagers' knowledge, attitudes and perceptions towards teenage pregnancy in a school setting.

THE SOCIAL ECOLOGY MODEL

The Model not only assumes multi-levels of influence, but also that these levels are interactive and reinforcing (Stokols, 1992 and 1996). In addition, the Model divides the environment into five spheres that influence and in turn are influenced by health behaviour (McLeroy et al., 1988). The five levels are: (1) the individual (2) the interpersonal; (3) the institutional or organisational; (4) the community; and (5) the policy level. The Model assumes that changes at the appropriate levels will result in changes in the individual, and as individuals change, the level characteristics also change, and this is reciprocal causation that Sheafor et al. (2009) and Bandura (1986) refer. The social, physical and cultural aspects of environment have a collective effect on health (Stokols, 1992; 1996).

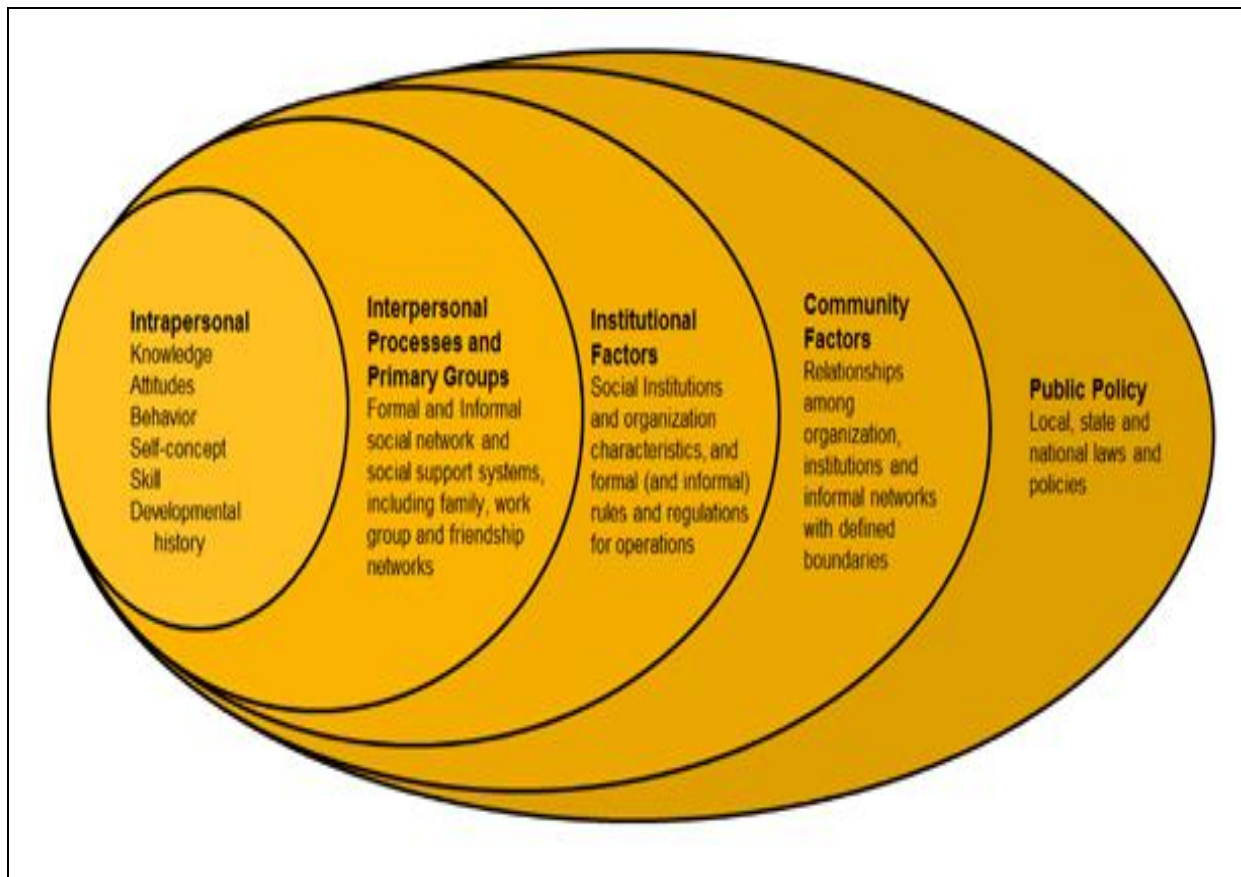


Figure 1: The Social Ecology Model McLeroy et. al (1988)

Individual/Intrapersonal Level

The individual or intrapersonal is the first level of the Model, and deals with the basic individual factors that have the potential of influencing behaviour such as beliefs, attitudes, knowledge and personality traits (McLeroy et al., 1988). Intrapersonal factors usually are located within the realm over which the individual has control, though these factors can be influenced by other levels of influence. For instance, in studying factors influencing diet and physical activity, Shepherd et al. (2006) found that lack of nutritional knowledge, attitudes towards certain healthy foods such as vegetables and fruits, perceptions of being already fit and lack of self-confidence to carry out specific diet regimes were barriers to uptake of healthy eating and exercise. Similarly, teenagers' attitudes and perceptions towards contraceptive use may hinder them from using contraceptives properly (Rasch et al., 2000; Jewkes et al., 2001; Manzini, 2001; Dunkle et al., 2007; Mfono, 2008).

For the purpose of intervention design and implementation, the individual level is the most critical, as individual behaviour affects and influences group dynamics (Glanz, Rimer & Lewis, 2002). This means that an understanding of teenagers' knowledge, attitudes and perceptions

towards teenage pregnancy in this study is best understood through an analysis of their individual characteristics before an analysis of the wider environment is made. The intrapersonal level seeks to change an individual's knowledge, beliefs, attitudes and skills.

Interpersonal/Relational Level

The interpersonal or relational is the second level of the Model. It includes primary social relationships surrounding the individual such as family, friends, co-workers, classmates, health care providers and peers. This level provides social identity, support and role definition to an individual (Sallis, Owen & Fisher, 2008). The interpersonal level is critical in the Social Ecology Model, as it includes formal and informal social networks that are a large aspect of a person's social identity. These networks provide insight toward the resources that could mediate health behaviour (McLeroy et al., 1988). An analysis of alcohol drinking among high school athletes revealed that an athlete was likely to drink if his or her peers were also consuming alcohol and were part of social groups (Leichliter et al., 1998). This suggests that primary relationships can influence health decision making.

Family and friends play an important role be it in their presence or their absence in an individual's life. Social networks are an important element in an individual's life as they provide support, information and access to new social contacts (Glanz, Rimer & Lewis, 2002). This level of the Model recognises the social and cultural norms to which groups and individuals subscribe (McLeroy et al., 1988). These norms are important as they have implications for intervention design and implementation. By design, interpersonal and institutional levels are meant to create change in social relationships. Change in these social relationships has an effect on the individual who interacts with the different social relationships at any given time (McLeroy et al., 1988).

Institutional/ Organisational Level

The third level of the Social Ecology Model is the institutional or organisational level, which is defined as the various organisations that exist in a community such as churches and schools that may promote or constrain adoption of certain behaviour (Glanz, Rimer & Lewis, 2002). As such, an example of an institution at this level is the school, which provides a physical, social and normative environment where learners are afforded an opportunity to imitate, learn and practice positive health behaviour. For example, the school may be an ideal environment where teenagers can be taught about safe sexual health behaviour and how best to protect

themselves against teenage pregnancy and other health related challenges such as diabetes, cancer, Tuberculosis, STIs and HIV and AIDS. On the other hand, the school is also a platform where teenagers can adopt and learn negative or risky behaviours that make them vulnerable to various conditions such as drug abuse, HIV infection and pregnancy. The institutional level may be used in this study to better understand how teenagers perceive teenage pregnancy.

Community/ Structural Level

Community or structural factors are the fourth level of the Social Ecology Model. These include social networks and norms, which exist either formally or informally among individuals, groups and institutions. At the structural level, socio-economic status, norms, values and cultures play an important part in promoting or discouraging health behaviour (Sallis & Owen, 2002). The community is viewed as a result of interconnected relationships that have an influence on an individual's health (McLeroy et al., 1988). The community should not be just confined to geographical definitions as it has wide and varied definitions all which are appropriate for Social Ecology Model purposes (ibid). They state that the community can be aggregated into three different structures and these are: (1) community as mediating structures; (2) the community as relationships among organisations; and (3) the community as power.

Families, churches and social networks are fundamental sources of social identity under community as mediating structures (McLeroy et al., 1988). These structures provide a link through which the individual can connect to the wider world; the structures also act as support when behaviour is being promoted. For instance, mediating structures are essential when teenagers are encouraged to talk openly about sex, therefore schools, churches and families become the platforms through which sex education and communication is conducted.

The community as relationships among organisations is defined as the relationships between the various organisations found within a particular geographical area (McLeroy et al., 1988). Where there are no relationships between organisations this may be manifested in competing for little resources available such as donations, duplication of service delivery and roles and a lack of collaboration on service delivery (ibid). This does not bode well for behaviour change, for example, a teenager who would like begin using contraceptives may receive conflicting messages from the various organisations within his or her community such as the church, school and health service provider, thus exposing the teenager to risk of teenage pregnancy.

The last definition of community according to McLeroy et al (1988) views community as power structures in cities, regions or local societies. These play an important role in defining health problems and coming up with the necessary skills, tools and resources to prevent the said problems. The structural level is important for this study as culture, values and norms play a significant role in health decision role.

Policy level

The final level of the Social Ecology Model is the policy level, which encompasses policies that affect and influences an individual's behaviour on all levels. These policies may stem from local policies right to national policies that are affected by both local and central government. For instance, the Choice of Termination of Pregnancy Act (No. 2 of 1996), The Department of Education's (DoE) 2007 Measures for the Prevention and Management of Learner Pregnancy are policies and laws put in place that influence teenage pregnancy in South Africa, and they have the ability to influence teenagers' behaviour. For instance, a teenager may choose not to use contraceptives banking on having an abortion in the event that pregnancy does occur. The policy level incorporates the local and national level policies that regulate or support healthy actions and practices for the prevention, care or support, detection and treatment of a condition (McLeroy et al., 1988).

The Social Ecology Model shows how each level is interdependent on the other, and how each level can have an effect on health behaviours including sexual behaviour. A teenage girl who is sexually active may not be using contraceptives, probably because at the *individual level* she has attitudes, beliefs and knowledge issues towards contraceptive use. It may be that she does not have enough information on how to use contraceptives or she may have negative perceptions towards contraceptives. At the *interpersonal level*, her boyfriend may not be happy with her using contraception because it affects pleasure, and may also label it as a trust issue that she is choosing to use contraception. Also, her family may have not discussed contraception with her, and her peers may think that contraception is really not important. At the *institutional level* she may not be able to access contraceptives from the local clinics because of the attitudes of the staff members towards teenage pregnancy. Her poor economic background may also affect the decisions she makes at the *structural level*, she may have no opportunities for social upward mobility and view having a sexual relationship as one such avenue to attain social mobility. At the *policy level*, the absence of youth-friendly clinics and

initiatives by the government and policies that are vague on teenage pregnancy may affect her as an individual.

By using the Social Ecology Model, this study seeks to present the relationship between the different levels of influence and the individual. At the individual level, knowledge, attitudes and perceptions guide the development and selection of the quantitative tools of data gathering for the study. In addition, teenagers' knowledge, attitudes and perceptions towards teenage pregnancy are interrogated using the different levels of influence of the Social Ecology Model to understand how teenagers identify themselves with the wider community.

The Social Ecology Model is the perfect fit for this study as it combines various levels of influence present in society as important factors that influence decision making. In addition, the model allows for greater depth of understanding human health behaviour decision making, as it incorporates the environment individuals are exposed to in understanding health behaviour and its influences (Corcoran, 1999; Salazar et al., 2005; McLeroy et al., 1988). The Social Ecology Model's emphasis on systems thinking (the importance of multiple influences) allows the researcher to present programming implications (the intervention) and provides problem conceptualisation by identifying influential factors at multiple levels and discussing their interactions. The Model allows for greater depth of understanding of the research problem (teenagers' knowledge, attitudes and perceptions towards teenage pregnancy). This is because the Model engages the processes that have an influence on individual's health decision making behaviour and provides appropriate context to otherwise simplistic results (Cocoran, 1999; Salazar et al., 2005; McLeroy et al., 1988).

Social Ecology Model Limitations

One of the biggest advantages of the Model over the bulk of health related theories is its ability to incorporate interdisciplinary views in an attempt to understand and account for health behaviour. The Model incorporates other disciplines such as economics, psychology, sociology, anthropology and health education just to mention a few in trying to understand human health behaviour and its influences. However, the multiplicity of the levels and different approaches needed to initiate change make it difficult for intervention implementation and monitoring (McLeroy et al., 1988).

As a meta-theory, the model presents a lot of work in terms of intervention implementation as it involves several sectors of society. One such level that is challenging to tackle is the policy level given the bureaucracy and red tape that exists in implementing or adopting policy changes (Sallis & Owen, 2002). Another challenge of the Social Ecology Model is the challenge of changing social norms and public policy. Norms are hard to change and initiating change or adoption of new behaviour may be met with resistance at every stage of the five spheres of influence.

Despite the weaknesses of the Model, it is still a perfect fit for this study as it is used to explore various influences on teenagers' decision making and be used to understand how teenagers and their environment affect each other (reciprocal causation).

THE HEALTH BELIEF MODEL

The Health Belief Model is widely used in health education and health promotion (Glanz, Rimer & Lewis, 2002). It enables a socio-physiological theory that focuses on an individual's attitudes and beliefs in trying to explain human behaviour. This Model is driven by the premise that knowledge change precedes behaviour change. Knowledge is important and essential in performing a motivational role for promoting adoption of behaviour change. On its own, knowledge cannot bring sustainable health behaviour adoption. Nevertheless, it is an important starting point in behaviour change cycle (Hayden, 2009). Perceptions about a disease also play an important role in determining health behaviour (ibid).

The Health Belief Model was developed in the 1950s by American psychologists to explain the widespread failure of Tuberculosis screening (Glanz, Rimer & Lewis, 2002). Irwin Rosenstock modified the model in 1974. Underpinned by value expectancy theory, the Model assumes that behaviour is a result of an individual's expectations, hence behaviour performed is in response to beliefs and values held (Armitage & Conner, 2000; Champion & Skinner, 2008). Therefore, an individual's values and beliefs towards health conditions influence their behaviour and decision making. Value expectancy theory assumes that individuals take precautionary measures (risk reduction) when they perceive themselves susceptible to a disease or condition, acknowledge consequences of a condition as severe, accept that taking precautionary measures will be beneficial in reducing risk, and that benefits of taking action will overcome perceived barriers (Melkote & Steeves, 2001; Rosenstock et al., 1994).

The Health Belief Model has been used to describe and explain a wide range of health behaviours. These are grouped by Conner and Norman (1996) into three distinct groups, mainly, preventative health behaviours, which include health promotion (diet, exercise), health risk (smoking) and contraceptive and vaccination practices. The second use of the model has been identified as compliance and adherence (sick role) to medical regimens and recommendations following diagnosis of illness. The last use of the model is clinical use, where the model has been used to explain health personnel behaviour such as an individual's visits to the doctor for whatever medical problem they have.

The Health Belief Model is applied in this study to understand teenagers' preventative health behaviours in terms of their knowledge, attitudes and perceptions towards teenage pregnancy.

The Health Belief Model assumes that an individual's health behaviour is influenced by six key constructs, namely: (1) perceived susceptibility; (2) perceived severity; (3) perceived benefits; (4) perceived barriers; (5) cues to action; and (6) self-efficacy.

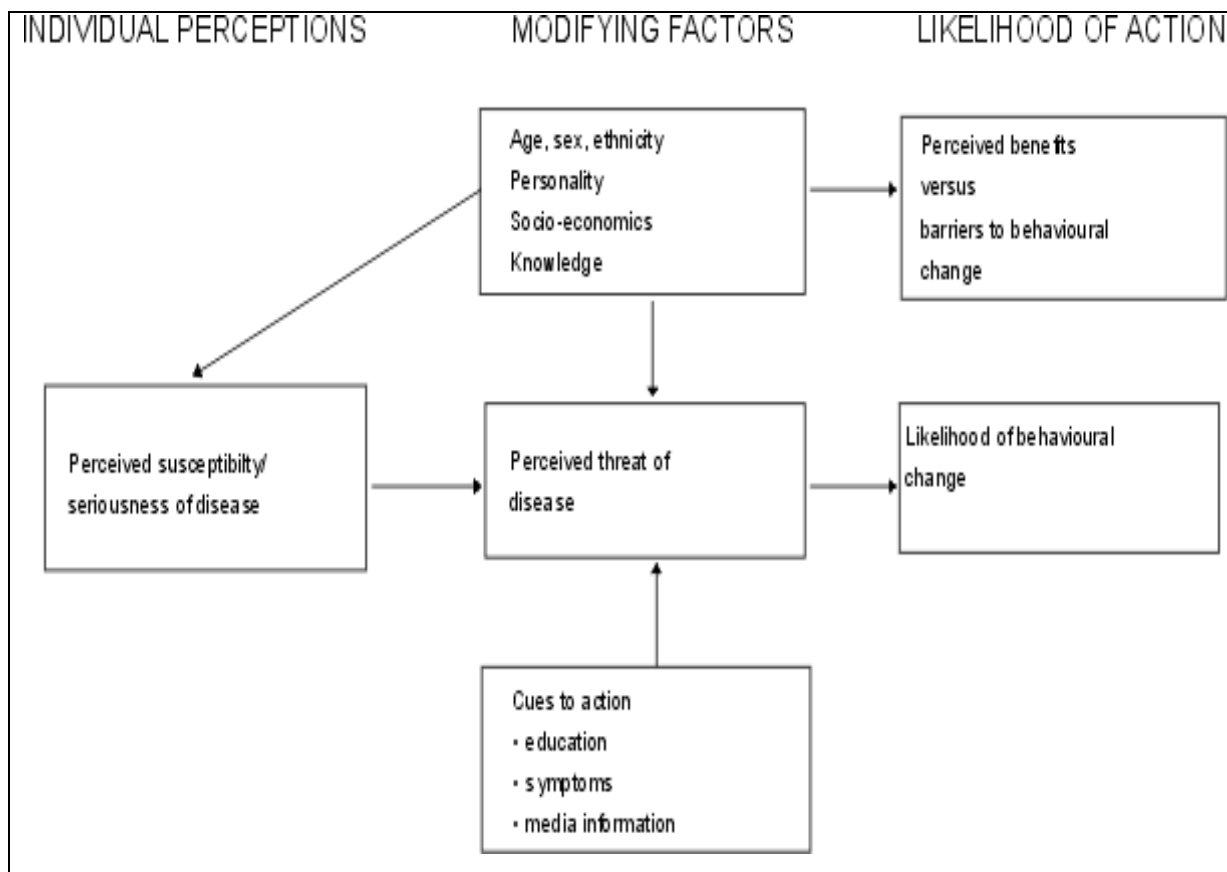


Figure 2 : The Health Belief Model Source: Glanz et. al (2002: 52)

Perceived Susceptibility

Perceived susceptibility refers to a person’s likelihood of getting a condition or a disease (Glanz et al., 2008). Perceived risk of contracting a disease refers to individuals’ personal awareness of their vulnerability to the disease (ibid). Perceived susceptibility has been found to be predictive of certain health behaviours. For example, women must believe that they are at risk of cervical cancer for them to uptake Pap smear. These women are better placed to adhere to cervical cancer screening recommendations if they feel they are susceptible to cervical cancer (Glanz et al., 2008). Similarly women who believe that they are not at risk of cervical cancer will not have Pap smear done. Uptake of health behaviour is also influenced by personal beliefs, where Pap smear is believed to be unnecessary; women are more at risk of cervical cancer.

Where perceived risk is low, unhealthy behaviour manifests and results development of disease or even death, in the case of non-Pap smear screening, cervical cancer is the result (Hayden, 2009). Interestingly, even were perceived risk is high, studies show that there is disregard for the perceived risk (Courtenay, 1998). Teenagers may perceive themselves at risk of unwanted and unplanned pregnancy, yet they will not employ preventative measures. This is one of the

shortcomings of the Health Belief Model where perception of susceptibility is always not explained by affirming behaviour. The weaknesses of the model as whole will be discussed later in the chapter. By exploring teenagers' knowledge, attitudes and perceptions towards teenage pregnancy, this present study will be able to explore their perceived susceptibility to pregnancy.

Perceived Severity

Perceived severity is defined as “an individual’s perception of the seriousness of contracting the disease or condition” (Champion & Skinner, 2008:85). Perceived severity takes into account personal feelings of the graveness of a condition based on the subject awareness of the consequences of that condition (Hall et al., 2010). According to the Health Belief Model, acknowledging potential threat of a disease is a vital cognitive process in adopting healthy related behaviours to avoid contracting a condition. Delores et al. (2004) found that African American women who are aware of the consequences of unhealthy eating habits are more likely to exercise and eat healthily in an effort to prevent obesity related diseases, such as coronary heart disease. Exercising and eating healthily are as a result of black American women’s belief that obesity related diseases have serious medical, social and economic consequences for them.

On the other hand, individuals with low perceived severity are less likely to take preventative measures. An individual is more likely to take action if they believe that the negative physical, social and psychological effects of a condition pose serious consequences, such as altered relationships, pain, disability, loss of employment, exclusion or even death (Champion & Skinner, 2008).

This study uses the teenagers’ perceived severity of pregnancy to inform the communication intervention around contraceptive use, delaying sexual debut and promotion of secondary abstinence. Perceived severity has been used to inform communication interventions (Glanz, Rimer & Lewis, 2002).

Perceived Benefits

An individual’s belief or opinion on the benefits of upholding certain behaviour is known as perceived benefits. Rosenstock (1974) defines perceived benefits as the steps an individual takes to prevent effects of certain conditions. For behaviour change to take place, there needs

to be belief that the preventative behaviour effectively prevents the condition (Hayden, 2012). For instance, individuals who believe that they can prevent themselves from Tuberculosis infection are able to embrace positive health related behaviour to prevent infection. Similarly, individuals who do not have the conviction that preventative behaviour will protect against a disease, will not bother with taking appropriate steps to prevent them from infection. For instance, smokers who do not believe that there is a causal relationship between smoking and cancer are unlikely to quit smoking because they believe that quitting smoking will not protect against cancer (Champion & Skinner, 2008).

Perceived benefits may be influenced by the availability of information regarding that particular condition (Hall et al., 2010). Perceived benefits are also important for the adoption of secondary prevention behaviour. Delores et al. (2004) in their study of African American women's eating habits found that women believed that eating healthily would contribute weight loss and eventually help prevent heart attacks and consequently lead to these women quitting smoking. Similarly, in this study will explore if teenagers believe that by practicing safe sex or abstaining from sex they also protect themselves from contracting HIV.

Perceived Barriers

Perceived barriers prevent an individual from adopting certain behaviour. Perceived barriers constitute factors that disrupt or hinder one's ability to perform a particular health behaviour (Champion & Skinner, 2008). These barriers may include cost, social support for the particular behaviour, pain and inconvenience. The value outcome of the Health Belief Model is represented when individuals evaluate the positive and negative aspects that accompany behaviour (Ogden, 2004). Perceived barriers for people to seek TB treatment include stigma attached to TB, people associate TB with HIV infection thus individuals may be wary to seek treatment for fear of being stigmatised (Ndoro, 2009).

The Health Belief Model assumes that the absence of perceived barriers motivates individuals to seek TB treatment and maintain healthy behaviours. Where perceived barriers or perceived cost outweigh perceived benefits then positive behaviour is not adopted. For example, individuals may believe that condom use is effective in reducing perceived susceptibility to HIV infection, but still consider the condom as a barrier to 'pleasurable' sex (Rosenstock, 1974; Sharma & Romas, 2008). Likewise teenagers have indicated that the condom as a contraceptive

interferes with the pleasure levels, thus the pleasure factor becomes a barrier to condom use (Rasch et al., 2000; Jewkes et al., 2001; Manzini, 2001; Dunkle et al., 2007; Mfono, 2008). On the other hand, side effects of contraceptives such as weight gain, hormonal changes, mood swings may also become barriers to contraceptive adoption and use among young people (Rosenberg & Waugh, 2008).

In order for a new risk reducing behaviour to be adopted, an individual needs to accept that the benefits of changing health behaviour outweigh the consequences of the old behaviour. This study explores teenager's perceived barriers with regards to contraceptives use, delaying sexual debut and secondary abstinence. These can then be used to inform an intervention design that addresses teenagers' perceived barriers to contraceptives use, delaying sexual debut and secondary abstinence. Perceived barriers act as the single most powerful predictor for decision making (Rosenstock, 1974; Sharma & Romas, 2008)

Cues to Action

Following continued research and modification, the Health Belief Model was later modified to include cues to action and self-efficacy as new constructs (Janz & Becker, 1984; Rosenstock et al., 1988). Cues to action are circumstances, events or people that motivate an individual to change (Hall, 2011; Janz & Becker, 1984). Cues to action give a disease or condition a 'human face' and make people aware of the disease (Rosenstock et al., 1988). Cues to action can be characterised as either internal or external (Mattson, 1999), internal stimuli may include a lump on the breast discovered during self-examination for breast cancer by a woman, and this can prompt her to go for breast cancer screening. External stimuli can include awareness campaigns from health care service providers, media awareness of the benefits of self-examination, invitations to breast cancer examinations and celebrating the month of October as breast cancer month all serve as external stimuli. Missed monthly periods for a teenage girl can be internal stimuli and can prompt her to change her sexual behaviour. External stimuli may include partners' fear over non contraceptive use or even seeing other teenagers falling pregnant.

Cues to action have a causal relationship with perceived susceptibility, where perceived susceptibility is low; there is a need for intense cues to action as they will stimulate interest in pursuing new behaviour.

Self-Efficacy

Albert Bandura (1977) developed the concept of self-efficacy, which is according to Rosenstock et al. (1988) an individual's confidence in their ability to perform a certain behaviour or action. An individual will not try out any behaviour or action if the confidence that they can perform the said behaviour is absent (Hayden, 2009). Self-efficacy is developed and improved by setting goals, as well as monitoring and reinforcing behaviour (Bandura, 2004). It is this aspect of self-efficacy, which allows an individual to continue in his or her attempt at making behavioural changes, despite the challenges and obstacles that he or she may be faced with (Bhana & Petersen, 2010). For example, self-efficacy for diabetes patients is their ability to correctly and consistently administer their insulin injections as prescribed by their doctors. Self-efficacy is important for the adoption of a new behaviour, for example an individual who believes that using contraceptives is useful (perceived benefits), but does not believe they are able to use them (perceived barriers); will not adopt the new behaviour because of low self-efficacy. Teenagers' attitudes and perceptions towards pregnancy maybe as a result of low self-efficacy, this study explores efficacy as an integral part of behaviour change.

This study uses all six concepts of the Health Belief Model in exploring knowledge, attitudes and perceptions towards teenage pregnancy among a group of male and female high school learners. The model's constructs are used to analyse data on teenagers' knowledge, attitudes and perceptions towards teenage pregnancy.

Limitations of the Health Belief Model

The Health Belief Model has been criticised when predicting sexual behaviour, because sexual decision making is not rational (Harari & Legge, 2001). Rationality in health behaviour decision making as argued by Cleary (1986) is questioned by Noh, Gagne and Kaspar (1994) who use smoking as an example of how the Health Belief Model fails to explain and account for rational health behaviour. They argue that smokers are aware of the consequences of smoking, yet they continue smoking. Furthermore, Rosenstock (1990) points out that some health behaviour is habitual, and the Health Belief Model does not address habitual behaviour, such as brushing teeth daily, which has nothing to do with rationality, but is purely habitual.

In addition, the Health Belief Model does not include the influences of other factors on health such as environment, economics, social norms, peer norms (a point to consider when dealing

with teenagers), which all play a role in decision making. Pressure from peers and partners may also influence decision making for teenagers and it is these aspects that the Health Belief Model does not account for. The Health Belief Model focuses more on perceptions (cognitive processes) and does not account for factors such as personal habits and socio-cultural norms (perceptions of femininity, sex taboos and value placed on virginity, religious values), which can influence decision making (Noh, Gagne & Kaspar, 1994).

Despite the limitations of the Health Belief Model, it is still the best suited model to use for this study, evidenced by previous research conducted on sexual health behaviour and teenage sexual health (Hall, 2011; Ekstrand, 2008; Pettit & Collins, 2012). To complement the Health Belief Model, this study also uses the Social Ecology Model, which accounts for the reciprocal relationship between the individual and the environment in terms of decision making. Reciprocal causation is an element that is absent from Health Belief Model, yet it is an essential element in accounting for the non-individual factors that affect and influence health behaviour.

CONCLUSION

This chapter discusses the Social Ecology Model and the Health Belief Model; these two models will be used for in this study to inform data analysis. The Social Ecological Approach is a meta-theoretical approach that encompasses other theories in its understanding of health promotion and behaviour change. The Social Ecology Model falls under the ecological perspective and draws from the Social Ecology Theory seminal work of Bronfenbrenner's (1979) Social Ecology Theory of child development. The Social Ecology Model has five levels of influence and it is through these levels that an understanding of how the individual is affected and in turn affects the environment (reciprocal causation) is framed. The Social Ecology Model is used to understand teenagers, their environment and how both affect the other in terms of teenage pregnancy knowledge, attitudes and perceptions.

The Health Belief Model, an individual level theory, is used to interrogate knowledge, attitudes and perceptions at an individual level and understand how teenagers perceive teenage pregnancy, their understanding of teenage pregnancy and their attitudes towards it. The use of these two models is adequate to discuss teenagers' knowledge attitudes and perceptions towards teenage pregnancy and provide theoretical rationale that underpins this study.

CHAPTER 4- RESEARCH METHODOLOGY

INTRODUCTION

This study is an analysis of teenagers' knowledge, attitudes and perceptions towards teenage pregnancy. The research participants were drawn from a Durban secondary school. Located within the qualitative and interpretive research approach, this study sought to understand the meanings teenagers attach to teenage pregnancy. The research approach was influenced by the purpose of this study. This chapter therefore presents the methodological framework used in this study to collect data, the sampling methods used to select the participants, the ethical

considerations taken into account during the process of data gathering and how data were analysed.

QUALITATIVE RESEARCH

In an effort to understand the meanings that high school teenagers attach to teenage pregnancy, this study is located within the qualitative research approach. Qualitative research seeks to analyse, describe and understand a social phenomenon in terms of the meaning everyday people attach to the phenomenon in question (Silverman, 2011). Teenage pregnancy is therefore studied through flexible methods that allow the researcher to interact with participants and access necessary and multiple realities and information that makes it easier to understand what is going on (Brink, 1996).

Qualitative research “involves an interpretive, natural approach to its subject matter, it attempts to make sense of, or to interpret, phenomena in terms of the meaning people bring to them” (Denzin & Lincoln, 2003: 15). Qualitative research is designed to assist the researcher to have a better understanding of the research participants’ world view thus allowing for a better understanding of complex and under researched areas (Creswell, 2003). Various strategies and methods of data collection are employed within qualitative research. This study makes use of focus group discussions as the method of choice, reasons for using focus group discussions over other methods will be discussed later in the chapter. Qualitative research is therefore ideal for the purposes of this research as it enables the researcher to explore teenagers’ meanings of pregnancy. In addition, qualitative research allows the researcher to access multiple, rich descriptive data that makes understanding of the phenomenon under study easier (Silverman, 2011).

INTERPRETIVE PARADIGM

The interpretive paradigm of research is concerned with “exploring the ways that people make sense of their social worlds and how they express these understandings through language, sound, imagery, personal style and social rituals” (Cohen et al., 2007:5). This paradigm is ideal for this study as it allows the researcher to “understand the phenomenon under study and interpret meanings within the ‘social context’ of the participants” (Cantrell, 1993:14). This is because the interpretive paradigm allows the participant to tell their own story from their own

perspective. A key element of the interpretive paradigm is that it focuses on the individual's subjective experiences of the world and is characterised by an understanding that human behaviour is varied (Cantrell, 1993). The interpretive paradigm enables the researcher to conduct research from an 'experience-near perspective' as the researcher seeks to allow ideas and perceptions to emerge from the participants.

The benefit of conducting this study within the interpretive paradigm is that the interpretive paradigm has potential for generating new understandings and meaning of complex, multi-faceted human behaviour such as teenage pregnancy. Interpretivism facilitates a deeper understanding of how teenagers make sense of teenage pregnancy within their lived experiences.

RESEARCH DESIGN

The research design is a plan of action that describes how the researcher intends to move from 'here' to 'there'. "'Here' is the initial set of questions to be answered and 'there' the answers and conclusions to the questions asked" (Yin, 1993:19). The function of a research design is to ensure that "the evidence obtained enables us to answer the initial questions as unambiguously as possible" (de Vaus, 2002:9). The study employs the single case study research design. "A 'case' is the unit of analysis about which information is collected and is used to understand the 'whole' " (de Vaus, 2002:220). The unit can take the form of person, an organisation, an event or even a community. The study uses the school as its case.

Since this study employs the interpretive paradigm to research and taking into account the nature of the research questions, the case study design is ideal for this study as it allows for systematic data collection and analysis. It also "brings out the details from the view point of the participants by using multiple sources data" (Yin, 1993:85). This allows the researcher to get deeper meanings and understanding of the phenomenon under study. The emphasis of case studies is not on representativeness but on what can be learned from a single case (Tellis, 1997:85).

The study is descriptive in nature as it seeks to answer the question 'what' do teenagers know about pregnancy and contraception. It is also explanatory, answering the question 'why' teenagers continue falling pregnant and 'how' teenagers feel about pregnancy.

The case study has been criticised for being non representative and the fact that the rich and complex data collected is open to different interpretations and researcher bias (Miles & Huberman, 2004). The underlying principle of single case study is that it seeks to ‘improve’ rather than ‘prove’ (Stufflebeam, Madaus & Callaghan, 2000:283) thus this study intends to improve understanding of teenage pregnancy through the lenses of teenagers more than it seeks to prove teenagers’ knowledge, attitudes and perceptions of the same.

Study population

The population sample was made up of ten girls and ten boys. Twenty was an ideal population size for the purpose of this qualitative and interpretive study inquiry. This line of thought is supported by Anderson (1998), who argues that sample size in qualitative research has no rules and should be governed by the purpose of the study and not the rules of academic.

Focus group	Participants	Total
1	3 black girls / 3 coloured girls	6
2	3 black boys / 3 coloured boys	6
3	2 black boys, 2 black girls, 2 coloured girls and 2 coloured boys	8

Table 2: Focus Group Discussion aggregation

Sampling was stopped after reaching saturation of which 20 was the saturation point. Saturation was reached because the sample size was big enough to generate information and meet the research objectives. The nature of the study also influenced the sample size, focus group discussions have an ideal number of participants for every session and as such, exceeding that number not only affects the quality of data gathered but makes the discussions unmanageable.

The research population was stratified by race and sex. This means that the population size was selected according to race, blacks and coloureds as the school is a co-ed school and according to sex. Research participants were chosen from Grade 11 and 12s who are between the ages of 16 and 18. This is because the 16-18 age groups are the most vulnerable group towards teenage pregnancy (Panday et al., 2009).

Sampling

The process of selecting a section of the population in order to study is known as sampling. “A sample is thus a sub-section of the population, which is selected to participate in a study. The selected sample should therefore have similar characteristics to the population under study to allow for generalisability of results to represent the population” (Polit & Beck, 2006:259).

Purposive sampling is defined as “non-randomly selecting participants to fulfil a specific purpose the researcher has in mind” (Cohen & Manion, 1994: 190). The school was purposively selected for this study as it has high teenage pregnancy rates (School admin, 2012: pers comm). Purposive sampling was perfect for this study as it enabled the researcher to solicit rich information from the research population. “A purposive sample is composed of elements that contain the most characteristics representative of typical attributes of the population” (de Vaus, 2002:99). The school has the typical characteristics of any other school in KZN that de Vaus (2002) talks about thus influencing why it was purposively sampled as the case study for this study. In addition the grades chosen for study were also purposively chosen as the learners in these grades have the largest prevalence of teenage pregnancy.

Participant selection was done using random sampling. Random sampling is defined as “the selection of a sample in such a way that every individual in the accessible population has an equal chance of being selected for the study. Random sampling is done from a list of all the members of the population (Brink et. al, 2006:126). The school attendance registers were used to randomly select the participants. To ensure that both the coloured and black learners had an equal opportunity of being selected, an initial random sampling was conducted. Those selected in the first round were then grouped according to race. The new lists were then randomly sampled according to race, to get the 10 female and male black learners and 10 male and female coloured learners. Random sampling was ideal for this study as increased the chances of all grade 11 and 12 learners being elected for this study.

Ethical considerations

Ethical approval was obtained from the School of Applied Human Sciences Higher Degree Committee. Consent to conduct research at the school was also obtained from the principal. Two consent forms were distributed to the participants. One form was for the parents and guardians of those participants below the age of 18 and the other form for all participants.

Participants were furnished with all the information pertaining to their participation in the research process. This information included their level of confidentiality, how much of their time was to be used for research purposes, what they could expect from the research, data storage and how the results were to be used (Kumar, 1999).

Methods of Data Collection: Focus Group Discussions

This study makes use of one qualitative data gathering tool, the focus group discussions. A total of three focus group discussions were conducted. The first two were gender specific with 6 participants each and the last one was a mixed discussion with a total of 8 participants. Participants were separated so as to elicit information from the different races and sexes on their knowledge attitudes and perceptions towards teenage pregnancy. The mixed focus group discussion posed new questions, formulated from the gender specific discussions held earlier on. The focus group discussion took a total of 90 minutes each, 'well designed focus groups usually last between an hour or two with 6-12 participants' (Fontana & Frey, 1994: 95).

It is important to note that the discussions do not concern these teenagers' private sexual behaviour but are about teenage sexuality. There is a difference between private sexual behaviour and sexuality. Private sexual behaviour is about the specific individual while sexuality affects and implicates the individual and society (Hlabangane, 2012). Conversations about teenage pregnancy in focus group discussions then become unhampered as the spotlight moves from teenagers as individuals but to teenagers as a group (ibid). The focus group discussions were conducted within the school as it is a familiar environment and is easily accessible to both the researcher and the participants.

Participants were interested in registering their opinions towards the topic under discussion. At times particular thoughts dominated the discussion only to be fractured by a throw away comment usually whispered by another participant. Throw away comments generated new discussions around teenage pregnancy. The focus groups yielded rich detailed information as some participants would use moral ground to argue their cause while others used culture to account for teenagers' behaviour. Group members challenged each other where there was difference of opinion, rallied together when they were in consensus and constantly created new meaning throughout the discussions. Fontana and Frey (1994) indicate that this process of

allowing participants to share their own experiences, insights and to build upon the responses of other participants enriches the process of data collection and the quality of data collected.

Responses and reactions were very different between the mixed focus group and the individual focus groups. In the same sex focus groups younger participants tended to be quiet while the older participants dominated the discussions. The researcher had to constantly prompt the quieter participants to engage and be part of the discussions. In the mixed race discussions, black girls were more vocal than the coloured girls while the coloured boys were also dominated by the black boys. The researcher allowed the animated discussions to run their full length for fear of cutting them lest important information was disregarded. A non-intrusive moderation style was employed as the researcher did not want to influence or affect the flow of the discussions. The role of the researcher most of the time was to seek clarification and ask certain questions where there was a need for them to be asked. The setting for the focus group discussions was circular to facilitate face to face interaction and make audio recording easier.

Focus group discussions were conducted in one of the rooms provided by the school, audio recorded and transcribed verbatim. The audio recorded discussions were also supplemented by discussion notes which the researcher was take during the focus group discussions. Recording the focus group discussions enabled the researcher to observe the non-verbal communication between the participants.

Information exchange

The research experience was a process of shared experiences amongst the participants themselves and with the researcher. The relationship between the researcher and the participants cannot be taken for granted as the rapport existing between these two made it possible for easy interaction and sharing of information. As such there was information shared that needed correction and demystification like the proper use and storage of condom and use of homemade mixtures to induce abortion. The researcher would make notes of these and after every session would address misinformation. The researcher felt it was important as continued misinformation is dangerous especially for sexual health as it is important that teenagers make informed decisions based on correct information.

Challenges faced in data collection

Throughout the focus group discussions, the researcher felt that the participants never lost sight of the factor that the research was part of the researcher's degree. Right at the beginning of the focus groups, participants asked the researcher whether they contributed anything to the final research project. The researcher told the participants that they played an important role as their knowledge, attitudes and perceptions towards the research problem were at the core of the study. Some participants were thus too eager with their responses naming other students in the discussions. This tended to divert discussions as the learners would then argue amongst themselves.

Knowledge, attitudes and perceptions are woven into the concept of 'truth'. Truth is relative and as such what seemed so 'untrue' to the researcher was 'true' to the participants. As such there is a natural desire to cross question and even challenge some of the statements by the participants. However, this desire was supplanted by an understanding that the study did not seek to analyse teenagers' behaviour but sought to understand the interwoven and complex factors that influence their knowledge, attitudes and perceptions towards pregnancy and to understand how these factors in turn influence their knowledge, attitudes and perceptions.

The composition of the discussions consisted of grade 11 and 12 learners who already knew each other from their various school interactions. This prior knowledge and 'background information' among participants may have played out during the discussions and was evident when some participants would challenge an individual thus affecting the atmosphere of the focus group. The moderator though did take time to make sure that participants understood the discussions were not about individual behaviour per se but about teenagers as a group.

DATA ANALYSIS

Data were analysed using thematic analysis. Thematic analysis is "a data analysis process of identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke 2006:79). Thematic analysis an appropriate analysis technique for research areas that are usually under-researched, complex or where the views of the participants are not known (Braun & Clarke 2006). Analysis was guided by Braun and Clarke's (2006) steps to data analysis.

Since the focus groups were conducted over three days, after every discussion. The researcher would take time listening to the recorded material with the intention of looking for detail that could be used the following day for the next discussions. Usually this was detail that the researcher thought was interesting and especially between the gendered focus group discussions when it was important to get the perspective of boys and girls.

Initial data analysis began with repeated listening of audio material, noting down interesting ideas before transcription and coding could be done. Coding is defined as the process of “conceptualising research data and classifying them into meaningful and relevant categories for the participant to study (unit(s) of analysis)” (Bowling, 1997:296). Patterns identified in the three focus groups were used to code. Repeated coding resulted in the development of themes, this was the next step after coding. Themes had to be revisited and refined in some cases there was need to rename themes and refine as some concepts were present in almost all the identified themes. The last part of the analysis process is the next chapter, where the most vivid and detailed extracts of discussions are analysed through theoretical lenses and literature reviewed.

Phase	Process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial code	Coding interesting features of the data in a systematic fashion across the entire data set; collating data relevant to each code

3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2); generating a thematic ‘map’ of the analysis
5. Defining and naming themes	On-going analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the Analysis

Figure 3: Thematic Analysis Steps Adapted from Braun and Clarke (2006, 87)

CREDIBILITY, TRUSTWORTHINESS AND AUTHENTICITY

Known as validity in quantitative research, credibility, trustworthiness and authenticity mean that the findings are true not only from the standpoint of the researcher but to the participants and readers of the study (Creswell & Miller, 2000). Credibility also refers to the degree the study reflects the lived experiences of the participants. One way of achieving credibility according to Patton (2002) is to ensure that the study is non-intrusive as is possible and create trust such that participants can act as they would normally act. A year long association with the school through ARROWSA helped create rapport and an atmosphere of trust with the school and the learners.

In an effort to achieve these concepts in this study, the researcher follows what Patton (2002) states are the basic requirements for credible qualitative research. The data is sufficiently described and analysed using qualitative tools of analysis, the data collection process also accounts for the interactions, dynamics and processes that took place during the collection period while the analysis section details how analysis was carried out. Again self-reflexivity of the researcher is an important element of credibility, trust and authenticity of research. In this study, reflexivity is also discussed in the data collection section.

Peer debriefing, according to Patton (2002) is another important element of assessing whether a study is credible, trustworthy and authentic. This is achieved through the involvement of another researcher to review the study to check if the study resonates with the experiences of participants. For this study, this was achieved through peer evaluations, every Friday the Centre for Culture, Communication and Media Studies holds research seminars where peers take time to review research work being conducted at the centre.

CONCLUSION

This chapter highlights the processes that shape the data collection process of this study. Grounded in the interpretive paradigm, this study is qualitative in nature and will take the form of a case study research design. Purposive sampling was used to select the school as the research site while random sampling was used to select the participants for the research. A total of 20 participants were used in the research. Focus group discussions were used to collect data. Thematic analysis was used to analyse data.

CHAPTER 5- DATA PRESENTATION AND ANALYSIS

INTRODUCTION

This chapter presents an analysis of the data gathered. It deals with what teenagers know, how they perceive teenage pregnancy and their attitudes towards it. The chapter makes a link between the data and the theories that inform this study. Engaging teenagers in conversations around their sexuality is important for policy as teenagers themselves come up with the solutions to the various challenges they face. Talking offers a platform for exchange of ideas between the teenagers themselves and the researcher. As such talking or conversations by teenagers around teenage pregnancy has the potential of establishing prevention and management strategies.

KNOWLEDGE, ATTITUDES AND PERCEPTIONS TOWARDS PREGNANCY

Individual knowledge levels, perceptions and attitudes influence health behaviour decisions. While knowledge, attitude and perceptions are shaped and influenced by other external factors, it is important to look at the individual factors that influence teenagers' knowledge, attitudes and perception towards teenage pregnancy.

Teenage pregnancy is viewed differently by different groups of teenagers. While this study did not intend to ask participants about their sexual activities, some participants shared their experiences. The female only focus group discussion had an Indian/coloured mother; the male only focus group had a black father while the mixed focus group discussion had a pregnant participant. These individuals brought an unexpected dimension to the discussions and in most cases were used as points of reference by the participants.

Knowledge is very important as it is the basis upon which decisions are made. It is also important as it helps shape an individual's reality. Sexual health knowledge is vital not only to adults but to teenagers as well. In the absence of adequate and factual knowledge, teenagers are bound to make unsound decisions that have a bearing on their lives. Participants indicated that they had knowledge on teenage pregnancy, contraception and condom use.

Teenage pregnancy is when a girl falls pregnant while she is still a teenager. It affects girls more than boys because girls are the ones that carry the baby. (Sabelo, male only FGD).

Teenage pregnancy is when a girl has unprotected sex and falls pregnant. (Hayden, female only FGD).

Teenage pregnancy occurs when there is unprotected sex and when people do not use emergency pills. (Javier mixed FGD).

Participants knew that teenage pregnancy is a result of unprotected sex. That was clear from all participants from the onset. It is important to note that knowledge does not translate to health affirming behaviour. While teenagers may have knowledge that pregnancy is a result of unprotected sex, it does not mean that teenagers use contraceptives consistently and correctly.

Javier's comment ushers discussion on teenagers' perception of the emergency pill. Clearly it is considered as an everyday contraceptive other than an emergency pill. Emergency pills will be discussed at length later in the chapter.

Perceived Susceptibility

Perceived susceptibility to pregnancy was high in girls and low in boys.

Chances that girls are pregnant by the time they finish matric are very high. Just look around the school, at grade 8 girls are pushing stomachs. The reasons why they are pregnant are different but the fact that you are a girl is enough for you to be at risk. You can be raped, so yes you are at risk because you are a girl (Portia, female only FGD).

Portia's reflections on girls' susceptibility to teenage pregnancy is based on the simple fact that she is a woman and by virtue of her being one she is susceptible to falling pregnant. Rape, a dominant feature in female discourse on sexuality highlights the fears that teenagers have. Power and gender dynamics also come to the fore in teenage relationships when the issue of rape is mentioned. This is because teenagers are involved in transactional and intergenerational relationships that render them vulnerable to pregnancy as they are unable to negotiate for safe sex practices by their partners. Cherel's comment on girls' susceptibility ties in well with the gender dynamic discourse,

¹ All names have been changed to protect participants' identity

We are at risk of pregnancy because we date sugar daddies! Simple, finish and klaar!

The issue of transactional and intergenerational sex cuts across the divide of the Social Ecology Model from the intra personal right down to policy level. The reasons why teenagers are involved in these relationships are interwoven into the other levels of the Social Ecology Model. While Cherel states that an association with older men (sugar daddies²) makes them susceptible to pregnancy her statement may be taken to mean that teenage boys do not pose as a risk to girls. This is not true as teenage boys also impregnate teenage girls. The sugar daddy phenomenon just like rape is also interwoven into the other levels of the Social Ecology Model.

Male participants on the other hand felt their susceptibility was very low considering that they too felt that sugar daddies were to blame for teenage pregnancies.

Akim: *I am not in danger of becoming a teenage father because a lot of girls belong to sugar daddies so I am safe there*

Moderator: *What if your girlfriend is double dating you?*

Akim: *Well in that case yes but usually we know of these things. If she has a sugar daddy I leave her and look for another one.*

Mqobi: *Boys are in control of their relationships. That's why we have condoms always with us. You can never go wrong when you have a condom. It's your license. If you don't have a condom then you are setting yourself up for stress and doom. The girl will lie that it's your baby yet she has a sugar daddy. If I have a condom I know it's not mine and she can never come and try and frame me (Mixed FGD).*

Power and gender dynamics once again come into play evidenced by the *control* that Mqobi mentions. Mqobi's assertion that boys are in control echoes findings from previous research on sexual health and gender relation/dynamics (Jewkes et al., 2001; Wood & Jewkes, 2006 and Macleod, 1999). While the issue of multiple partners was raised, participants in this instance did not mention HIV as a circumstance of having unprotected sex in as much as having unprotected sex caused pregnancy.

² There was contention on the definition of a sugar daddy. The general consensus was a sugar daddy is any man who is 10-15 years older than the girl. He may not necessarily be married but he has more money than the girl. This means that a 26 year old university student is considered a sugar daddy by a 16 year old high school student. That same 16 year old girl considers a 45 year old man a sugar daddy by virtue of his age.

Perceived Severity

There are no advantages of being a young mother. You will leave school and stay at home. You won't come to classes because you have to a mother to the child. It's terrible. What about your future? Your dreams? It's a risk being a young mother. (Hlobisile mixed FGD).

How do you concentrate in class when you know you have a child back home? Even with the grant you won't rest. Having a child and coming to school is like having two jobs. My sister has a baby and she goes to university, she has no life. It's either school or the baby. That's no life for a young person. You have to enjoy being a young person then enjoy your career and then think about having a family (Mbuso, all male FGD).

Disruption of school has been identified as one of the consequences of early child birth; see (Macleod & Tracey, 2010). According to Hlobisile and Mbuso there are no benefits of being a young mother. The 'future' plays an important role in teenagers' lives; Hlabangane (2012) defines Hlobisile and Mbuso's desire to have a 'future' and rise above current social conditions as upward mobility. A lack of upward mobility leads to teenage pregnancy as teenagers have nothing to look forward to especially in areas of entrenched poverty and areas where teenagers do not have a sense of entitlement to anything (Hlabangane, 2012 & Arai, 2008). The lack of upward mobility can be evidenced in teenagers' reasons for falling pregnant, where the pregnancy is planned but unwanted and is viewed as a means to an end.

Hlobisile touches on the issue of shared parental responsibility of the child be it between the two parents or between the mother and a caregiver of the child. Where there is no one to take care of the baby, the teenage mother is forced to drop out of school to take care of the child herself (see Swartz & Bhana, 2009; Grant & Hallman, 2006). Hlobisile and Mqobi also highlight the struggles that young mothers face in playing dual roles as mothers and as students. Mqobi sums up this struggle succinctly when he asks *what life is that?*

As mentioned earlier on, the research was never about individual sexual behaviour of teenagers but along the course of the discussions participants shared their personal experiences. Of the 20 participants, two were parents while one was pregnant. The two parents indicated that support from home played a huge role in enabling them to come and continue with their studies.

My parents help take care of my daughter. My parents were disappointed, but they accepted what had happened. They even paid damages for the baby mama. My daughter stays with us and not the baby mama because she goes to work. My parents treat my daughter as their last

child. But I know if it were not for my parents maybe I would not be here because I know a lot of people with babies who leave school or struggle to make it work (Ayanda, male only FGD).

I fell pregnant in grade 10. My mother almost disowned me and I lived with my grandmother until I gave birth. My husband couldn't marry me then because I was too young according to my mom, when I gave birth I moved back to my mother's house. My husband paid damages. She takes care of the baby while I am at school. I do not stay with my husband because I am still not 18, when I finish matric this year then I will move in with him (Hayden, all female FGD).

Hayden and Ayanda's narratives concur with Swartz and Bhana (2009) and Grant and Hallman (2006) findings that the presence of an older relative usually a female at home enables young parents to continue with school while the absence of the same forces the young parents to drop out of school. This is supported by Ayanda's acknowledgement that the presence of his parents is reason why he is back at school while his peers have failed to return to school because of lack of parental support.

Perceived severity is affected by attitudes, knowledge and the environment that an individual finds themselves in. For instance Hayden is a Coloured/Indian, she spent time explaining how she wanted to abort but because of her beliefs as a Hindu she couldn't and that she was also quite aware that since she comes from a well to do family she is in a privileged position to be back in school while other peers could not come back because of their economic status. The same can be said for Ayanda who because of his privileged background was able to continue with his education.

Fear and despair for according to Hayden (a mother) and Hlobisile (a pregnant learner) are some of the emotions that they face as pregnant learners and mothers in school.

I was so afraid of my mothers' reaction, more than I was afraid that the baby father would say the baby was not his. I was more worried about what my mom would say and do. I also did not know how the baby father would respond but when I told him he said he already knew the baby was his so I was left with my mother. My mother was furious. She did not talk to me for days. She did eventually and there was a meeting set up between both families and we came to school to tell them that I was pregnant (Hlobisile).

Hlobisile and Hayden's stories facilitate discussion around perception towards pregnancy by other teenagers and the community as a whole. A pregnant teenager is subjected to a lot of

negativity from peers who make life at school difficult, to nurses who ridicule and embarrass them in front of other patients, parents who either disown them or do not accept that they are pregnant, anxiety of wondering whether the responsible partner will accept responsibility and the attitudes of teachers at schools. Such negativity and fears have the potential of influencing an individual to opt for abortion which in most cases is done clandestinely resulting in either death or serious injury to the womb. The negativity towards pregnancy is summed up succinctly by Hlabangane (2012:303-4) “this deep-seated aversion to teenage pregnancy emanates primarily from the ingrained notion of life as characterised by distinct chronological stages of development. Teenage pregnancy contravenes this”.

Literature on teenage pregnancy indicates that pregnancy in an African society is viewed as a status enhancer for the girl as she process that she is fertile and for the boy as he proves his ‘manhood’ thereby upgrading one’s social status (see Preston-Whyte & Zondi, 1992 ; Varga & Makubalo, 1996; Wood *et al.*, 1997). This study refutes such literature as participants indicated that teenage pregnancy does not enhance status but rather destroys one’s status in society. These findings resonate with findings by Hlabangane (2012) and Varga (2003).

My uncle told me I was ruined. My friends pitied me. I was an outcast. Nobody wanted anything to do with me, not even my teacher, she was disappointed. You know when someone held you in high esteem and then all of a sudden they stop doing what they were doing and you know you are on your way out. (Hayden).

And

Why would I be pregnant and still be at school? I am young and dependant on my parents. I cannot imagine myself being pregnant. What is I have major exams and the baby is ill and needs my attention as its mother? How do I balance that? I can’t think straight when my mom is ill and I am at school. Imagine what a baby will do to me (Cherel).

These extracts speak for themselves as it is clear that pregnancy presents new challenges for teenagers as they have to juggle with school and parenthood as mentioned earlier on. African culture has it that a male who impregnates a girl and does not marry her pays ‘damage’ to the girl’s family. Ayanda had this to say,

Damage means that you are ruined akiri? Something that is damaged is now in a bad state. So who wants second hand material? That is why the family will make you pay damage. Like what

I was made to do. My parents paid damage fees so pregnancy does not make you a better individual but actually says you are ruined as far as your parents are concerned.

Ayanda demonstrates that proof of fertility does not attract suitors as claimed by (Preston-Whyte & Zondi, 1992; Varga & Makubalo, 1996; Wood *et al.*, 1997) but instead ruins any chances of the same as the girl is regarded as 'second hand goods'. Kaufman *et. al* (2001) concur with Ayanda adding that the monetary value is compensation to the parents over the pregnancy.

Pregnancy was also viewed in light of the school's reputation.

Donnell: *Our school is referred to as a baby making factory or a maternity ward. It's not a good thing. Sometimes you are embarrassed even to mention the name of your school because of the many girls who are pregnant or parents here at school.*

Moderator: *On a scale of 1-10 how would you rate prevalence of teenage pregnancy at your school?*

Donnell: *I would give a 7 or even an 8. People are pregnant hey.*

There is conscious recognition that the school is an important part of their socialisation and as such there is need for reputation management. Pregnancy ruins a school's reputation. As such there are no benefits of pregnancy when it comes to school reputation.

Perceived Benefits

Perceived benefits play an important role in influencing behaviour change. Where an individual believes that the benefits of adopting new behaviour outweigh old behaviour, new behaviour is adopted. Where teenagers believe that having a baby is a means to an end then teenage pregnancy will continue to be a problem until the root of the problem is attended to.

The Child Support Grant (CSG) has always been a bone of contention in South Africa. One camp firmly believes there is no link between the CSG and teenage pregnancy (Kesho Consulting, 2006; Makiwane & Udjo; Macleod, 2009; Makiwane, 2010) while the other camp argues that there is a link (Case, Hosegood & Lund, 2005; Tyali, 2012). This study corresponds with findings from the later camp.

Girls fall pregnant because they want a grant. Sometimes it's not because they want to be pregnant but because they are very poor. The grant is used to help around the house especially

buying groceries or even paying for electricity. It's not much but it helps (Tamsin, female only FGD).

I know of girls who intentionally get pregnant. They know about contraceptives but they will make sure they fall pregnant. If someone is proud about their pregnancy you will see them pushing their stomachs around school. They make you suffer in class by always having to use the toilet so they sit in front in class so you are not disturbed. They complain about funny smells and some puke³ in class and it's so disgusting. We have to go all through this because someone is after the grant. Sies! (Abel, male only FGD).

The benefit derived from pregnancy therefore is access to the CSG. What is important to note in this instance is that the perceived benefit is driven by the circumstances an individual finds themselves in. That is why the pregnancy is termed planned but unwanted. Entrenched poverty, which is an environment that these teenagers grow up in results in the lack of upward mobility that Hlabangane (2012) and Arai (2008) refer to. Health behaviour thus is affected and influenced by the environment and in turn the environment affects and influences health behaviour. This interaction between the environment and health behaviour is termed reciprocal determinism. As Sheafor *et. al* (2009:92) put it “the problems people face or experiences in social functions are a result of the people-environment exchange rather than being a result of individual”.

While some girls fall pregnant to access the CSG because of the economic status, other girls have planned and wanted pregnancies so as to access the grant not because they come from poor families but because they want money for their own personal needs.

A girl comes from a good family she lacks for nothing. She has everything but she still falls pregnant for the grant. Usually it's these girls in squads⁴ who do that. They want the grant to spend on their own needs. The baby is taken care by their families and they still go and claim the grant. Their families will not be knowing that this is happening (Donnell, male participant mixed FGD).

³ Vomit

⁴ Groups of girls who are friends.

It is clear that the reasons for accessing the grant are varied. The issue of friends (squads) and peer pressure plays a huge role in influencing behaviour. This will be discussed in detail under interpersonal level.

Teenage pregnancy denotes unprotected sex thereby increasing the risk of HIV among teenagers. The threat of HIV is like a spectre over the lives of teenagers, who are conscious of their perceived risk to HIV. HIV poses as a threat to teenagers' future.

Every time you have a lollipop⁵ you know you are dancing with death. HIV is real and people are dying, even here at school we have kids who are positive and it's sad. If you die early you leave nothing for people to remember you by. So it's better to have a child now when I am still young and without HIV so that I can see my child grow, if I have HIV later its ok because I have a child. The funny thing with AIDS is you live with it even if you are negative. (Sandisa, female mixed FGD).

The consequence of HIV/AIDS on teenagers' lives is evident from the above extract. The disease is an important facet of everyday teenage live. Their lives are shaped by the circumstances they find themselves and HIV/AIDS is one such circumstance that shapes and influences their decisions and general outlook on life. In this instance the desire to procreate is spurred by the fear of dying young due to HIV/AIDS. The above extract reveals that knowledge does not necessarily translate to practise. Clearly they have the knowledge on HIV but their sexual behaviour is the opposite of this knowledge that they have.

Another perceived benefit derived from early child bearing is described as follows,

Girls are very funny. If you are in a relationship with her maybe for a few months and you want out, she will try by all means to hang on to you . A baby is a guarantee that she will be with you for the rest of your lives. So they use babies to trap boys (Mbuso, all male FGD).

CONTRACEPTIVE AND CONDOM USE

Knowledge on the types of contraceptives available was over whelming among the majority of the participants. They had information on where to get the contraceptives how to use them and the side effects of using certain contraceptives.

Contraceptives are pills, injections and condoms used to prevent pregnancy.

⁵ Unprotected sex or oral sex. In this instance it was used to mean unprotected sex

If you want to prevent pregnancy then you take pills, you use condoms and visit the clinic for injections.

The male condom remains the contraceptive of choice for all teenagers mainly because of the several advantages it offers over the other forms on contraception.

Nokwanda: *The male condom is the best form of protection. I can't use the pill because I have to take it every day at the same time. Where will I hide the tablets?*

Moderator: *Why do you hide the pills and who are you hiding them from?*

Nokwanda: *From my mother of course! She would be mad and disappointed if she ever knew that I am taking the pills. It means I am having sex, she should never ever find out. I would be disowned. Haybo! She may know about it but she shouldn't know ...*

Two issues emanate from the above extraction, all pertinent to the discourse of teenage pregnancy, where and how teenagers locate themselves within in. The pill clearly is a source of inconvenience as it exposes the teenager to the risk of 'discovery'. This insinuates a curtain of silence over sexual issues between the teenager and the parent. It is this curtain of silence that encourages the perpetuation of myths, secrecy, anxiety, and misinformation and makes teenage sexuality dreaded terrain when in actual fact it should be discussed openly. Macleod (2009) puts forward that culture prevents parents from talking to their children about sex and sexuality. Children are left to the mercy of their friends and the media for information; on the other hand, teenagers also cannot take their parents into confidence over their sexual activities because of this unwritten rule on sex and sexuality. One other reason that may explain parents' reticence to speak about sex and sexuality to their children is that parents do not have the self-efficacy to talk openly about sexual issues with their children. The lack of self-efficacy may be attributed to the generational cycle of teenage pregnancy that Hlabangane (2012) talks about. Fear of being questioned over past mistakes may indeed make the parent reluctant about any sex talk.

The second aspect evident from the extract is the issue of 'tacit' knowledge that parents have about teenagers' sexual activities. They may know that teenagers are having sex but the teenage should never be caught or discovered. Feigned knowledge by the parent and assumed innocence by the teenager is ingrained in 'ukuhlonipha⁶' (cf. Varga, 2003). The visibility of

⁶ Principle of respect between parents and children

pregnancy in teenagers then becomes an act of disrespect and insubordination as the invisible lines of respect are assumed broken. It is such scenarios that may force an individual to hide their pregnancy and eventually opt for fatal back street abortions.

The pill on the hand has perceived benefits apart from it being a contraceptive. Apparently it causes weight gain and is used to clear facial pimples.

Some girls will be on the pill so that they gain weight. Others use the pill so that they do not get their periods. I know if you take certain pills your menses will stop. It's also good to take pills to clear your face especially if you have outbreaks (Portia)

There is a dearth on information on the female condom. The female condom by virtue of it being unavailable becomes unfavourable to teenagers. It is this unavailability that Macleod (2011) maintains makes females vulnerable as they are unable to negotiate for safe sex. The decision for the use of protection remains firmly with the males, females are without 'choice' as they fear discovery by their parents while the female condom is unavailable.

I have never seen the female condom outside school. I only saw it during LO classes. How does it look like? They should teach us about the female condom. Serious I know nothing about it (Nonhlanhla, all female FGD).

I have seen it when we attended an AIDS workshop. It doesn't look nice though. It's ugly. Not user friendly at all! I was shocked that they expect us to insert all that plastic into our bodies. (Hayden, female only FGD).

The female condom is weird, it's all circles at the top and at the bottom, and I wonder how women use them. I would never imagine myself having sex with a girl wearing a female condom not at all. I have never seen it being advertised like the male condom (Javier mixed FGD).

My brother tells me having sex with a daije⁷ wearing a female condom is just not on. He says there is a lot of noise from the condom. It's just not on. So I rather use the male condom than the female condom (Donelle, male only FGD).

The 'user friendly' description of the female condom sheds light on the attitude that teenagers have towards the condom. This attitude is influenced by the dearth of information on the condom and its unavailability and its lack of visibility. The media also plays a role in the not

⁷ Slang for girl

disseminating female condom information as stated by Javier. The absence of the female condom in the media means that information on the condom remains scarce while at the same time negative attitudes, perceptions and myths are formed, expressed and cemented in the process. Information on the female condom can help fill the gaps in knowledge while at the same time clearing any myths and misconceptions that may surround the condom.

The injection as a form of contraception was dismissed on several grounds.

The injection is better than the pill because it's just once a month. The bad thing about it is I have to go to the clinic and get it. The nurses are horrible. They make you feel bad such that you never want to go back ever again. They question you about why you want to have the injection. They have no right to do that. After all it's my body not theirs (Hlobisile, female mixed FGD).

It's impossible to go to the clinic and not have your mom know about it you will definitely meet someone who knows you or knows your mother. One way or the other your mom will know you visited the hospital and naturally she will want to know what you were there for, that is if she has not been told (Cherel, female, mixed FGD).

Negotiation of nurses' attitudes by teenagers at clinics is well documented (cf. Ehlers, 2003; MacPhail & Campbell, 2001; Macleod, 2011). Nurses' attitudes serve to reinforce the notion of the curtain of silence drawn over sexuality by elders; their attitudes are influenced by tradition as alluded to by Macleod (2011). The injection is also disregarded because of side effects such as weight gain, vaginal discharge and its 'unsuitability' for teenagers in school.

Negative attitudes and perceptions towards other forms of contraception markedly increase the risk of pregnancy among girls as they are limited to one form of contraceptive by process of elimination and unavailability. The notion to view girls as powerless in the face of male sexuality is common in adolescent sexual research. Power relations in relationships can be challenged when the question of who carries the condom is posed.

A lot of girls here at school carry male condoms because of different reasons (Javier, Male Mixed FGD).

If your man does not want to use the condom then you carry it yourself. There is nothing wrong with me carrying a condom. I make him use it. If he doesn't want then kabooooom I leave. (Tamsin)

Boys are very clever they have a billion reasons why they don't want to use condoms but if you are wise you carry the condom yourself. If you are going to meet your boyfriend wise up and carry a condom. It may just save you from a lot of problems (Enhle)

Ja girls are carrying condoms these days. There is no rule that says anyone person should carry a condom. After all both of us benefit from sex so anyone of us can carry the condom. (Mbuso)

Whether girls carrying condoms does really translate to power exchange or power balance is something to think about mainly because having a condom on hand does not mean it will be used correctly. The above narratives deviate from previous research finding that indicate girls are unable to carry condoms around for fear of victimisation by their peers (cf. Campbell, 2003).

While the condom is the contraceptive method of choice, correct and consistent use needs to be taken into account as this is important for HIV and teenage pregnancy management. Consistent condom use is particularly difficult for teenagers as there are other factors at play.

I can want to use a condom every time with my girlfriend but what about those times when I have no condom on me? And the moment is upon us? We can't just go around with condoms in our pockets. If my condoms are discovered in my pocket at home then.... (Mqobi mixed FGD).

Spontaneity and haste mark teenage sexual lives as half the time location of sexual escapades is dependent upon where the teenagers are. 'The moment is upon us', signifies how teenagers view sex. Sex is viewed as an uncontrollable urge, one that has to be given into as they have no control over it. Teenagers view themselves as helpless in the face of sex and thus may view pregnancy as an inevitable circumstance of sex.

Popular research scripts indicate that boys are reluctant to use condoms, while this was also apparent in this research boys counter accused the girls of refusing to use the condom for various reasons.

A daije can refuse to use a condom do you know that. You tell her you doing it the safe way but she will look at you funny and say dude you do not trust me?What is a guy to say? (Akeim, mixed FGD).

Moderator: *When do you guys talk about safe sex, during the course of the relationship or just before having sex?*

Abel (male only FGD): *This is a tricky question you know. We can talk about it during the course of the relationship and agree that we will use protection but come the day it happens its either you do not have protection on you or just sh*t hits the fan bru.*

Nokwanda (female only FGD): *We talk about it kwi relationship and right before sex but then boys are clever. He will pretend something went wrong or that the condom burst just to have an excuse for ukukudla unjalo(condomless sex). If a guy tells a girl that she is the only one and that he trusts it's another excuse. Basile laba (They are very clever).*

Ayanda: *A girl or boy who refuses to use a condom is dangerous. Why is he or she eager not to use one? To me that's dangerous. It means he or she is infected and wants to infect you too. I never ever, even if I am drunk I use a condom.*

Hlobisile (mixed FGD): *I think girls need to be empowered there is something wrong with the way we think or it's the way we are brought up I don't know. You know a guy who is well known here at school even at home will come and ask you out and you still say yes. Why? The other thing girls are afraid to say no. If you refuse to use protection your man thinks you are cheating. I think we need to be empowered.*

These scripts reveal varying narratives of attitudes towards use of condoms as a dual protection, against HIV infection and risk of pregnancy. Abel alludes to the notion that they do not have control over sex, when it happens and if ever any safety protocol is spoken about. Ayanda's perceived risk on non-condom use propels him to use the condom. His narrative paints a different picture of HIV/AIDS knowledge and awareness while at the same time reiterating previous research findings that alcohol and drug abuse play a big role in HIV/AIDS prevalence rates among teenagers. Nokwanda refers to the 'boys are clever' tradition that makes boys ultra-powerful leaving the 'defenceless woman' in his wake. Hlobisile was the only participant who spoke about empowerment. She was quite passionate about girl empowerment.

She taps into feminist ideology that emancipation of girls is key to their ability to negotiate safe sex and counter patriarchal practices that exist in society. The recognition for a need for empowerment becomes the cues to action for teenage pregnancy prevention and general adoption of safe sexual behaviour. However her 'feminist thinking' is then immediately taken away by the dilemma that faces most girls. She alludes to the somewhat complex circumstances that girls find themselves in. The desire to hold on to a man and the need to enforce safe sex

practices. The desire to hold on to a man may come from a background of socio-economic deprivation and the absence of a male figure in a young girl's life.

Consistent use of condoms is also affected by brand choice. Brand choice vs. price of preferred condom brand is another reality that teenagers face in their daily lives. This reality is an issue among teenage only relationships as intergenerational relationships do face this dilemma. Sugar daddies can afford the condom brand of choice while the adolescents hardly ever afford.

It's common knowledge that choice⁸ condom is fake. You can use it when you do not have anything on you but I wouldn't advise that. (Abel male only FGD).

Choice condoms are thin; they break easily and are poor quality. My friends do not use those cheap condoms. (Javier mixed FGD).

It's simple, the choice condoms break during sex, that's why people are getting pregnant because they rely too much on the choice condoms, they are free but they are expensive in the future. (Hlobisile)

Commercial brands are preferred over free government condoms (cf. Mulwo, Tomasselli & Dalrymple, 2009). Negative perceptions towards government condoms result in the government condoms not being used. This exposes teenagers to risk of HIV infection and teenage pregnancy. The desire to use commercial branded condoms is hampered by price as these condoms are expensive for teenagers; this explains why branded condoms are not an issue in intergenerational relationships but among teenage relationships. Attitudes and perceptions towards the government condom may also be influenced by hearsay and not actual experience. Government's continuous recall of condom batches also increases mistrust of the government condom.

Faced with the dilemma of preferred contraceptive and price of contraceptive, teenagers are thus left with very few choices to protect themselves against pregnancy and possible HIV infection.

We use withdrawal method. Before the sperms com out the boy must pull out. That way you are safe from pregnancy (Portia, female only FGD).

⁸ Choice condoms are government supplied condoms

If you do not have a condom you can have thigh or just breast sex. It's safer than have actual sex. Thigh sex does not result in pregnancy neither does breast sex (Nokwanda).

Black girls whose families still practice virginity testing are sometimes caught in between. The desire to preserve their chastity and the pressure either from friends and male partner to engage in sexual activities mounts pressure on them thus resulting in anal sex.

Some families still have ukuhlo⁹wa. It's a small process but you are checked by your aunt or your gran if you are still a virgin. Sometimes we have to do that as a whole village so if you are found not to be one you will have disgraced your family uyabo. It's important not to disgrace umzali wakho ngaleyondlela(your parent in that manner). On the other hand you are in a relationship and he insists on sex, if you have been having breast sex naturally you want to go further, you can't have breast sex for ever. I can't risk my virginity so girls these days will go via the sewage works (Enhle).

Anal sex presents new challenges for teenagers as they risk HIV infection. The simple fact that the male partner insists and she cannot say no probably because of the fact that these young girls want to 'hang on to a man' as mentioned by Abel in the male only focus group is an indication of the power dynamics at play. On the other hand the girl's agency cannot be overlooked as she also consents somewhat surreptitiously when she says 'you can't have breast sex for ever'. She acknowledges that it is important not to disappoint parents while at the same time she has desires, culture in this instance plays a role in health behaviour as teenagers are forced to navigate their sexuality through narrow channels that leave them susceptible to diseases.

The injection

Knowledge on the injection as a form of contraceptive exists among teenagers. Females preferred the male condom over the injection for the same reasons they did not want to use the pill. Apart from the fear of discovery, females pointed out that the injection is not ideal for young girls because it causes weight gains and moodiness.

If you are on the injection be sure that you are ready to gain weight. It causes you to be fat. You will have breakouts all over your face and even have mood swings. You are like a yoyo. One time you are ok and the next you are moody (Hlobisile).

⁹ Virginity Testing

As teenagers we have a lot stress in our lives, the injection is not reliable at all. If you are stressed it may not work. The nurses at the clinics tell us so. So it means we can't use the injection because we are always stressed. I prefer using something I know I have control over than the pill. Use the injection at your own risk (Cherel).

While female participants did not mention anything to do with vaginal wetness, the male participants did.

I know that the injection is not good for girls because it makes them wet down there. My brother told me that girls who use the injection have lots of fluids down there and it's not nice (Sabelo).

Akim, a male participant in a mixed FGD agreed with Sabelo

When you sleep with a girl who uses pills and one who uses the injection for contraception you can tell the difference. One is sloppy and the other is tight, clean, you know what I mean.

The female participants were ignorant of this 'wetness' issue. Vaginal wetness has been an issue of contention among men and women (cf. Wood, Maforah & Jewkes, 1998). Interpersonal relationships play a huge role in disseminating information and influencing attitudes and perceptions towards the injection. Siblings and friends are considered as voices of authority especially if they have the experience and so called 'facts' to back themselves. Effective pregnancy management requires strategies that also target interpersonal relationships as they are pivotal in behaviour change and adoption.

The emergency/morning after pill and abortion

Information abounds on the morning after pill and like other contraceptive pills is subject to perceptions and attitudes that influence non-use. In light of the factors that militate against the use of morning after pill, participants stated that they use the following as forms of morning after pills. There was a thin line between their forms of morning after pills and 'abortion'. This was because using the morning after pill is equated to aborting rather than a preventative measure against pregnancy.

- Washing the vagina with water immediately after sex.
- Drinking salt water immediately after sex (this cleans the womb and the sperm will come out).
- A concoction of ash, paraffin and disinfectants such as Jeys liquid and Domestos,

- Stameta¹⁰
- Water boiled with newspapers
- Water boiled with steel wool
- Boiled Coca-Cola with headache pills left for half the day to cool and then taken will cause abortion.
- Coca-cola boiled with bleach
- Turpentine¹¹
- ½ a glass of paraffin and water will also induce abortion.
- Being punched in the abdominal area
- Throwing oneself down a staircase

Doing either one of these or a combination of any two is regarded as a sure fire way of aborting or can serve as a morning after pill. The above methods are used only during the first trimester while advanced pregnancies required the services of a doctor or a ‘bush doctor’.

If you want to have a proper abortion you go to the doctor at the clinics. They will ask you a lot of questions and insult you. It is also expensive to have a proper abortion at the clinic (Nokwanda female only FGD).

Nurses’ attitudes again prevent these young girls from accessing goods and services. They risk their lives by going to back street clinics and administering abortion inducing concoctions themselves.

The clinics are not very nice to go especially if you are going to have an abortion. That’s why girls prefer backstreet abortions. Though those people lie that it’s pain free. I know it’s not because I went with a friend and they used a hanger down there to pull the baby out. When they couldn’t pull it out they gave her a pill. Wacitsha wafa! (She nearly died!). She eventually had to be taken to the government clinic to be cleaned (Sandisa, female FGD).

Information on the dangers of using ‘bush doctors’ for abortion is available but teenagers are forced to go there for services. Their choices are influenced by the environment, that is, economic situation they find themselves in and the attitudes of the nurses. The community and interpersonal level factors affect their choices. The perceived severity of using these back street

¹⁰ A range of single and multi-species blends designed to treat various ailments and conditions

¹¹ Paint thinners

doctors is outweighed by the apparent perceived benefit which exposes them to untold cervical damage and even death.

Lack of accurate and comprehensive knowledge and nurses' hostile service are evidently a service barrier because even though some teenagers may know the circumstances under which a legal abortion can be obtained, where it can be obtained and for how much, their inaccurate or lack of knowledge including their uncertainty concerning other equally essential stipulations may deny them the opportunity to exercise and enjoy their reproductive rights.

Hlobisile: *One reason that can force me to abort is my mother's reaction to the news that I am pregnant.*

Moderator: *Would she react any differently knowing that you have aborted?*

Hlobisile: *I would make sure she never finds out that I have aborted. If she finds out then that's that. I'd rather she punishes me for aborting than she deals with me for falling pregnant.*

Backlash from their parents and fear of disappointing their parents also drives these young girls to backstreet abortions.

Adrian: *Girls also abort because boys are not responsible. They have unprotected sex with a girl and when the girl comes with news of the baby, the boys always say the baby is not theirs. What's a girl to do? She will abort. That is why we have a lot of bitterness today. Disappointments.*

Again young men who do not claim responsibility for their action also play a role in driving girls towards abortion. It can also be surmised patriarchal society plays a role here as a girl is left with no option mainly because she is disempowerment on a lot of levels simply because of her sex. In most societies, men still have the last say; this continues to strengthen the perception that women are powerless. It thus played out well when teenagers abort because the responsible man has denied responsibility. There is a possibility that men are still seen as gate-keepers in terms of whether a woman is allowed to have an abortion or not, hence the fear of parental retribution or discord with spouses/partners may be one of the reasons why teenagers still undergo 'backstreet' abortion (Varga, 2002).

This section sought to discuss teenage pregnancy in relation to contraceptive use. Teenage pregnancy is an old phenomenon that keeps changing with changing environments and social

systems. Contraceptive use is beleaguered by issues to do with access, apathy, misinformation, attitudes and perceptions towards contraception. An understanding and appreciation of these factors within the context teenagers find themselves is important for policy and health behaviour strategy development. In addition, this selection sought to emphasise that teenage pregnancy cannot be understood from a reductionist view but as a result of a cocktail of social ills.

INSTITUTIONAL

The bulk of teenagers' time is spent in school thus the school plays an important socialising role. It helps inform and shape teenagers' sense of reality while at the same time creating an atmosphere for ideological exchange. Since it is an environment that allows ideological exchange, it becomes a site for struggle as realities are negotiated, changed and adopted.

In an effort to mitigate teenage pregnancy, life skills such as Life Orientation were introduced in schools by the Department of Education. Life Orientation is meant to discuss all issues that affect teenagers especially teenage sexual behaviour. However, Life Orientation does not address what it is supposed to do.

Teachers waltz over issues. You know they assume that we already know when we do not know. If she ever does talk about sex you can see that she is uncomfortable and she does not answer all our questions. So we do not know not because we are dull but because no one bothers to tell us the right thing. That's why we end up using Google (Andile).

The LO period is just too short. And it's once a week. We discuss things that are not real because the teacher says we are already known but we don't that's the crazy thing. Those that know are very few compared to us who don't (Donnelle).

The thing with LO is the teacher is never comfortable when it comes to sex. We are lucky because we talk about some of these things in Life Sciences but then again you can tell that teacher does not want to entertain our questions. Some ask because they do not know, not because they want to put the teacher in the hot seat (Hayden).

This apparent discomfiture that educators have over sex is attributed to the moral atmosphere that sex talk is approached with. Adults assume that sex talk is meant for adults thus negate any sex talk to teenagers. Such attitudes by educators are not in line with the learning outcome

of LO which states that LO aims to “addresses issues related to the prevention of substance abuse, diseases of lifestyle, sexuality, teenage pregnancy, sexually-transmitted infections including HIV/AIDS, and the promotion of personal, community, and environmental health” (Department of Education, 2003a: 11).

Teenagers also do not have access to material designed for them such as the 2012 booklet on teenage pregnancy produced by the Department of Health. This booklet is meant for teenagers yet teenagers do not have access to the information. Thus teenagers’ knowledge, attitudes and perception is affected and influenced by lack of information not on their part but on the part of institutions that ought to be delivering such information to the necessary audiences.

Thus at an institutional level, teenagers’ knowledge, attitudes and perceptions are affected and influenced by institutions of socialisation such as the school that does not give them sufficient knowledge because of teachers’ attitudes towards teaching sex at school. Knowledge is also affected by higher institutions like the Department of Education that fails to deliver booklets in conjunction with the Department of Health. Lack of adequate knowledge thus affects perceived susceptibility and perceived risk.

POLICY

The Child Support Grant

The Child Support Grant (CSG) is a topical issue in South Africa, the controversy of the CSG lies in the debates whether access to the grant results in teenage pregnancy. While Naong (2011), Macleod (2006) and Makiwane and Udjo (2006) conclude that there is no relationship between the CSG and teenage pregnancy, participants indicated that there is a link as some girls fall pregnant to access the grant. Tamsin (Female only FGD) says;

A lot of girls fall pregnant because they want ‘igrant’. Sometimes it’s not because they want to be pregnant but because they are very poor. The grant is used to help around the house especially buying groceries or even paying for electricity. It’s not much but it helps.

Tamsin opposes scholars who argue that there is no link between the CSG and pregnancy. There is a link as indicated by Tamsin, Tyali (2012) concurs and notes that in Plantfontein (South Africa), teenagers not only fall pregnant to access the CSG but intentionally want to contract HIV and AIDS so they can access the HIV and AIDS grant.

In the same discussion, Nokwanda had this to say

How do you come to school hungry, knowing your little sister is also going to school hungry and you don't have clothes to wear? Maybe your mother died and you stay with your grandmother who also gets a small grant, so the options available is to have a baby and get the grant or even have a sugar daddy. It's tough out there.

The grant pay-out is R275 and according to Adrian (male only FGD participant)

...it's not enough to buy skimbies¹². The sad thing is that even if they get a grant some never use the money on the baby but use it for themselves buying clothes and have other babies so that they have more grant money.

The male only FGD participants felt that while girls may want to access the grant to help out families they are not responsible enough as they always buy personal stuff as babies are left with grandmothers and mothers to care for. They also bemoaned the fact that an increase in the grant value was usually between R5 and R10 not enough for those who really need the money as R275 is not enough to buy formula milk let alone baby clothes.

Here teenage pregnancy is linked to the economic status of individuals who are somewhat driven by their circumstances to have babies so that they can take care of their families. Such cases of teenage pregnancy cease to be unplanned but remain unwanted. Pregnancy is used as an end to a means. Similarly, Kanku and Mash (210) conclude that teenagers are pressured by their parents to have babies so as to access the CSG and increase household income.

INTERPERSONAL LEVEL

Relationships that an individual has affect and influence their behaviour. The behaviour patterns of these relationships influence and help shape an individual's attitudes and perceptions towards a certain behaviour. This contributes to the individuals' range of behaviours. Family, friends, teachers and community health workers all make up the relationships that a teenager is likely to have at the interpersonal level.

¹² Diapers or nappies

Peer Pressure

Teenage pregnancy is a result of various interconnected reasons. On top of the list of the causes of pregnancy is peer pressure. Naong (2011) concludes that peer pressure plays a huge role in teenage pregnancy as teenagers are eager to please their friends or even engage in sexual activities to gain access to certain social groups.

They are pregnant because they want to be like their friends who are having sex. So you can see that a group of friends can all be mothers or even pregnant. It's cool to them to be pregnant. You can't be their friend if you are not pregnant or having sex. Friends will change the way you behave. (Nokwanda, female only FGD).

The role of peer relationships in sexual health decision making cannot be overlooked in light of such revelations. Using the Social Ecology Model to understand teenage pregnancy, friends fall under the interpersonal level. This level provides social identity, support and role definition to an individual (Sallis, Owen & Fisher, 2008). To some teenagers, social identity and acceptance comes from peers who play an important role in defining social identity.

Friends are important but they also mislead. I trust my friends because they are part of me but again they are not...If my friends are having sex, they will tell me all they are doing sometimes even invite me to their houses and leave windows open so that I see what they are doing. Then I will be the witness when they tell others that they are having sex. Or we can even arrange to have the whole thing recorded...so I trust my friends in this way. If you have an older brother or even an uncle who tells you things you can pretend to be having sex to fit in with your friends (Mbuso, male only FGD).

Clearly peer pressure is a site of negotiation as it can be negative or positive. Social acceptance within peer groups is important for teenagers who don't want to be labelled 'queer' thus they are pressured to be part of some of these groups and because of lack of proper sexual health information they end up pregnant and vulnerable to STIs.

While peer pressure mounts pressure on certain individuals, others have ways of handling the negative influence from friends. Family is a crucial factor in providing support and giving guidance. Like friends, family falls under the interpersonal level which seeks to provide support and social identity (Sallis, Owen & Fisher, 2008). Advice from home is protective from peer pressure.

You cannot decide to have sex just because your friends are having sex! Your background is important. What has your mother been teaching you or even your granny? If you have a problem you talk to your mother because she is wiser than you are and she will always tell you what to do. If I can't ask my mother then who shall I ask? (Sabelo, male participant mixed FGD).

We are different. Some people come from rich families so they can afford to have babies and not attend classes. I cannot afford that, my mother works hard for me to go to school so falling pregnant will ruin my life and disappoint my mother. I have seen a lot of girls dropping out because they have babies and I don't want that for myself. My mom knows my friends and so we are ok with the people I hang around..... (Nonhlanhla, all female FGD).

Circumventing peer pressure is key to not falling pregnant and 'ruining lives' according to the above transcripts. '*We are different*', implies that an understanding of where one comes from also plays a role in avoiding negative peer pressure. Those from poor backgrounds cannot afford being mixed with bad friends; the implication being those from rich families can afford to ruin their lives. Clearly there are certain things that one can be persuaded to do by friends while others cannot be excused hence the '*I can't afford*' expression from Nonhlanhla.

The notion of what can be allowed to influence and what cannot be allowed can also be analysed through the Health Belief Model (HBM). Perceived severity takes into account personal feelings of the graveness of a condition based on the subject awareness of the consequences of that condition (Hall et al., 2010). A teenager will weigh the consequences of caving in to peer pressure. A teenager with low perceptions of risk is likely to cave in to pressure while one with high risk perceptions is likely to use preventive measures such as family or changing friends to prevent being influenced by friends.

Sugar Daddies

Sugar daddies are known for having money that teenage girls do not have and providing them with luxury goods such as expensive cell phones, jewellery, airtime and taking girls to expensive hotels. What sugar daddies have to offer compared to what the girls have to offer results in transactional sexual intercourse. Transactional sex leaves the girl powerless to negotiate for safe sex. In an effort to understand the sugar daddy phenomenon, the researcher asked the participants to identify the men who fit the description of a sugar daddy and why these people are ideal candidates for sugar daddies.

Javier (male participant, mixed FGD) jovially describes the sugar daddy;

They are usually 10 years older than the girl, married and have lots of money. Here at school they drive into the school during break time with lunch (KFC). The girl knows the time the sugar daddy will be here. If she can't see him in the school yard she will go and wait by the gate and ask the security guard or even passer-bys to hand her,her food. It's not hard to see a girl who has a sugar daddy; she changes hairstyles every week or has too much money with her and spoils her friends. She also has the latest phone because her man can afford it.

Javier's statement indicates that girls are only after material goods from the sugar daddies that are only too eager to provide these in exchange for sex. The sugar daddy concept also brings into picture the issue of multiple sexual partners as these men are married according to Javier. Since the girls do not have negotiating power for safe sex, they become part of a sexual network exposing them to the risk of HIV and other STIs. 'Sugar babies' (girls in transactional relationships with older men) also have their own 'Ben 10s' (young boys or men who have relationship with older women or in this context, boys of the same age with the girls but of a lower economic status). 'Ben 10s', sponge off the 'sugar babies' who have 'money' from the sugar daddies. This creates a cycle and even a sexual network that continues to grow and becomes riskier with the addition of each character.

Sugar daddies were also attributed to peer pressure as girls are pressured to have inter-generational relationships so as to fit into certain groups amongst friends or even be able to afford to maintain a certain style or look.

Sometimes a whole group of friends has sugar daddies and so you can't be their friend if you do not have one... People are also mistaken that poor girls have sugar daddies; even girls from rich families have sugar daddies. It's a big problem.... (Hayden, female only FGD)

Enhle (female only FGD) gives a different view of the sugar daddy relationship;

Sometimes the sugar daddy is like a father figure to a girl. He just wants companionship, someone to talk to and not sex as everyone here thinks. He will listen to you and help you with your problems and not even kiss you. Such men exist!

Enhle's contribution resulted in an uproar as other participants were quick to point out that no such relationships take place as all sugar daddies want *inyama encane kanje* (young fresh meat). While Enhle's peers may have denied the existence of such relationships, Enhle

facilitates the discussion on the relationship between father and daughter and what the absence of the father has on a girl. The presence of a father in a girl's life has the potential of delaying her sexual debut. The norms and sexual behaviour of the male figure influence the behaviour of the girl (Blum & Mmari, 2005). This may be the explanation for Enhle's extract that it's not necessarily about the money but about companionship and an attempt to fill in the void that the absence of a father creates.

With the exception of Enhle all other participants felt sugar daddies were after 'free' sex as a lot of money to a school girl is different to a lot of money to a university girl or even a working woman.

A sugar daddy will buy a teenager airtime worth BIS (Blackberry Internet Services) that is too much to the girl and nothing to him because he can still buy a university student airtime for R90. So this is 'free' sex to the sugar daddy who considers R30 to be nothing. (Akim, male participant mixed FGD)

Akim infers that sugar daddies have it easy as the girls have very low expectation compared to what the sugar daddy has a potential of offering. Considering though that according to Javier, a sugar daddy is a male older than the girl by 10-15 years; a 26 year old male is considered a sugar daddy by a 16 year old girl while a 26 year old girl will also consider a 36 year old male a sugar daddy. The 'definition of a sugar daddy shifts as age increases and who a sugar daddy is, is important to teenagers.

A student sugar daddy being a university student for example cannot be compared to a working class sugar daddy. The student sugar daddy while a closer generation to the teenager holds no light to the sophistication and monetary power the working class sugar daddy has over the young girls.

Like the CSG, motivation for engaging in transactional sex varies from one teenager to another. Girls from disadvantaged backgrounds are forced to engage in transactional sex so as to get money for basic needs. Others are involved in transactional sex for material gains. It's not that they come from impoverished backgrounds but they want extra material things like airtime, expensive phones and jewellery.

Entrenched in the sugar daddy script is the issue of status. Where the girl gets status from being ‘arm candy’ for the sugar daddy, the sugar daddy gets status from bedding a younger woman as this indicates his not so diminishing virility and gives them a sense of longevity¹³.

I can his arm candy but he is also getting something from me. His money makes my life easier (Portia).

This study also found out that these sugar daddy and ben 10 relationships exist among the lesbians and gays though the focus of this study was not on lesbians and gays.

¹³ This is for the older men 20 and above year older

CHAPTER 6 - FINDINGS AND CONCLUSION

This study is premised upon the notion that the knowledge attitudes and perceptions of teenagers towards teenage pregnancy are intricately woven into their social broader social environments they find themselves in. Thus teenagers' sexuality is studied from the teenagers' perspective, allowing them to express how they interpret it and the contextual influences that shape teenage pregnancy as a social phenomenon.

What's love got to do with it?

Sugar daddies are a major driver of teenage pregnancy, and most teenagers are involved in these transactional relationships not because of love but because of the socio-economic circumstances they find themselves in. Their bodies become the only currency available to them to make a living. Money and whatever material benefits obtained from these relationships is used to take care of families especially in the case of child headed families and instances of entrenched poverty where the money is used to complement family income.

Instead of stigmatising and moralising intergenerational and transactional relationship, there is need to address the structural problems that encourage such relationships, such as poverty and gender power dynamics and self-esteem of young girls. There is need for girl child empowerment and have her equipped with the necessary skills that ensure they are not exploited and taken advantage of in the transactional and intergenerational relationships. This empowerment process can begin with availing economic opportunities to these girls instead of making them dependent on donors or hand-outs; this has the potential of increasing their self-efficacy. In addition, uptake of healthy behaviour can be encouraged without stigmatising transactional relationships. An appreciation of the nature of transactional sex is a starting point in understanding teenage pregnancy and all its complexities.

Government campaigns on sugar daddies like the one conducted in KZN receive next to no attention because teenagers feel the government does not understand them and their needs. Future campaigns and strategies need to be 'people centred' and not be abstract as this can only be a waste of resources. For instance the proposed provision of condoms in schools is opposed by teenagers who already harbour negative attitudes towards the Choice condoms which they said break and produces noise. If government does supply these condoms without an appreciation of how learners feel about them, chances are high that they won't use these subsidised condoms as government expects them to.

It is therefore important that teenagers be seen and considered as full partners in designing, implementing and monitoring the very same programmes designed to manage and control teenage prevalence rates. Another important element in the struggle to control and maintain teenage pregnancy is parents. Thus, there is a need to draw upon their support as individuals and as communities in the provision of correct contraceptive and sexual health information and services.

Let's talk

Central to behaviour change is communication. Participants noted that there is little communication that takes place around sex and sexuality be it in their homes or at school. The school, being an environment where teenagers spend the bulk of their time at, needs to be one place where sex education is conducted in a manner that teenagers understand and appreciate. While the Ministry of Education introduced Life Orientation as a platform for sex education research indicates that conversation around sex and sexuality are usually stilted and stiff as educators appear uncomfortable. Participants from this study also raised the same concerns, indicating that educators assume that all learners have the correct information; 'waltz' over sex talk and are never prepared to answer questions. Such behaviour results in teenagers relying on friends who are also misinformed themselves resulting in the creation of sexual myths giving birth to negative attitudes and perceptions towards sexual health and positive sexual health behaviour. Educators and in particular, LO educators, may have to be taken for reorientation or refresher courses in an effort to facilitate adequate sexual conversations in classrooms. Sex education ought to start in earlier grades as indicated by participants. This is because as early as 14 years teenagers are already having sex and most of it is unprotected, hence the need for comprehensive sex education cannot be overstated.

Access to national material on teenage pregnancy is limited and in some instances non-existent, for instance the Department of Education's booklet 'Teenage Pregnancy' is a source of information on teenage pregnancy but none of the participants had access to it. These resources are produced for teenagers yet teenagers do not have access to them. Distribution of such material needs to be scaled up. Although the booklet is informative it still has heavy moral tones and stigmatises early sexual debut. Instead of moralising teenage sexuality there is need to understand and negotiate the meaning of teenage pregnancy and equip these teenagers with the necessary information and skills to deal with their sexuality.

Parents on the other hand also need to be free and be able to discuss sexual issues with their children. Participants indicated how they prefer to speak to their parents or guardians about sex issues but fear their parents' reactions. Open communication channels in particular about sex ensure that the girl child does not have to hide birth control pills and the boy child does not have to hide condoms. This furtive behaviour usually results in incorrect use of these contraceptives resulting in early child birth. Discussion around sex needs to be conducted in enabling environments where parents are open and furnish their children with adequate information rather than giving ambiguous advice such as 'if you play with boys you will see'.

Open communication on sexual issues seems to be more prominent among the coloured community more that it is in the black community. Probably because of culture that Madu, Kropiunigg and Weckenmann (2002) refer to, as discussed earlier open lines of communication must be maintained so that misinformation and perpetuation of sexual myths can be dealt with.

Double Dutch

Apart from the male and female condom, all other contraceptives prevent unwanted pregnancy but offer no protection against HIV infection. Teenage pregnancy is an indicator of unprotected sex and risk of HIV infection is high, therefore there needs to be an increase in the use of dual protection 'double Dutch' which will protect teenagers from pregnancy and infection. Dual contraception se is very low among teenagers and there is need for upscale in correct and consistent use of dual contraception as this may be the one answer to manage increasing HIV and pregnancy rates.

The female condom is an important option for girls as it gives them the power to negotiate safe sex. There is need for the female condom to be made visible and available just like the male condom. By virtue of the female condom being unavailable and invisible, girls are disadvantaged. More education on the female condom needs to be done as teenagers do not know the female condom nether do they know how it is used. Of those who know of the condom, they complain about the noise the female condom produces during sex, there needs to be education around this contraceptive and maybe development of one that produces less noise and is user friendly.

It takes two to tango

While sugar daddies are part of the teenage pregnancy equation, boys both in and out of school also play a part. However, men seem to be excluded in the conversations around pregnancy,

making pregnancy the sole responsibility for the girl child. This exclusion suggests patriarchal practices still exists within society, it is these practices that put the girl at a significant disadvantage especially when it comes to safe sex negotiation. It cannot be ignored however that efforts are being made to include young men but there is a lot of work to be done in terms of inclusion of young men in the teenage pregnancy discourse.

There are many ways to kill a cat...

Ukuhlolwa (virginity testing) is still being practised in some communities; the purpose of virginity testing is to ensure that a girl maintains her purity and preserves her chastity for her husband alone. Virginity testing mounts pressure on girls who want to maintain their purity while at the same time please boyfriends and be acceptable within their peer groups. One way of dealing with such situations is non-penetrative sex, usually breast, thigh sex and ‘tea bagging’. Anal sex is another option open to these girls who are caught in between. As indicated by one of the participants, all these are perceived by teenagers as safe forms of contraception. While non-penetrative sex (thigh and breast) has its own benefits anal sex on the other hand offers new challenges as it has risks of transmitting and contracting HIV. Education around contraception and again unprotected anal sex needs to be done as there is a lot of misinformation among teenagers regarding anal sex.

The Child Support Grant

Contrary to research (Kesho Consulting, 2006; Makiwane & Udjo, 2006 and Macleod, 2009), there is a link between the CSG and teenage pregnancy. The CSG is perceived as alternative income by girls who come from poor economic backgrounds, resulting in planned though unwanted pregnancies. Planned in the sense that the girl has an intention of accessing the grant unwanted because circumstances force her to be a mother at an early age. The CSG also lures girls from well to do families who do not need to compliment family income with the CSG but who use the CSG to complement their pocket money.

Abortion and the emergency pill

Misconceptions about the emergency pill abound as evidenced by the narratives of the participants. Home-made ‘emergency pills’ have dangerous and sometimes fatal results. Back street abortion are still being preferred over safe government provided services mainly because of service provider attitudes which still exist and fear of discovery on the part of the teenage mothers. The dangers of conducting backstreet abortions, use of home-made ‘emergency pills’ need to made clear to teenagers while at the same time safe government abortion services need

to be advertised. Service provider attitudes need to be addressed in an effort to make clinics and other health facilities youth friendly and accessible to teenagers.

Abstinence

Primary abstinence does not feature much in the teenage conversations. Where it is discussed it is usually embedded in religious beliefs, other than that teenagers expressed how it is difficult to have sexless relationships. Abstinence only programs advocate for primary abstinence instead of looking at secondary abstinence as an option. Participants indicated that it is possible to practise secondary abstinence, thus interventions ought to encourage both forms of abstinence and where possible and applicable then religion can be used to encourage either form of abstinence.

Finally there is need appropriately group types of pregnancy and their circumstances as suggested by Macleod (2009). Bulking teenage pregnancy under one umbrella has implications on intervention design and implementation. Teenage pregnancy can be unplanned and unwanted (this is usually where there is no knowledge on contraception or misinformation), unplanned but wanted (instances like rape and where the individual did not want to be pregnant but will not terminate the pregnancy), planned but unwanted (where the goal is access the CSG for instance) and finally planned and wanted (in cases where the individuals want to have children because they fear contracting HIV).

CONCLUSIONS

Teenage pregnancy places numerous demands not only on the teenagers themselves but also on the wider community as a whole. Society continues to struggle to find ways to manage the ever increasing teenage pregnancy rates despite the fact that fertility rates have dropped over recent years. Teenagers on the other struggle with their sexuality because of lack of adequate information and youth friendly communication avenues.

Teenage pregnancy can be viewed from many angles such as the utilitarian angle which focuses on the individual and the choices they make or fail to make thereof. However, this approach divorces the individual from the economic, social and cultural environment they come from and within which teenage pregnancy takes place. This study did not thus divorce teenagers and their experiences from the realities that make their everyday lives. This approach enabled the

researcher to capture the very essence of teenagers' knowledge, attitudes and perceptions towards teenage pregnancy.

The aim of the study was to analyse teenagers' knowledge attitudes and perceptions towards teenage pregnancy. It sought to explore teenagers' knowledge, attitudes and perceptions towards teenage pregnancy. In addition, the study sought to account for the factors that influence these attitudes and perceptions.

Teenage pregnancy in its nature, presents problems that cannot be understood at a surface level, but requires analysis via a multi-level approach that links human behaviour and the environment, as well as an individual level approach that focuses on the individual's knowledge, attitudes and perception. Against this background, the study was informed by the Social Ecology Model (McLeroy et al., 1988) and the Health Belief Model (Rosenstock, 1974). Central to the Social Ecology Model is the concept of reciprocal determinism which has it that the environment affects and is in turn affected by the behaviour. Reciprocity is evident in the analysis chapter where for instance teenagers' attitudes towards contraception are influenced by the negative attitudes of health care providers who are also influenced by their individual beliefs concerning teenage sexuality. This reciprocity creates a cycle thus an understanding of knowledge, attitudes and perceptions must be undertaken with a conception of reciprocal determinism or causation. The Health Belief Model was applied in this study to understand at an individual level, teenagers' knowledge, attitudes and perceptions towards teenage pregnancy. The theoretical rationale of this study is premised upon an appreciation of the importance of comprehending teenage pregnancy as a social phenomenon that is influenced by other structural factors outside the individual.

The study is located within the qualitative research approach. The qualitative approach allows the researcher to acquire meaning of everyday phenomenon from the participants' perspective. The case study was used as the research design of choice because it paves way for the participants to tell their own story allowing the researcher to acquire rich detail of the phenomenon under study. Focus group discussions were used to collect data as they allow for rich detail to be obtained from the participants. Focus group discussions were preferred over other forms of data collection as these other forms of data collection bring the spotlight on the teenager as an individual. This study was not about the teenagers' private sexual lives but about teenagers' sexuality. As indicated in chapter four, there is vast difference between private sexual behaviour and sexuality.

Peer pressure plays a huge role in teenage sexuality as discussed in chapter five. Contrary to common findings that the CSG does not influence teenage it was found that indeed some teenagers fall pregnant to access the grant either out of a desire to fit in with friends or driven by their socio economic status. There is need for contraceptive knowledge on use to be adequately disseminated as teenagers know about the contraceptives but do not know how to use them. While knowledge of contraception is one thing, correct use is another concept all together that needs to be dressed. Availability and visibility of the female condom needs to be increased because its sheer unavailability limits girls' choice and power of the use of contraception. In the era of HIV/AIDS there is also need for the encouragement of dual contraception as teenagers use just one form of contraception in most cases.

Teenagers are also not conversant on the laws and policies that guide and inform their being in school in the event of pregnancy. This ignorance may also explain certain attitudes towards reluctance to return to school after child birth. In addition, schools need to be conducive environments that accommodate young mothers and fathers as well as pregnant girls.

To develop interventions for teenage pregnancy, future research can explore teenage pregnancy and sugar daddies as these are arguably one of the biggest drivers and contributors to teenage pregnancy. In addition, further research can be conducted around how structural determinants that affect and influence teenage pregnancy can be addressed so as to manage and reduce the rates of teenage pregnancy.

REFERENCES

- Ajzen, I. (1985). From intentions to actions: A theory of planned behaviour. In J. Kuhl & J. Beckman (Eds.), *Action-control: From cognition to behaviour*. Englewood Cliffs, NJ: Prentice-Hall.
- Ajzen, I., & Fishbein (1980). *Understanding attitudes and predicting social behaviour*. Englewood Cliffs, NJ: Prentice-Hall.
- Anderson, G. 1998. *Fundamentals of educational research*. London: Falmer Press.
- Arai, L. (2008). Low expectations, sexual attitudes and knowledge: explaining teenage pregnancy and fertility in English communities. *Insights from Qualitative Research. Sociological Review*. 5 (2), 199-217.
- Armitage, C. J. & Conner, M. (2000). Social cognition models and health behaviour: A structured review. *Psychology and Health*. 15 (2), 173-189.
- Baloyi, G. O. (2006). *The evaluation of the National Adolescent Friendly Clinic Initiative (NAFCI) program in the Greater Tzaneen Sub-District, Limpopo Province South Africa*. Masters thesis. University of South Africa.
- Bandura, A. (1977). *Social Learning Theory*. New York: General Learning Press.
- Bandura, A. (1986). *Social foundations of thought and action: A Social Cognitive Theory*. Englewood Cliffs, N.J: Prentice Hall.
- Bandura, A. (1990). Mechanisms of moral disengagement, in: W. Reich (Ed.), *Origins of Terrorism: Psychologies, Ideologies, Theologies, and States of Mind*. Cambridge: Cambridge University Press.
- Bandura, A. (2004). Health promotion by social cognitive means. *Health Education & Behaviour*. 31 (2), 143-164.
- Becker, M. H. (1990). The Health Belief Model and personal health behaviour. *Health Education Monographs*. 2(4), 22-32.
- Bhana D., Clowes, L., Morrell R., & Shefer T. (2008). South African responses to pregnant girls and young parents: A study of some Durban and Cape Town secondary schools. *Agenda*. 76, 78-87.
- Bhana, A. & Petersen, I. (2010) .HIV and youth: A behavioural perspective. In: Rohleder, P., Swartz, L., Kalichman, S.C. & Simbayi, L.C. (Eds.). *HIV/AIDS in South Africa 25 years on: psychosocial perspectives*. New York: Springer.
- Blum, R. & Mmari, K. (2005). *Risk and protective factors affecting adolescent reproductive health in developing countries*. Geneva: World Health Organization.
- Bowling, A. (1997). *Research Methods in Health: Investigating Health & Health Services*, Buckingham: Open University Press.

- Braun, V., Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*. London. Arnold Publishers.
- Brink, H. I., Van Rensburg, G., & Van der Walt, C. (2006). *Fundamentals of research methodology for healthcare professionals*. (6th Ed). Cape Town: Juta.
- Brink, H. I., 2006, *Fundamentals of Research Methodology for Health Care Professionals*, 2nd edn.). Juta, Cape Town.
- Bronfenbrenner, U. (1989). Ecological systems theory. *Annals of Child Development*. 22, 723–742.
- Brook D. W., Morojele, N. K., Zhang, C. & Brook, J. S. (2006). South African adolescents: pathways to risky sexual behaviour. *AIDS Education and Prevention*. 18(3), 259-272.
- Byrnes, J. P. (2001). *Minds, Brains, and Education: Understanding the psychological and educational relevance of neuroscientific research*. New York: Guilford.
- Cameron, N., Richter, L., McIntyre, J. Dhlamini, N. & Garstang, L. (1996). Progress report: Teenage pregnancy and birth outcome in Soweto. Unpublished report: University of the Witwatersrand, Johannesburg, South Africa.
- Cantrell, D.C. (1993) Alternative paradigms in environmental education research: the interpretive perspective, in: Mrazek, R. (Ed.) *Alternative Paradigms in Environmental Education*. Troy: North American Association for Environmental Education.
- Case, A., Hosegood, V. and Lund, F. (2005). The Reach and Impact of Child Support Grants: Evidence from KwaZulu-Natal. *Development Southern Africa*. 22(4), 467-482.
- Champion, V. L. & Skinner, C. S. (2008). The Health Belief Model. In: Glanz, K., Rimer B. K., & Viswanath K.V., (Eds). *Health Behaviour and Health Education: Theory, Research and Practice*. 4th ed. San Francisco: Jossey-Bass, Inc.
- Chonzi, E. (2000). *Factors Contributing to Low Utilization of Family Planning Services among Secondary School Students in Zomba Municipality*: Mzuzu University.
- Cleary, P. (1986) .*Methodology: Themes and approaches* .In: McHugh, S. & Vash, T. M (Eds). *Illness behaviour: A multidisciplinary model* .New York. Plenum Press.
- Coates, T.J., Stall, R.D., Catania, J. A., & Kegeles, S. M. (1988). Behavioural factors in the spread of HIV Infection. *AIDS*. 2 (1), 239-246.
- Cocoran, J. (1999). Ecological factors associated with adolescent pregnancy: A review of literature. *Adolescence*. 34, 603-619.
- Cohen, L., & Manion, L. (1994). *Research Methods in education*. (4th Ed.). London: Routledge.

- Cohen, L., Manion, L., & Morrison, K. (2007). *Research methods in education* (6th Edition). London: Routledge.
- Cole, G. E., Holtgrave, D. R. & Rios, N.M. Systematic Development of TransTheoretically Based Behavioural Risk Management Programs. *Risk: Issues in Health & Safety* (in press)
- Concise Oxford Dictionary. (1999). 4th Edition. Oxford: Oxford University Press.
- Conner, M. & Norman, P. (1996). *Predicting Health Behaviour. Search and Practice with Social Cognition Models*. Open University Press: Ballmore: Buckingham.
- Corkindale, C. J., Condon, J. T., Russell, A., & Quinlivan, J. A. (2009). Factors That Adolescent Males Take Into Account in Decisions about an Unplanned Pregnancy. *Journal of Adolescence*. 32, 995-1008.
- Courtenay, W. H. (1998c). Communication strategies for improving men's health: The 6-Point Health Plan. *Wellness Management*. 14(1), 3-4.
- Creswell, J. W. 2003. *Research Design: Qualitative, Quantitative, and mixed methods approaches*. Second edition. Sage Publications.
- Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice*. 39(3), 124-130.
- Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007.
- de Jong, T., & Ferguson-Hessler, M. (1996). Types and qualities of knowledge. *Educational Psychologist*. 31(2), 105-113.
- De Vaus, D. (2002). *Surveys in Social Research* (5th ed.). London: Routledge.
- Delores, J. (2004). Factors Influencing Food Choices, Dietary Intake, and Nutrition Related Attitudes among African Americans: Application of a Culturally Sensitive Model. *Ethnicity & Health*. 9, 349-367.
- Denzin, N. K & Lincoln, Y. S. (2003) (Eds.). *Handbook of qualitative research* (2nd Ed). Thousand Oaks, CA: Sage.
- Department of Basic Education. (2010). *General Household Survey (Ghs) 2010: Focus On Schooling*
<http://www.education.gov.za/LinkClick.aspx?fileticket=B%2BHsGNjcYyo%3D&tabid=358&mid=1261> . [Accessed 6 April 2012].
- Department of Education. (2007). *Measures for the Prevention and Management of Learner Pregnancy*. Pretoria: Department of Education.
- Department of Health .(2012) *Preventing Teenage Pregnancy*. Pretoria.
- Department of Health Policy Guidelines Department. (2001).*Health for Adolescent Health*
<http://www.doh.gov.za/docs/policy/2001/part1.pdf> [Accessed 15 January 2013].

Department of Health. (2000). *An Evaluation of the Implementation of the Choice of Termination of Pregnancy Act*. Johannesburg: Colour Press.

Department of Health. (2012). *National Strategic Plan on HIV, STIs and TB 2012-2016* <http://www.doh.gov.za/docs/stratdocs/2012/NSPfull.pdf> [Accessed 20 June 2012].

Dlamini, S., Taylor, M., Mkhize, N., Huver, R., Sathiparsad, R., de Vries, H., Naidoo, K., & Jinabhai, C. (2009). Gender factors associated with sexual abstinent behaviour of rural South African high School going youth in KwaZulu-Natal, South Africa <http://her.oxfordjournals.org/content/24/3/450.full.pdf+html> [Accessed 9 May 2012].

DSD, SASSA and UNICEF. (2012). *The South African Child Support Grant Impact Assessment: Evidence from a survey of children, adolescents and their households*. Pretoria: UNICEF: South Africa.

Dunkle, K., Jewkes, R., Nduna, M., Jama, N., Skweyiya, Y., & Koss, M. (2007). Transactional sex with casual and main partners among young South African men in the rural Eastern Cape: Prevalence, predictors and associations with gender-based violence. *Social Science and Medicine*. 65, 1235-1248.

Eaton, L., Flisher, A. J. & Aaro, L. E. (2003). Unsafe sexual behaviour in South African youth. *Social Science and Medicine*. 56, 149-165.

Edgardh, K., & Ormstad, K. (2010). Prevalence and characteristics of sexual abuse in a national sample of Swedish seventeen-year-old boys and girls. <http://onlinelibrary.wiley.com/doi/10.1111/j.1651-2227.2000.tb01333.x/pdf> [Accessed 18 February 2012].

Ehlers, V. (2003). Adolescent mothers' utilisation of contraceptive services in South Africa. *International Nursing Review*. 50, 229-241.

Ekstrand, M. (2008). *Sexual Risk Taking– Perceptions of Contraceptive Use, Abortion, and Sexually Transmitted Infections among Adolescents in Sweden*. PhD Thesis. Uppsala University . Sweden.

Fisher, P.A.; Stoolmiller, M.; Gunnar, M. R.; and Burraston, B. O. (2007). Effects of a Therapeutic Intervention for Foster Pre-schoolers on Diurnal Cortisol Activity. *Psychoneuroendocrinology*. 32(8-10), 892-905.

Fleisch, B., Shindler, J., Perry, H. (2010). Who is out of school? Evidence from the Community Survey 2007, South Africa. *Journal of Education Development*. Doi.10.1016/j.ijedudev.2010.05.002

Fontana, A. & Frey, J. H. (1994). Interviewing: The art of science. In Denzin, N. K. & Lincoln, Y. S. (Eds), *Handbook of Qualitative Research*. Thousand Oaks: Sage.

Foucault, M. (1978). *The history of sexuality (vol 1): An introduction*. Translated by Hurley, R. New York: Pantheon.

- Garlick, R., Ineichen, B., & Hudson, F. (1993). The UPA score and teenage pregnancy. *Public Health*. 107, 135–9.
- Genius, S. J. & Genius, S. K. (2004). Adolescent behaviour should be a priority. *British Medical Journal*. 328 (7444), 149-165.
- Geronimus, A. T., Sanders, K. & Marianne, M. (1994). Does Young Maternal Age Affect Child Development? Evidence from Cousin Comparisons in the United States. *Population and Development Review*. 20(3), 585-609.
- Glanz, K., Rimer, B. K. & Lewis, F. M. (2002). *Health Behaviour and Health Education. Theory, Research and Practice*. San Francisco: Wiley & Sons.
- Glanz, K., Rimer, B. K., & Viswanath, K. (2008). *Health behaviour and health education theory, research, and practice*. 4th Edition. San Francisco: Jossey Bass.
- Grant, M., & Hallman, K. (2006). Pregnancy-related School Dropout and Prior School Performance in South Africa. Policy Research Division Working Paper 212. New York. Population Council.
- Grant, M., & Hallman, K. (2008). Pregnancy-related School Dropout and Prior School Performance in KwaZulu Natal, South Africa. *Studies in Family Planning*. 39(4), 369- 82.
- Grosh, M., Del Ninno, C., Tesliuc, E. & Ouerghi, A. (2008). *For protection & promotion: The design and implementation of effective safety nets*. Washington, DC: The World Bank
- Hall, K. S., White, K. O., Reame, N. & Westhoff, C. (2010). Studying use of oral contraception: a systematic review of measurement approaches. *Journal of Women's Health*. 19(12), 2203-2210.
- Hallman, K. (2005). Gendered socioeconomic conditions and HIV risk behaviours among young people in South Africa. Paper presented at the Annual meeting of the Population Association of America, Minneapolis.
- Hallman, K., Quisumbing, A., Ruel, M. T. & de la Briere, B. (2005). Mother's work and child care: Findings from the urban slums of Guatemala City. *Economic Development and Cultural Change*. 53(4), 855 – 886.
- Halperin, D., & Epstein, H. (2007). Why is HIV prevalence so severe in Southern Africa? The role of multiple concurrent partnerships and lack of male circumcision. *Southern African Journal of HIV Medicine*. 26, 19-25.
- Harari, P. & Legge, K. (2001). *Psychology and Health*. Oxford: Heinemann.
- Hayden, J. A. (2009). *Introduction to health behaviour Theory*. Jones and Barlett Publishers: Ontario. Canada

- Hendricks, L., Swartz, S., & Bhana, A. (2010). Why young men in South Africa plan to become teenage fathers: Implications for the development of masculinities within contexts of poverty. *Journal of Psychology in Africa*. 20 (4), 527-536.
- Hickley, C. (1997). Factors influencing teenage motherhood. Centre for Social Research, Zomba: University of Malawi.
- Hlabangane-Sikhosana, N. L.(2012). The political economy of teenage sexuality in the time of HIV/AIDS: The case of Soweto, South Africa. Unpublished dissertation (PhD.). University of the Witwatersrand. South Africa.
- Hubbard D. (2009). Gender & sexuality in Namibia. Legal Assistance Centre, Windhoek.
- Human Sciences Research Council. (2007). Youth Policy Initiative Roundtable 4: Learner Retention. Reserve Bank, Pretoria.
- Human Sciences Research Council. (2008). Youth Policy Initiative – Proceedings of Roundtable 5: Teenage Pregnancy. Pretoria: Human Sciences Research Council.
- Hunter, M. (2002). The changing political economy of sex in South Africa: The significance of unemployment and inequalities to the scale of the AIDS pandemic. *Social Science & Medicine*. 64 (3): 689-700.
- Janz, N. K., Becker, M. H.(1984). The health belief model: a decade later. *Health Ed Quar*. 11(1):1-47.
- Jewkes, R., Morrel, R. and Christofides, N. (2009). Teenage pregnancy: Rethinking prevention. Paper prepared for the HSRC Youth Policy Initiative Roundtable 5: Teenage Pregnancy. Reserve Bank, Pretoria.
- Jewkes, R., Vundule, C., Maforah, F., & Jordan, E. (2001). Relationship Dynamics and teenage pregnancy in South Africa. *Social Science and Medicine*. 52, 733-744.
- Kanku, T. & Mash, R. (2010). Attitudes, perceptions and understanding amongst teenagers regarding teenage pregnancy, sexuality and contraception in Taung. *South African Family Practice*. 52(6), 563–572.
- Kaufman, C. E., de Wet, T. & Stadler, J. (2001). Adolescent pregnancy and parenthood in South Africa. *Studies in Family Planning*. 32, 147-160.
- Kesho Consulting and Business Solutions (Pty) Ltd. (2006). Report on incentive structures of social assistance grants in South Africa. Pretoria: Department of Social Development.
- Kiprop Mulwo, A., Tomaselli, K. G. & Dalrymple, L. (2009). Condom brands, perceptions of condom efficacy and HIV prevention among university students in KwaZulu-Natal, South Africa. *African Journal of AIDS Research*. 8(3), 311-320.
- Kiselica, M. S., & Sturmer, P. (1993). Adolescent pregnancy and parenting services: Indiana resources directory. Indianapolis. Indian Council on Adolescent Pregnancy.

Kumar, R. (1999) *Research Methodology: A Step-by-Step Guide for Beginners*. Thousand Oaks, CA: Sage Publications

Kunda, J. L & Tomaselli, K. G. (2012). "New Wineskins, New Wine": Confusing Public Health with Militant Nationalism – the Case of South African AIDS Policy. In: Quinlan, T. and Ige, S. (Eds). *AIDS and the State: Critical Perspectives on Rhetoric and Politics of HIV/AIDS in Africa*. Pietermaritzburg: UKZN Press.

Leclerc-Madlala, S. (2008). Age-disparate and intergenerational sex in Southern Africa: The dynamics of Hyper vulnerability. *AIDS*. 22, 1–9.

Leichliter, J., Meilman, P., Presley, C., & Cashin, J. (1998). Alcohol use and related consequences among students with varying levels of involvement in college athletics. *Journal of American College Health*. 46, 257-262

Lloyd, C. & Mensch B. (1999). Implications of formal schooling for girls' transitions to adulthood in developing countries. In: Bledsoe, C. H., Casterline, J. B., Johnson-Kuhn, J. A & Hagan, J. G. (Eds.). *Critical Perspectives on Schooling and Fertility in the Developing World*. Washington, DC: National Academy Press.

Macleod, C. & Durrheim, K. (2002). Racialising teenage pregnancy: 'culture' and 'tradition' in the South African scientific literature. *Ethnic and Racial Studies*. 25(5), 778-801.

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

Macleod, C. (1999a). Teenage pregnancy and its 'negative' consequences: Review of South African research - Part 1. *South African Journal of Psychology*. 29 (1), 1-7.

Macleod, C. (1999b). The 'causes' of teenage pregnancy: Review of South African research - Part 2. *South African Journal of Psychology*. 29 (1), 8-16.

Macleod, C. (2001). Teenage motherhood and the regulation of mothering in the scientific literature: the South African example. *Feminism and Psychology*. 11(4), 493-511.

Macleod, C. (2006). The management of risk: adolescent sexual and reproductive health in South Africa. *International Journal of Critical Psychology*. 17, 77-97.

Macleod, C. (2011). 'Adolescence', pregnancy and abortion: Constructing a threat of degeneration. London: Routledge.

MacPhail, C. & Campbell, C. (2001) 'I think condoms are good but, aai, I hate those things': condom use among adolescents and young people in a southern African township. *Social Science and Medicine*. 52 (11), 1613-1627.

- Madu, S. N., Kropiunigg, U. & Weckenmann, M. (2002). Health complaints of high school students in the Northern Province and taboo themes in their families. *South African Journal of Education*. 22(1), 65 – 69.
- Magnani, R., Sabin, K., Saidel, T. & Heckathorn, D. D. (2005). Sampling hard to reach and hidden populations for HIV surveillance. *AIDS*. 9(2), 67-72.
- Makins. M. (1991). *Collins English Dictionary* (eds). Harper Collins.
- Makiwane, M. (2010). The child support grant and teenage childbearing in South Africa. *Development Southern Africa*. 27(2), 193-204.
- Makiwane, M., & Udjo, E. (2006). *Is the Child Support Grant with an increase in teenage fertility in South Africa? Evidence from the National Surveys and Administrative Data*. Pretoria: HSRC Press
- Manzini, N. (2001). Sexual initiation and childbearing among adolescent girls in KwaZulu-Natal, South Africa. *Reproductive Health Matters: By and For Women and Men*. 9(17), 44–5.
- Mashau, N. F. (2001). An investigation into the knowledge, attitude and health practices of students towards sexually transmitted diseases: HIV/AIDS at a tertiary institution in the Northern Province .Unpublished masters dissertation. Thohoyadou. University of Venda
- Masuku, N. (1998). Pregnant schoolgirls must go. *Agenda*. 37, 37-38.
- Mathews, C., Guttmacher, S. J., Flisher, A. J., Mtshizana, Y. Y., Nelson, T., McCarthy, J. (2009). The quality of HIV testing services for adolescents in Cape Town, South Africa: Do adolescent-friendly service make a difference? *Journal of Adolescent Health*. 44, 188-190.
- Mattson, M. (1999). Toward a reconceptualization of communication cues to action in the Health Belief Model: HIV test. *Communication Monographs*. 66(3), 240.
- McLeroy, K. R., Bibeau, D., Steckler, A. & Glanz, K.(1988). An ecological perspective on health promotion programs. *Health Education Quarterly*. 15:351–377.
- Melkote R. S. & Steeves L. H. (2001). *Communication for development in third world: Theory and practice for empowerment*. London: Sage Publications.
- Mfono, Z. (1998). Teenage contraceptive needs in urban South Africa: A case study. *International family planning perspective*. *Proquest Nursing Journals*. 24(4), 22–48.
- MiET. (2011). Improving the lives of children. <http://www.miet.co.za/site/entityview/26/view> [Accessed 3 June 2012].
- Miles, B. M. & Huberman, A.M. 1994. *Qualitative Data Analysis. An expanded Sourcebook*. Sage Publications.
- Mkhwanazi, N. (2010). Understanding teenage pregnancy in a post-apartheid South African township. *Culture, Health and Sex*. 12(4), 347-358.

- Morrell, R., Bhana, D. & Shefer, T. (2012). *Books and babies: Pregnancy and young parents in schools*. Cape Town, South Africa: HSRC Press.
- Mpanza, D. N. & Nzima, (2010). Attitudes of educators towards teenage pregnancy. <http://www.sciencedirect.com/science/article/pii/S1877042810014928> [Accessed April 1 2012].
- Muchuruza, P.P. (2000). Social, economic and cultural factors associated with pregnancy in adolescent girls in Magu district, Mwanza. Unpublished dissertation. Muhimbili University of Health and Allied Sciences. Dar-es-Salaam, Tanzania
- Munthali, A. C., Chimbiri, A. & Zulu, E. (2004). *Adolescent Sexual and Reproductive Health in Malawi: A Synthesis of Research Evidence, Occasional Report*. New York: The Alan Guttmacher Institute.
- Naong, M. M. (2011). The impact of matriculation results on management of school principals: A South African case study. *African Journal of Business Management*. 5(5), 1589-1597.
- National Institutes of Health. (2005). *Theory at a Glance, Application to Health Promotion and Health Behaviour (2nd Edition)*. <http://www.cancer.gov/cancertopics/cancerlibrary/theory.pdf> [Accessed 19 August 2012].
- Ndoro. T. R. S. (2009). Attitudes and perceptions towards TB in Grahamstown East in a time of HIV/AIDS. Masters Thesis. Rhodes University. South Africa.
- Neves, D., Samson, M., van Niekerk, I., Hlatshwao, S. & du Toit, A. (2009). The use and effectiveness of Social Grants in South Africa, FinMark Trust, PLAAS, EPRI.
- Noh, S., Gagne, J. & Kaspar, V. (1994). Models of health behaviours and compliance: applications to audio logical rehabilitation research. <http://www.audrehab.org/jara/1994SI/Noh%20Gagne%20Kaspar,%20%20JARA,%20%201994.pdf> [Accessed 9 October 2012].
- Odgen, J. (2004). *Health psychology a textbook*. 3rd Edition. Open University Press: London
- Oni, T.E., Prinsloo, E. A. M., Nortje, J.D. & Joubert, G. (2005). High school students' attitudes, practices and knowledge of contraception in Jozini, KwaZulu-Natal. *South African Family Practice*. 47(6), 54 – 57.
- Palamuleni, M. (2002). *Needs Assessment Report on Preventing Sexually Transmitted Infections, HIV/AIDS and Teenage Pregnancy among People in Dowa District in Malawi? Zomba*.
- Panday, S., Makiwane, M., Ranchod, C. and Letsoalo, T. (2009). *Teenage pregnancy in South Africa with a specific focus on school-going learners*. Pretoria: HSRC Press.

- Panter-Brick C., Clarke, S. E., Lomas, H., Pinder, M. & Lindsay, S.W. (2006). Culturally compelling strategies for Behaviour Change: A Social Ecology Model and Case Study in Malaria Prevention. *Social Science and Medicine*. 62, 2810-25.
- Parker, W. (1994). The Development of Community-based Media for AIDS Education and Prevention in South Africa: Towards an Action-based Participatory Research Model. MA dissertation. University of KwaZulu-Natal, South Africa.
- Patton, M. Q. (2002) *Qualitative Research & Evaluation Methods* (3rd Edition). Thousand Oaks: Sage.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd Ed). Thousand Oaks, CA: Sage.
- Paz Soldan, V.A. (2004). How family planning ideas are spread within social groups in rural Malawi. *Studies in Family Planning*. 35(4): 275-290.
- Pettifor, A., Rees., H. V., Steffenson, A. E., Hlongwa-Madikizela, L.& McPhail, C. (2004). HIV and sexual behaviour among young South Africans: A national survey of 15-24 year olds Johannesburg: University of the Witwatersrand, RHRU.
- Pettit, G. S., & Collins, W. A. (2011). Competence, social capital, and life adjustment. *International Journal of Behavioural Development*. 35, 471-474.
- Planned Parenthood Association of South Africa. (2003). Teen parent programme: a baseline survey and needs assessment for adolescents and teen parents in South Africa. Johannesburg: PAPAS.
- Polit, D.F. & Beck, C. T. 2006. *Essentials of nursing research methods, appraisals and utilization*. (6th Edn). Philadelphia: Lippincott Williams & Wilkins.
- Preston-Whyte, E. & Zondi, M. (1992). African teenage pregnancy: Whose problem? In S. Barman & E. Preston-Whyte (Eds), *Questionable issue: illegitimacy in South Africa* Oxford: Oxford University Press.
- Preston-Whyte, E. (1991). Teenage pregnancy in selected coloured and black communities. Unpublished report, Human Sciences Research Council, Pretoria.
- Quinn, P. C. (2002). Category representation in infants. *Current Directions in Psychological Science*. 11, 66-70.
- Quinton D. (2002). *The Transition to Fatherhood in Young Men. Influences on commitment*. University of Bristol.
- Rafaela, M., & Crockett, L. J. (2003). Sexual risk taking in adolescence: The role of self-regulation and attraction to risk. *Developmental Psychology*. 39, 1036-1046.
- Ranieri, L. G. & Wireman, C. M. (2007). Social ecological predictors of repeat adolescent pregnancy. *Perspect Sex Reprod Health*. 39, 39-47.

- Rasch, V., Margrethe, S., Mchumvu Y, and Mmary V. (2000). Adolescent girls with illegally induced abortion in Dar es Salaam: The discrepancy between sexual behaviour and lack of access to contraception. *Reproductive Health Matters*. 8 (15), 52-62.
- Richter, M.S. & Mlambo, G.T. (2005). Perceptions of rural teenagers on teenage pregnancy *Health SA*. 10(2), 61–69.
- Rosato, M. (1999). Teenage fertility in England and Wales: trends in socioeconomic circumstances between the 1971 and the 1981 censuses', Longitudinal Study (LS) Working Paper 78, Centre for Longitudinal Studies, Institute of Education, University of London, London.
- Rosenberg, M. J. & Waugh, M. S.(1998). Oral contraceptive discontinuation: a prospective evaluation of frequency and reasons. *Am J Obstet Gynecol*. 179, 577-582.
- Rosenstock , I. M., Stretcher , V. J. & Becker, M. H. (1988). Social learning theory and the health belief model. *Health Ed Quar*. 15(2), 175-184.
- Rosenstock, I. (1974). Historical Origins of the Health Belief Model. *Health Education Monographs*. 2 (4).
- Rosenstock, I. M. (1966) Why people use health services. *Milbank Memorial Fund Quarterly*. 44, 94–124.
- Rosenstock, I. M. (1990). The Health Belief Model: Explaining Health Behaviour through experiences. In: Glanz, K., Lewis, F. M, & Rimer, (eds). *Health Behaviour and health education: theory research and practice*. San Franscisco. Jossey-Bass Publishers.
- Rosenstock, I. M., Strecher, V. J., & Becker, M. H. (1994). The health belief model and HIV risk behaviour change. In: DiClemente,R. J. (ed.).*Preventing AIDS: Theories and Methods of Behavioural Interventions*. San Franscisco. Jossey-Bass Publishers.
- Rutenberg, N., Kaufman, C.E., Macintyre, K., Brown, L. & Karim, A. (2003). Pregnant or positive: adolescent childbearing and HIV risk in KwaZulu Natal, South Africa. *Reproductive Health Matters*. 11(22), 122-133.
- Salazar, L. F., Crosby, R. A., Diclemente, R. J., Wingood, G. M., Lescano, C. M., Brown, L. K., Harrington, K. & Davies S. (2005). Self Esteem and Theoretical Mediators of Safer Sex among African American Female Adolescents: Implications for sexual risk reduction interventions. *Health Education and Behaviour*. 32 (3), 413-427.
- Sallis, J. F. & Owen, N. (2002). Ecological models of health behaviour. In: Glanz, K. Rimer., & Lewis, F. M. (Eds.). *Health Behaviour and Health Education: Theory, Research, and Practice*.(3RD edition). San Francisco: Jossey-Bass.
- Sallis, J. F., & Owen, N. (1997). Ecological models. In: Glanz, K., Lewis, F. M. & Rimer, B. K. (Eds.) *Health behaviour and health education: Theory, research, and practice* (2nd Ed.) San Francisco: Jossey-Bass.

- Sallis, J.F., Owen, N., & Fisher, E.B. (2008). Ecological models of health behaviour. In: Glanz, K., Rimer, B. K., & Viswanath, K. (Eds.), *Health Behaviour and Health Education: Theory, Research, and Practice* (4th edition.). San Francisco: Jossey-Bass.
- Sathiparsad, R & Taylor, M. (2011). Making Meaning Of Teenage Pregnancy Among School-Going Youth: The Case of Selected eThekweni Municipality Secondary Schools. *Agenda*. 72-84.
- Selman, P. (1998). Teenage Pregnancy, Poverty and the Welfare Debate in Europe and the United States. Paper presented at CICRED seminar, Poverty & Family Planning, Mexico City.
- Sharma, M. & Romas, J. A. (2008). *Theoretical foundations of health education and health promotion*. (2nd Ed.). Jones and Barlett Publishers. Ontario Canada.
- Shefer, T., Bhana, D., Morrell, R., Manzini, N and Masuku, N. (2012). 'It isn't easy': Young parents talk of their school experiences. In Morrell, R., Bhana, D and Shefer, T. (eds). Cape Town: HSRC Press.
- Shepherd, J., Harden, A., Rees, R., Brunton, G., Garcia, J., Oliver, S., & Oakley, A. (2006). Young people and healthy eating: A systematic review of research on barriers and facilitators. *Health Education Research*. 21(2), 239-257.
- Shisana, O., Rehle, T., Simbayi, L. C., Parker, W., Zuma, K., Bhana, A., Connolly, C., Jooste, S. & Pillay, V. (2005). *South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2005*. Cape Town: HSRC Press.
- Silverman, D. (2011). *Qualitative Research* (3rd Ed.). London, England: Sage Publications.
- Smedley, B. D. & Syme, S. L. (2000). *Promoting Health: Intervention Strategies from Social and Behavioural Research*. Washington, DC: National Academy Press.
- Smith, T. (2003). Influence of socioeconomic factors on attaining targets for reducing teenage pregnancies. *BMJ*. 306, 1232-5.
- Stokols, D. (1992). Establishing and maintaining healthy environments: Toward a social ecology of health promotion. *American Psychologist*. 47, 6-22.
- Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion*. 10, 282-298.
- Strassburg, S., Meny-Gibert, S. & Russel, B. (2010). *Left Unfinished: Temporary Absence and Drop-out from South African Schools*. Access to Education Series. 2.
- Stufflebeam, D.L., Madaus, G.F., & Kellaghan, T. (2000). *Evaluation models: Viewpoints on educational and human services evaluation*. (2nd Eds.). Boston: Kluwer Academic Publishers.
- Swartz, S. & Bhana, A. (2009) *Teenage tata: voices of young fathers in South Africa*. Cape Town: HSRC Press.

Tellis, W. (1997). Introduction to Case Study. *The Qualitative Report*, Volume 3, Number 2. <http://www.nova.edu/ssss/QR/QR3-2/tellis1.html> [Accessed 14 February 2013].

The department of justice and constitutional development. *SEXUAL OFFENCES ACT 23 OF 1957* <http://www.justice.gov.za/legislation/acts/1957-023.pdf> [Accessed 28 September 2012]

Tomaselli, K. G., Shepperson A., & Parker, W. (2002) . Comprehensive and integrated HIV/AIDS prevention campaigns: potentials for South and Southern Africa. In: Alali A. O., Jinadu B. A., (eds.). *Health Communication in Africa: Contexts, Constraints and Lesson*. New York: University Press of America.

Tomaselli, & Chasi, C.(Eds.) (2011). *Development and Public Health Communication , Mass Communication and Societ*. Pinelands Pearson: South Africa.

Tyali ,S. 2012. Investigating Beneficiary Communities' Participation in HIV/AIDS Communication through Community Radio Stations: A case study of X-K FM. MA Thesis, University of KwaZulu Natal.

UNAIDS. (2012). Global AIDS response progress report 2012 http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_ZA_Narrative_Report.pdf [Accessed 28 January 2013].

Varga, C. A. & Makubalo, L. (1996). Sexual (non)negotiation among Black African teenagers in Durban. *Agenda*. 28, 31-38.

Varga, C.A. (2000). How Gender Roles Influence Sexual and Reproductive Health among South African Adolescents. *Studies in Family Planning*. 34(3), 160 – 172.

Vundule, C., Maforah, F, (2001). Risk factors for teenage pregnancy among sexually active black adolescents in Cape Town. A case control study. *S. Afr. Med. J.* 91 (1): 73-80.

Warenuis, L. V., Faxelid, E. A, Chishimba, P. N., Musandu, J. O, Ong'any, A A, & Nissen, E. B. (2006). Nurse-Midwives' Attitudes towards Adolescent Sexual and Reproductive Health Needs in Kenya and Zambia. *Reproductive Health Matters*. 14(27), 119-128.

Wilson, S. H., Brown, T. P., Richards, R. G. (1992). Teenage conception and contraception in English regions. *Public Health Med.* 14, 17-25.

Wood, K., & Jewkes, R. (2006). Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive Use in South Africa. *Reproductive Health Matters*. 14(27), 109-118.

Wood, K., Lambert, H., & Jewkes, R.(2008). 'Injuries are beyond love': young South Africans' understandings of limit and legitimacy in relation to physical violence in their sexual relationships. *Medical Anthropology*. 27(1): 43-69.

Wood, K., Maepa, J. and Jewkes, R. (1997). „Adolescent Sex and Contraceptive Experiences: Perspectives of Teenagers and Clinic Nurses in the Northern Province. Final project report prepared for Health Systems Trust (SA), Durban, South Africa.

Wood, K., Maforah, F. and Jewkes, R. (1998). "He forced me to love him": Putting violence on adolescent sexual health agendas. *Social Science and Medicine*. 47, 233-242.

World Health Organisation (2012). Trends in maternal mortality. http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf [Accessed 8 April 2013].

World Health Organisation. (2007). Adolescent pregnancy – Unmet needs and undone deed: A Review of the literature and programmes. Geneva: World Health Organisation Press.

Yin, R.K. 2003. *Case Study Research: Design and Methods*, 3rd Edition. Sage Publications.

APPENDICES

Parental/Caregiver Consent Form

My name is Prestage Murima and I am a Masters student at the University of KwaZulu-Natal (UKZN) Howard College. I am conducting research on better understanding teenage pregnancy under the Centre for Communication and Media Studies (CCMS). My research is titled ASSESSING TEENAGERS' KNOWLEDGE, ATTITUDE AND PERCEPTIONS TOWARDS TEENAGE PREGNANCY. THE CASE OF A DURBAN HIGH SCHOOL. The purpose of this study is to understand teenagers' knowledge, attitudes and perceptions towards teenage pregnancy; your child has been invited to participate in the research and will take part in a focus group interview and/or a one-on-one interview.

Please note that there will be no personal questions in this discussion.

Information about the study:

- Your child's participation is entirely voluntary. They may refuse to take part in the interview, and they may stop at any time if you or they do not want to continue. They also have the right to skip any particular question or questions if they do not wish to answer them.
- The time it takes to complete the interview will vary, but the average amount of time for this interview is half an hour.
- The interview will take place at their school, Bechet High School, in a safe and private room.
- Your child has the right to ask questions at any point before, during and after the interview.
- All information collected for this study will be kept strictly confidential. While the data collected will be used for research purposes, information that could identify your child will never be publicly released in any research report or publication.

PARENT/CAREGIVER:

By signing below, I signify that I agree that my child participate in this study, and that their participation is entirely voluntary.

NAME: _____

SIGNATURE: _____ DATE: _____

RESEARCHER:

By signing below, I signify that I have received this Parental/Caregiver Consent Form from the participant.

NAME: _____

SIGNATURE: _____ DATE: _____

For any information, please do not hesitate to contact myself or my research supervisor.

Prestage Murima
Researcher

Dr. Josianne Roma-Reardon
Research Supervisor

Tel: 078 849 2177
murimap@gmail.com

Tel: 083 295 3562
josianne@indigoinnovation.co.za

Participant Consent Form

My name is Prestage Murima and I am a Masters student at the University of KwaZulu-Natal (UKZN) Howard College. I am conducting research on better understanding teenage pregnancy under the Centre for Communication and Media Studies (CCMS). My research is titled ASSESSING TEENAGERS' KNOWLEDGE, ATTITUDE AND PERCEPTIONS TOWARDS TEENAGE PREGNANCY. THE CASE OF A DURBAN HIGH SCHOOL. The purpose of this study is to understand teenagers' knowledge, attitudes and perceptions towards teenage pregnancy. You have been invited to participate in the research and you will take part in a focus group interview and/or a one-on-one interview.

Please note that questions will focus on what you know and how you feel about teenage pregnancy. There will be no personal questions in this discussion.

Before I begin the interview, I want to make sure you understand the following information about the study:

- Your participation is entirely voluntary. You may refuse to take part in the interview, and you may stop at any time if you do not want to continue. You also have the right to skip any particular question or questions if you do not wish to answer them.
- The time it takes to complete the interview will vary, but the average amount of time for this interview is half an hour.
- You have the right to ask questions at any point before, during, or after the interview is completed.
- All information collected for this study will be kept strictly confidential. While the data collected will be used for research purposes, information that could identify you will never be publicly released in any research report.

PARTICIPANT:

By signing below, I signify that I agree to participate in the study, and that my participation is entirely voluntary.

NAME: _____

SIGNATURE: _____ DATE: _____

RESEARCHER:

By signing below, I signify that I have read the above information to the participant, and provided them with an opportunity to ask questions.

NAME: _____SIGNATURE: _____
DATE: _____

For any information, please do not hesitate to contact myself or my research supervisor.

Prestage Murima

Researcher

Tel: 078 849 2177

Email: 212557655@stu.ukzn.ac.za

Dr. Josianne Roma-Reardon

Research Supervisor

Tel: 083 295 3562

josianne@indigoinnovation.co.za

Focus Group Guide

Knowledge:

1. What do you understand by teenage pregnancy?
2. How do girls fall pregnant?
3. How do teenagers prevent pregnancy?
4. What is contraception/birth-control?
5. What is the reason for using contraceptives?
6. Describe correct use of i) male condoms ii) female condoms iii) the pill iv) injection and v) the intrauterine device IUD vi) 'morning-after' pill?
7. Where can teenagers get contraceptives?

Attitudes

1. How do you feel about girls who fall pregnant while at school?
2. How do you feel about boys who get girls pregnant?
3. How do you feel about men who get girls pregnant?
4. How do you feel about contraceptive use?
5. How do you feel about teenagers who use contraceptives?
6. How do you feel about condom/contraceptive distribution in schools?
7. How do you feel about the service that is given at clinics where teenagers can access contraception?
8. How do you feel about sex education in school?

Perceptions:

1. How does teenage pregnancy affect girls of your age?
2. How does teenage pregnancy affect boys your age?
3. Do you think teenage pregnancy affects school work? How?

4. Is teenage pregnancy a problem in your community? Why?
5. Whose problem is teenage pregnancy?
6. Why do you think teenagers are falling pregnant?
7. Who do you think is to blame for teenage pregnancy?
8. What do you think can or should be done to reduce the number of teenagers who get pregnant?
9. Why is contraception important for girls your age?
10. Why is contraception important for boys your age? And older boys/men?
11. What are the challenges faced by teenagers (boys and girls) in accessing contraceptives?
9. Why do you think there are some contraceptives that are better than others?
10. What are the challenges faced by young people in accessing contraceptives.
11. What are the challenges faced by young people in using contraceptives.
12. What are the challenges you think influence teenagers in accessing information on reproductive health (information about sex, contraceptives, STIs, HIV etc.)?
13. What is the role of Life Orientation in reducing teenage pregnancy?
14. How has Life Orientation class helped reduce teenage pregnancy?

GENERAL QUESTIONS

15. When you are in your social space (with your friends and family), do you talk about issues about HIV and AIDS, STIs, pregnancy and contraception?
16. Why is it important to talk about teenage pregnancy?
17. Where should we be talking about teenage pregnancy?
18. Who should be talking about teenage pregnancy?
19. How should we be talking about teenage pregnancy?
20. Where do you get your information on sexual health?
21. Who in particular gives you this information?
22. Why do you trust this information?
23. How do you use this information?

ETHICAL CLEARANCE LETTER



19 June 2012

Ms Prestage Murima (212557655)
School of Applied Human Sciences

Dear Ms Murima

PROTOCOL REFERENCE NUMBER: HSS/0389/012M
PROJECT TITLE: Assessing knowledge, attitudes and perceptions of teenagers on contraceptive use and teenage pregnancy: The case of ██████ High School

PROVISIONAL APPROVAL

This letter serves to notify you that your application in connection with the above has been approved, subject to the following:

1. Necessary gatekeeper permission from School Principle.

This approval is granted provisionally and the final approval for this project will be given once the above condition has been met. In case you have further queries/correspondence, please quote the above reference number.

Kindly submit your response to the Chair: Prof S Collings, Research Office as soon as possible

Yours faithfully

Professor Steven Collings (Chair)
/ms

cc Supervisor: Professor Keyan Tomaselli
cc Academic Leader: Professor JH Buitendach
cc Ms Nondumiso Khanyile

Professor S Collings (Chair)
Humanities & Social SC Research Ethics Committee
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban, 4000, South Africa
Telephone: +27 (0)31 260 3587/8350 Facsimile: +27 (0)31 260 4609 Email: ximbop@ukzn.ac.za / snymanm@ukzn.ac.za

Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville



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CONSENT LETTER FROM SCHOOL



[REDACTED] SCHOOL
[REDACTED]

TO WHOM IT MAY CONCERN

APPROVAL TO CONDUCT RESEARCH AT [REDACTED] HIGH SCHOOL.

The Management, staff and learners at [REDACTED] High School hereby wish to indicate that approval has been granted to the researcher, **Ms P. MURIMA**, to proceed with research in respect of the study Great Expectations? Analysing teenagers' knowledge, attitudes and perceptions towards teenage pregnancy.

We hope that the results of this research will benefit the entire nation.

Warm regards

SIGNED: 

[REDACTED]
Head of Department – Languages

DATED: 21 February 2013

College of Humanities
Schedule of Revisions Completed Post-Examination
Masters/PhD

(Please enumerate and describe, in the form below, the concerns expressed or revisions required by the examiners as well as how the concerns/revisions were addressed/effected in the revised dissertation. Please add numbers if more are needed.)

Student Name: PRESTAGE MURIMA

Student Number: 212557655

Degree: MASTERS

Title of Dissertation: Assessing teenagers' knowledge, attitudes and perceptions towards teenage pregnancy. The case of a Durban High School

#	Concern Expressed/Revision Required (verbatim, source, by whom, page reference)	My understanding of the concerns	Actions taken (detailed description, new page reference if applicable)
Concerns: Examiner 1 (Internal)			
1	Moralistic tones in Chapter 5 and 6	I need to tone down and be more academic	All the necessary corrections in were made the script
2	Correct intext referencing through out the thesis	I must correct intext referencing throughout the thesis and take note not to confuse myself in the process	All the necessary changes were made in the script.
3	Remove any indication of the name of the school as requested by the school	I must black out all sections in the gate keepers letters that mention the name of the school.	Blacked out the name of the school in all gate keeper letters.
4	The dates and the places are missing when referring the interviews in the footnotes.	Add the dates and places on the footnotes when referencing the interviews.	Date and places added on the references given on page 3 and page 15
#	Concern Expressed/Revision Required (verbatim, source, by whom, page reference)	My understanding of the concerns	Actions taken (Detailed description, new page reference if applicable)
Concerns: Examiner 2			
1	Change last word of aim to 'them'	Change the aim to have them at the end	Changed the aim to have them at the end
2	Reference the first paragraph of the literature review	I must reference the first paragraph of the thesis where necessary	Referenced parts of the first paragraph of the literature review
3	Delete anecdotal evidence aspect of lit review on page 12	I muse delete anecdotal evidence aspect of lit review on page 12	Deleted anecdotal evidence aspect of lit review on page 12