Experiences of teenage mothers in the informal settlements: An analysis of young females' reproductive health and challenges, a case study of Siyanda Informal Settlement.

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Abstract

The reported percentage of births attributable to school going learners has highlighted the concern for adolescents engaging in early and unsafe sexual practices. A review of literature suggests that early sexual initiation and the likelihood of experiencing teenage pregnancy can impede on adolescents' ability to acquire skills, attain high levels of education, and access socioeconomic opportunities. Relatively less attention has been paid to the reproductive patterns and sexual behaviour of adolescents within informal settlements. This research, conducted in Siyanda informal settlement on the outskirts of KwaMashu Township, is designed to explore the sexual patterns and reproductive behaviour of the adolescents there. The study examines differences in sexual behaviour and childbearing experiences among teen mothers, currently pregnant teens; and those that have never experienced pregnancy.

The findings suggest that the majority of adolescents residing in informal settlements experiment with and engage in sexual intercourse at ages much earlier than 19. Most teenagers experienced their first sexual intercourse by the second year of high school education. Teen mothers reported higher incidence of multiple sexual partners. Across all adolescents interviewed, the preferred sexual partners were much older males because of level of maturity, financial status; and the ability to negotiate use of contraceptives. Part of the cause of high incidents of teenage pregnancy within this environment was the lack of consistent usage of contraceptives. Many adolescents perceived usage of contraceptives to be impractical prior to conception of first birth.

The experience of childbearing was found to have detrimental implications on these young females' educational attainment. Many of these adolescent failed to resume school to complete their education due to the lack of

emotional and financial support from their partners and family members. Many adolescents highlighted their discontent with the lack of youth integration in community based programmes. Furthermore, communication barriers in nearby health facilities as well as transport restricted their accessibility to obtain counselling with regards to their sexual activities and reproductive patterns. Thus, it is recommended that service delivery should be improved, including providing more health facilities especially the range of methods through which health officials such as nurses, social workers and counsellors which can be made easily accessible to these adolescents on a regular basis.

Declaration

Submitted in fulfilment /partial fulfilment of the requirements for the degree of Masters in Population Studies, in the Graduate Programme in the School of Development Studies, University of KwaZulu-Natal, Durban, South Africa.

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I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. I confirm that an external editor was/was not used and that my Supervisor was informed of the identity and details of my editor. It is being submitted for the degree of Masters in Population Studies in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

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Date

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Editor name and surname (*if applicable*)

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Dedication

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ASFR	Age Specific Fertility Rate
CSG	Child Support Grant
DHS	Demographic Health Survey
FET	Further Education and Training
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
KZN	KwaZulu Natal
LEDNA	Local Economic Development Network of Africa
LO	Life Orientation
MRC	Medical Research Council
SADHS	South Africa Demographic and Health Survey
SADOH	South Africa Department of Health
SADOE	South Africa Department of Education
STI	Sexually Transmitted Infection
Stats SA	Statistics South Africa
TFR	Total Fertility Rate
WHO	World Health organisation
WFS	World Fertility Survey

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Chapter One: Introduction

1.1 Background

The high prevalence of adolescent childbearing has been met with great concern within South Africa, but also as a global phenomenon. Many research studies in the past have examined the unfavourable conditions of experiencing a teenage pregnancy. In addition, it is apparent that adolescent childbearing has ramifications on a personal, societal and global level (Hallman 2004; Kaufman, et al. 2001; Singh 1998; Hofferth, et al. 1979). The adolescent transition phase is considered to be crucial, since sexual patterns, behaviours and decisions acquired during this period have lifelong consequences. In addition adolescents are seen as 'gateways to health' because their choices and behavioural patterns obtained now usual last throughout their adult lives (Dehne and Riedner 2001). The determinant of young females overall health is dependent on their sexual and reproductive behaviours (Lloyd 2007). Hence, examining the sexual and reproductive behaviours of teenagers is essential for the implementation and integration of health policies.

Despite having a decline in total fertility rates from 2.87 in 2001 to 2.38 children born per women in 2007 (Stats SA 2007), there is still a large proportion of births attributed to school going learners. In an era with a major HIV/AIDS epidemic is so rife, adolescents' sexual and reproductive behaviours are considered significant. According to statistics, 15% of KwaZulu Natal's youth aged between 15 to 24 years are infected with HIV/AIDS (Rutenberg, et al. 2003). The high prevalence of HIV/AIDS infection among this age group suggests that unsafe sex is initiated at earlier ages (Manzini 2001).

The experience of sex at earlier ages for young females marks the beginning of exposure to various problems. These include unplanned and unwanted pregnancies, unsafe abortions that could affect the child's health and maternal health, and the likelihood of contracting STI's, HIV and AIDS

(Manzini 2001). By 18 years of age, more than 30% of teens have given birth at least once (Chigona and Chetty 2007; Kaufman, et al. 2001).

Adolescents that engage in early sexual activity are less likely to be consistent with contraception. Thus the sexual activity becomes unguided and unsafe (Manzini 2001; Maharaj 2001). Unfortunately socio economic status is inversely correlated with age at menarche (WHO 2004; Hallman, 2004; Berry and Hall 2010; McCulloch 2001). The relative economic disadvantage[1] and low socio economic status was found to increase the likelihood of unsafe sexual behaviours (Hallman 2004). For instance, poverty and lack of economic resources compel young females to engage in unsafe sexual behaviours. These include exchanging sex for goods and money, and the increase likelihood experiencing multiple sexual relations, coerced sex and early childbearing (Hallman 2004). Communities that are exposed to high levels of crime, unemployment, poverty, population density and low educational levels have influence on adolescents' sexual behaviours. These characteristics govern the risk of exposure for adolescents engaging in risky and unsafe sexual activities (Kirby 1999 citied in Kaufman, et al. 2004).

1.2 Adolescent childbearing in South Africa

South Africa has one of the lowest fertility levels in Sub Saharan region (Cooper, et al. 2004; Garenne, et al. 2007). However the consistent high rates of teenage pregnancy in South Africa still poses a problem. Given that the total fertility rate has declined to 2.38 children born per women in 2009 (Stats SA 2007), there is still significantly a large percentage of births that are concentrate amongst school going learners (Human System Trust 2007). In South Africa, 35% of female teenagers have reported to have been pregnant by age of 19 (Mqhayi, et al. 2004; Rutenberg, et al. 2003; Swartz 2003; DHS 2003; Kaufman, et al. 2001). Subsequently, one in five 18 year old females has given birth and more than 40% have become teenage mothers by 20 years of age (Grant and Hallman 2008). The occurrence of

[1] According to Hallman (2004), relative economic disadvantage can manifest itself in a number of ways including lack of access of jobs, health and educational opportunities, and decision making power.

teenage pregnancy in South Africa rises with age. Hence, the chance of experiencing an early pregnancy is determined by a female's start of her sexual and reproductive behaviour (Berry and Hall 2010).

Despite adolescent fertility declining from 1996 (78 births per 1000) to 2001 (65 births per 1000), the mean age has not increased (Moultrie and McGrath 2007). As a result, the high prevalence of premarital fertility[2] reflects the low incident of contraceptive usage before first birth. This also further confirms that unsafe sex begins at much earlier ages for teenagers than in the past (Mqhayi, et al. 2004; Manzini 2001).

The occurrence of early childbearing in South Africa shows disparity amongst the population groups. For instance, the African population accounts for the highest adolescent births with 71 births per 1000 females between ages 15- 19 years; the coloured population showed 60 births per 1000 females between ages 15 -19, and relatively lower levels were observed for the White and Indian population with 14 and 22 births per 1000 females between ages 15- 19 years (Panday, et al. 2009; Moultrie and Timaeus 2003). It is also important to consider that the African population group comprises the majority of the population for South Africa. Therefore this can explain for the high occurrence of teenage pregnancy.

It is apparent that approximately half of the total metropolitan African population reside in informal settlements. Informal settlements are associated with poverty, crime, high levels of unemployment and low educational levels, hence relative economic disadvantage under these living conditions seem to govern the risk of exposure and probability of experiencing early unsafe sexual activities (Marx and Charlton 2003).

[2] According to Garenne and Zwang (2008), premarital fertility is defined here as any birth prior to the first marriage.

1.3 Rationale for the study

It has already been established that adolescent childbearing has ramifications on a personal, societal and global level (Singh 1998). The experience of a teenage pregnancy not only alters the teenage mother's life opportunities and chances, but also has detrimental effects on the familial structure. Many teen mothers receive no financial and emotional support from their families. This is the primary reason for teen mothers failing to resume school and complete their education (Manzini 2001). In South Africa 12.7% of pregnant women aged between 15 – 19 years were found to be infected with HIV (Manzini 2001). Consequently a much higher percentage of teenagers engage in unsafe sexual activities.

In most instances, the experience of early childbearing hinders young females' educational attainment (Chigona and Chetty 2007; Grant and Hallman 2008). Motherhood presents a new set of circumstances that teen mothers have to consider (Hallman 2008). Adolescents perceive childbearing as a challenge for them resuming school and completing their education. Although the South African Educational System allows teen mothers to attend and resume school subsequent to child birth (Kaufman, et al. 2001), there is a significant proportion of young females that never resume school and therefore achieve a much lower educational level. This ultimately has on impact on their life opportunities. According to South Africa Department of Education (SADOE) 2007, 30% of unenrolled and unmatriculated 15 -18 year females reported pregnancy as their primary reason for not resuming school. It is apparent that adolescents are therefore exposed to the possibility of a lifetime of poverty. This cycle of economic disadvantage and low socio- economic conditions seems to perpetuate from generation to generation.

In order for adolescents to make informed decisions about their sexual lifestyles, they need to be provided with adequate knowledge. Barriers of communication between adolescents and their parents, educators and partners prevent teenagers from acquiring the necessary information. Factors that contribute to teenagers engaging in early sexual activities are

lack of communication between parents, lack of decision making power in the relationship, peer influence, and involvement with older partners (Harrison, et al. 2008).

1.4 Research objectives

The study aims to address the characteristics of teenage pregnancy, specifically teen mothers at informal settlements and furthermore to examine these young females' reproductive patterns and behaviours under these specific living conditions. Therefore the main objectives of the study are:

- To identify factors and issues that initiate teenage pregnancy within these environments,
- To determine the types of sexual practices (choice of having multiple/single partners, older men) around adolescences engagement, and
- To examine the teenage female experience of childbearing.

1.5 Organisation

This dissertation is divided into five chapters; the first chapter provides a brief background to the area of interest, however a more detailed account for the study can be reviewed in the second chapter, the literature review. Chapter three provides the study methodology and conceptual framework. Chapter four reports the findings of the study with the interviews conducted on adolescents' childbearing experiences. Chapter five presents the discussion and conclusions for the study; recommendations for future research are also drawn and briefly highlighted.

Chapter two: Literature review

2.1 Introduction

In recent decades the phenomenon of adolescent childbearing appears to have significant consequences at a personal, societal and global level (Singh 1998; Hallman 2004; Bongaarts 2010; Kalipeni 1995). Although fertility rates are declining rapidly on a global scale, and in some countries reaching below replacement fertility levels (WHO 1998), there is still a significant proportion of births that occur each year which are attributed to adolescents. This is problematic for adolescents since the current environment in which adolescents' experience their lives and are growing up in places a greater dilemma on their acquisition of skills and educational attainment, which are often ramifications of early sex and pregnancy coupled with the potential vulnerability to sexually transmitted diseases and HIV/AIDS (Mensch, et al. 2001). Adolescent childbearing and sexual and reproductive behaviour have major implications on the individual's physical health and social and economic well being (Mensch, et al. 2001; Hallman 2004; Hallman and Grant 2008). This chapter draws on relevant key literature upon which the research study has been constructed. The sub sections to follow explores various areas of the topic including the aspect of adolescent childbearing on a global level and the experience of early childbearing within the Sub Saharan and South African context. This chapter examines determinants that are associated with adolescent childbearing and the effects that they has on life choices, behaviours and sexual patterns thereafter.

2.2 Levels and determinants of early childbearing

2.2.1 Globally

A global perspective on the definition of a teenager/ early adolescent can be applied as they are defined as any persons between 10 and 19 years of age, in which tremendous physical and emotional changes are experienced (WHO 1998). Consequently, the transition from childhood to adulthood is considered to be a crucial phase of a person's life for the reason that, most of an individual's behavioural and sexual patterns that are acquired during

this period have the tendency to last throughout their life (Dehne and Riedner 2001). Although adolescent childbearing has become a worldwide phenomenon and more recently a health concern, the rates of early childbearing widely differ from regions, countries and even within social and ethnic groups (WHO 2004). The most prominent difference of early childbearing is between developed and developing countries. Regardless of several developed countries having reduced and achieved low fertility levels, it is important to mention that by the time fertility had started to decline in developing countries, the highly developed countries had already achieved much lower fertility levels therefore had an advance in the overall fertility decline (Caldwell 2001). These developing countries in particular have gained through the implementation of family planning programs, introduction of new contraceptive methods, advancement in medical technology and educational attainment of young women (Caldwell 2001 and Burgard 2004).

As a result, the prevalence of adolescent pregnancy and adolescent birth ultimately varies across regions and countries (WHO 2004). The average number of births per 1000 females between 15-19 years varies and is inherently determined by factors within the social context, such as age at marriage or age at first sexual intercourse, educational attainment, and access to health services (WHO 2004). Worldwide statistical reports have illustrated that Sub Saharan African countries have the highest adolescent pregnancy and birth rate, with 143 births per 1000 females between 15-19 years of age (WHO 2004). This is substantially higher than the world average of 65 per 1000 births. Furthermore, one in five adolescent females in Sub Saharan African continent give birth each year, and as a result, a great percentage of females have experienced early childbearing at least once before reaching 20 years of age (WHO 2004). Despite a high adolescent pregnancy rate, it is vital to mention that not all developing countries experience a substantially high level of adolescent pregnancy (Singh 1998). In countries where the age specific fertility rates (ASFR) are shown to decline, it is often the case that there is a decline in the proportion of young

women having much fewer children in their teenage years, rather than change in the overall adolescent fertility (Singh 1998). Moreover Latin America and the Caribbean show a greater decline in childbearing rates among adults rather than adolescents (Singh 1998), whereas Sub Saharan Africa illustrates a greater decline in adolescent childbearing and these rates have preceded declines at older ages (Singh 1998). Accordingly, adolescent fertility decline in Sub Saharan Africa is the result of delays in age at marriage and therefore impacting adolescent fertility decline.

Latin America and the Caribbean have the second highest early childbearing rates, which range from 80-100 births per 1000 females between ages 15 and 19 years (Singh 1998; WHO 2004). East and South of Asia have a rate of 56 births per 1000 females between aged 15 and 19; however there is a vast discrepancy in the different regions contribution. While Japan constitutes of 4 births per 1000 females, Bangladesh has a rate of 115 births per 1000 females (WHO 2004). Early marriage is common in South Asia, especially in Bangladesh with 69% of females between 15 and 19 years being married (WHO 2004; Singh 1998).

Therefore the experience of early childbearing within these regions can be attributed to the prevalence of early marriages occurring after menarche (WHO 2004).

The United States of America (USA) contributes the highest adolescent fertility rates from developed countries, whereas Europe and Scandinavian countries have the lowest adolescent fertility rates in the world (Singh 1998; WHO 2004).

Thus it can be highlighted that on a global scale, Sub Saharan African countries and Latin American Countries demonstrate the world's highest proportions of adolescent pregnancy and adolescent births. As a result in these particular countries, the declining childbearing rate among adults is a bigger component of fertility decline compared to the declining rates among adolescents (Singh 1998).

2.2.2 Sub Saharan Africa

Sub Saharan Africa remains the continent with highest levels of adolescent fertility with 143 births per 1000 females, although some regions of Northern Africa and Southern Africa have low Total Fertility Rates (TFR) (Garenne, et al. 2007). In more recent decades, cultural influences on adolescents' sexuality in Sub Saharan Africa have diminished and it is rather peer interaction and modern influence that have gained importance (Barker and Rich 1992). Of the total births in 11 countries in Sub Saharan Africa, 15–20% can be attributed to early childbearing (Barker and Rich 1992).

The occurrence and incidence of adolescent pregnancy and adolescent births widely differs according to a particular region's social and ethnic background, family formation, and their norms and practices. According to the World Fertility Survey (WFS) and Demographic Health Survey (DHS), urban areas have experienced the most fertility decline, however, the speed of fertility decline was found to be variable across the countries (Garenne, et al. 2007).

The countries of observed fertility decline in this continent were particularly Northern and Southern Africa (Kalipeni 1995; Bongaarts 1997; Chimere-Dan 1996). Recent literature on many Sub Saharan African societies suggests that family formations and practices are changing. In these contemporary societies, age at marriage is increasing, the age at menarche is declining and premarital fertility is increasing (Meekers 1994). The age specific fertility rate for young women between the age group of 15-19 years ranges between 120 to about 160 per 1000 in most countries of this region (Singh 1998). These figures illustrate that the level of early childbearing for young women within the age group of 15 and 19 is prominent and high. This also suggests that the high prevalence of early childbearing is rather a result of latter marriage occurring within these societies. For instance, women that particularly wait longer to get married actually increase her exposure to experiencing an early childbirth (Meekers 1994).

Teenage childbearing has always been evident in Sub Saharan Africa as a result of marriage taking place at earlier ages and bearing a child within the first year of marriage; however, due to social change and the delay of marriage, a substantial proportion of adolescents' child births have occurred to the never married young females (Meekers 1994). In light of the HIV/AIDS epidemic and persistent high levels of early childbearing, this has become a great health and social concern (Bankole, et al. 2007). At this point it is important to mention that although fertility decline is demonstrated in Sub Saharan Africa, the decline in childbearing among adults has been greater and more effective when compared to the declining rates among adolescents (Singh 1998).

Fertility decline has much variation in different regions and countries (Bongaarts 1997), therefore each determinant's influence on early childbearing is highly context specific. Essentially the overall fertility decline experienced in Sub Saharan Africa is largely attributed to several aspects such as women's change in behaviour and attitude towards their reproductive health, higher educational attainment, the availability and accessibility to health care services such as family planning programmes, and contraceptive usage (Garenne, et al. 2001). There is still a strong persistence among adolescents of low contraceptive use, much earlier age at sexual initiation, and high premarital childbearing, which ultimately has sexual and reproductive health consequences for adolescents (Bankole, et al. 2007).

2.2.3 South Africa

South Africa is one of the countries with the lowest fertility levels in Sub Saharan Africa (Cooper, et al. 2004). The total fertility rate in the Sub Saharan region range from 7 births per 1000 women in countries such as Niger, to below 3 births per 1000 in countries like South Africa (Bongaarts 2010). Primarily, the political and government initiatives as well as health programmes have had a decisive influence over the demographic trends that South Africa experienced over the years (Caldwell and Caldwell 1993). Throughout South Africa's immense political struggles and history,

variations in fertility levels occurred across the country, between provinces but more evidently between the four racial groups: black, white, Indian and coloured. Although South Africa has institutionalised national family planning programmes since 1974 and the existence of non-governmental family planning movements at the time, these programs at large had vast discrepancies within them (Caldwell and Caldwell 1993). As a result these programs not only gave rise to fertility control among the different race groups, but are also partially accountable for the divergent in total fertility rates among race groups evident today. Subsequently it is important to mention that the onset of fertility transition was inherently attributable to the social and economic advancement of the country (Caldwell and Caldwell 1993; Moultrie and Dorrington 2004).

South Africa has observed decreasing fertility levels throughout the years, however, these levels tend to be concentrated among specific age groups. Although South Africa's total fertility shows declines since the 1950s, whereby the TFR from 6.0 in the 1950s, to 4.3 in the 1980s, and 3.3 in 1993 (Camlin, et al. 2004; Sibanda and Zuberi 1999; Chimere-Dan 1993; Caldwell and Caldwell 1993), fertility levels amongst adolescents has not changed much. In 2009 the TFR declined to 2.38 children born per woman (Stats SA 2007), however, a significant proportion of births that occur each year is attributable to adolescents (Human System Trust 2007). Even though adolescent fertility has declined by 10% from 1996 (78 births per 1000) to 2001 (65 births per 1000), the mean age has not increased; two thirds of the pregnancies are unplanned and unwanted (Moultrie and McGrath 2007). The age specific fertility rates (ASFR) for 15-19 year olds is estimated at 66 births per 1000 women (Makiwane and Udjo 2006 citied in Macleod and Tracey 2010).

According to Swartz (2003) and Department of Health (2003), 35.1% of all adolescents had been pregnant or had a child by the age of 19 years, and approximately 2% of women aged 15-19 are reported to be pregnant with their first child (Medical Research Council 2007; DHS 2003; SADHS 1998). The African population demonstrates the highest prevalence of adolescent

pregnancy and adolescent births with a rate of 71 births per 1000 females between the ages of 15-19 (Panday, et al. 2009; Moultrie and Timaeus 2003). The coloured population accounts for 60 per 1000, whereas whites and Indians have a rate of 14 and 22 per 1000 females between the ages of 15-19 (Panday, et al. 2009; Moultrie and Timaeus 2003). These figures above illustrate the adolescent fertility levels of South Africa among race groups in which early childbearing is most predominant. The highest prevalence of adolescent pregnancy is found to be amongst the female age group of 17 and 19 years, however adolescent pregnancy and childbearing is still prevalent among younger ages (SADHS 1998; DHS 2003). As a result, early childbearing in South Africa has to be understood within an age specific context, for the reason that the teenage fertility rises with age and therefore the chance of experiencing an early pregnancy is determined by a female's start of her reproductive and sexual behaviour.

The extent of adolescent childbearing varies across provinces within South Africa, with teenage pregnancy rates ranging from 1% in Guateng to 6.4% in Eastern Cape (SADHS 1998; DHS 2003). Despite variation in adolescent fertility levels between urban and rural areas, the modern contraceptive usage, for females between urban and rural regions, are relatively the same. The province of KwaZulu Natal is one of the most poorest and rural provinces of South Africa and has a consistent pattern of high teenage fertility rates especially for school going learners (LEDNA 2008). In spite of the consistent prevalence of adolescent childbearing, KwaZulu Natal has the highest modern contraceptive usage of 77% in the South Africa amongst females, with a peak usage among women between the age of 35 and 49 years (SADHS 1998; DHS 2003). Regardless of modern contraceptives being widely and freely available in all health facilities in South Africa, adolescents experience barriers in obtaining and using them (Maharaj 2001; Sibeko and Moodley 2006; Adebola, et al. 2008).

In recent studies conducted on sexual initiation and childbearing amongst adolescents girls in KwaZulu Natal, South Africa suggests that adolescents who begin sexual activities at earlier ages are less likely to practice

contraception usage and therefore the lack of preparedness of these activities lead to the activity itself being unprotected, unguided and uninformed (Manzini 2001). This inherently has detrimental implications on the individual's physical health and socio-economic opportunities in the future.

Adolescents in South Africa endure power struggles with their partners in the relationship. For instance, young females often feel they have no decision making authority, lack of choice, or opinion in the relationship with regards to their reproductive and sexual behaviours, thus ultimately increasing the likelihood of experiencing early childbearing. Young females have the perception that by allowing their partners sexual decision making authority, they in return gain respect (Varga 2003; Harrison, et al. 2006). These types of relationships and notions assist in adolescents engaging in risky sexual activity at early ages, but also expose them to vulnerable situations such as unplanned and unwanted pregnancies, substance abuse, violence, and exposure to sexually transmitted diseases (Varga 2003). Furthermore, there is also a cultural importance emphasized by young black females to prove their fertility before marriage and could constitute for the primary reason of South Africa having high adolescent pregnancy rates (Varga 2003).

2.3. Determinants of early childbearing

The experience of an early childbirth is inherently an outcome of the health decisions and reproductive choices that are made by an adolescent. However these decisions and choices that are presented to teenagers are also influenced by social determinants such as an individual's socio economic status, peer pressure, family instability, educational attainment, and age. Under these adverse circumstances, early childbearing can be experienced as a result or in relation to one of the factors mentioned above. The following section will elaborate on determinants of adolescent pregnancy and adolescent births in South Africa.

2.3.1. Demographic determinants

2.3.1.1. Age at first sexual intercourse

In an environment in which the HIV/AIDS pandemic is so prevalent, age at first sexual intercourse particularly amongst adolescents is crucial and therefore a health and social concern. In a South African context, teenage fertility rises with age, therefore the chance of experiencing pregnancy at an early age is determined by a female's start of her reproductive and sexual behaviour (LEDNA 2008). In 2003, 1.2% of 15 year old females were reported to have been pregnant, 3.5% of 16 year old females, 9.5% for 17 year old females, 12.3% for 18 year old females and 23.4% of 19 year old females were pregnant (Chimere-Dan and Makiwane 2009).

Adolescents that engage in sexual activities at early ages are inclined to adopt certain sexual and behavioural patterns that last throughout their lifetime (Dehne and Riedner 2001). Hence, the initial age of first sexual intercourse is inevitably a crucial determinant which correlates with the experience of adolescent childbearing. This can be substantiated by the 1998 DHS reports in which 35% of 19 year old females had already been pregnant, while in 2004, 15% of 15-19 year old females have ever been pregnant and 54% attributed to the age group of 20-24 year old females (Hallman 2004). Furthermore this illustrates that the proportion of teenagers whom are likely to experience pregnancy rises rapidly with each years of age within South Africa (Berry and Hall 2010). In addition, South African adolescents do engage and experience sexual activities at much earlier ages than in the past and therefore the probability of experiencing early childbearing is higher.

Varga's (2002) study on pregnancy termination among South African adolescents highlights that childbearing often begins in the middle to late teens and there is little difference between those in the 15-19 age group and 20-24 year olds, furthermore that urban adolescents are more likely to be sexually experienced and start having sex at an earlier age than rural adolescents. Although childbearing may occur within the defined years above, there are still a significant percentage of teenagers that actually

engage in sexual activity at much younger ages. Research conducted by Zulu et al (2002) on sexual risk taking in the slums of Kenya suggested that the characteristics of younger women between the ages of 15-24 are more prone to the experience of having multiple sexual partners than older women between the ages 35-49. The later could inherently be due to many reasons such as the development of stable and trustworthy relationships at later stages of women's lives, the delay of marriage to later years, fear, and being more knowledgeable about the dangers of having multiple sexual patterns.

In comparison, younger women are more promiscuous and susceptible to engaging in risky sexual behaviour, they are also more vulnerable in expressing their desperation and sexual needs and exchanging these desires for sums of money (Zulu, et al. 2002). As a result, as teenagers come to age their chance of experiencing a pregnancy also increases.

Early childbearing has crucial implications for future socio-economic opportunities such as not only limiting their educational attainment, and exposing them to further unplanned and unwanted pregnancies, STI's, but also limiting the opportunity of these young adolescents to escape the intergenerational cycle of poverty which has the tendency of perpetuating itself from generation to generation.

2.3.1.2. Population group

Although it has been established that the experience of early childbearing is greatly determined by an adolescent sexual and reproductive behaviour, this outcome also varies within and between racial groups (Meschke 2000). Poverty cannot be confined to specific race group, it is however concentrated amongst the black African population of South Africa (Swartz 2004). The percentages of early childbearing are disproportioned amongst the four race groups. Teenage pregnancy seemed to be more prevalent amongst the African population with very little or no education (Swartz 2003). In addition an analysis of a study conducted by Panday et al (2009) established that older adolescents between ages 17-19 years accounted for majority of the

teenage pregnancies with higher rates, particularly amongst African (71 births per 1000) and coloured (60 births per 1000) populations, whereas whites and Indian populations (14 and 22 births per 1000) were approximated to the minority fertility level. The differences between these populations and teenage fertility rates were a result of the wide variations in the social conditions under which these adolescents were exposed and grew up in (Panday, et al. 2009). Consequently, the incidence of early pregnancy maybe an intergenerational experience, in which the cycle of poverty, crime, low educational attainment and family sexual behaviour has the propensity to develop and have an effect on the current teenager's health and reproductive choices.

2.3.1.3. Place of Residence

Several studies have been conducted in the past which dealt separately with fertility trends in South Africa and focused particularly on policy initiatives and programs that have been contributing to decline in fertility levels, contraceptive methods, and usage amongst males and females. These studies highlighted the accessibility of health care facilities, and attendance by pregnant mothers, and perspective of condom usage amongst teenagers particularly in informal settlements (Maharaj 2001; Sibeko 2006; Adebola, et al. 2008). These studies have revealed that teenagers and early adolescents whom resided in urban informal settlements perceive early motherhood as a norm within their particular society and environment (Setswe and Simbayi 2009). These studies have paid attention to the reproductive health challenges that disadvantaged residents face under their socio economic living conditions. The reality of the situation is that the underlying factor of poverty (lower socio-economic status, unemployment, crime, low educational attainment, familial environment and so forth), which are experienced within informal settlements, seems to create a hub that fosters teenage challenges and problems such as engaging in risky sexual behaviour and experiencing and exposing themselves to early childbearing and sexually transmitted diseases. In addition 33%, of the total metropolitan African population are living in informal settlements (Marx and Charlton 2003).

Through various research studies conducted in informal settlements, it is understood that poverty, crime, and unemployment under these socio-economic living conditions is seen to govern the risk of exposure and probability of experiencing adolescent pregnancies (Marx and Charlton 2003). According to Zulu, et al 2002 and Kaufman, et al 2004, women who live in communities under these adverse socio-economic conditions are driven by poverty and desperation to actually engage in risky sexual behaviours including multiple sexual partners, and these usually begin at much earlier ages of their lives. As a result being a resident of such adverse conditions can also influence the likelihood of experiencing early childbearing.

There are discrepancies regarding the prevalence of teenage pregnancies between urban and rural areas. ' The reproductive and health policy and services under apartheid were racially segregated whereby the population was divided into race categories in which Black South Africans were denied political, social and economic and health rights' (Cooper, et al. 2004 :70). Although public health systems were provided, this was largely determined and influenced by geographical and racial inequalities (Cooper, et al. 2004), and therefore the differences in fertility trends and patterns presented between urban and rural contexts are a result of these policies. Hence, one of the reasons for the rural variations in age patterns of fertility as compared to an urban context is the implementation and availability of health care provided within these areas. Historically, despite the integration of family planning into primary health care, there was still a large proportion of the African population that was predominantly rural and this had major implications on the fertility levels because most of the family planning programs and the introduction of contraceptives later occurred in urban town and cities (Caldwell and Caldwell 2002).

Most rural areas are identified and characterized by low levels of income according to the South African standards, and these incomes are usually generated from jobs performed in the public services, money sent home by migrant workers, or income received from pensions (Garenne, et al. 2001;

Zulu, et al. 2002). Furthermore, the educational attainment amongst this population is close to the average for the black population in South Africa (Garenne, et al. 2001).

Hence from these characteristics mentioned above, we can establish that fertility as a demographic event is largely influenced by the adverse socio-economic conditions, and therefore the unequal distribution of income, for instance, will in due course have drastic effects on the level and quality of education, accessibility and availability of health services and facilities, as well as the living conditions (environment) in which one inhibits.

Social inequalities that are experienced within a household in these particular areas many also contribute to the fertility trends and patterns experienced. For instance, fertility decision making and the demand for children are often studied as a household level variable rather than at an individual level. This could immensely impact on the quality and quantity of health services that a female receives and also determine the beginning of her sexual activities and reproductive career (Bruce, et al. 1989).

In contrast, urban areas exhibit characteristics that may also contribute towards risky sexual activities and the likelihood of teenage pregnancy. Urban areas have a higher HIV prevalence than rural areas, although urban residents show greater awareness of the AIDS epidemic (Zulu, et al. 2002). Furthermore, urban areas host unsafe sexual behaviours such as prostitution, involvement with multiple sexual partners, and teenage pregnancy is illustrated to be very common (Zulu, et al. 2002). This is further substantiated by young people living in poor urban informal settlements that maintain a high prevalence of HIV, as compared to wealthier urban areas or rural areas (Hallman 2004). These outcomes demonstrate that, despite health care facilities made accessible and available within urban areas, the high prevalence of HIV infection is indicative of many young people engaging in unsafe and risky sexual activities. As a result this is just one of the underlying factors of engaging in

unsafe sexual activities that can contribute to the likelihood of experiencing an early childbearing.

Undoubtedly past research has illustrated that rural areas have a higher fertility rate than urban areas, and that fertility is predominantly higher among the uneducated than among the educated, and higher in households with lower incomes (Bongaarts 2003; Bongaarts 2010). In KZN, rural areas have the highest national fertility levels, with 60% of adolescents in rural areas being sexually active (Camlin, et al. 2004), however they display a high prevalence of contraceptive usage (Chimere-Dan 1996).

As a result, place of residences, communities and environments that adolescents reside in have an immense influence on their sexual risk taking, sexual partners, and overall wellbeing (Kaufman, et al. 2004).

2.3.1.4. Familial arrangements

The family and living arrangements of adolescents also have the propensity to influence their sexual activities. This can be exemplified by the DHS (1998) and Meschke (2000) studies which illustrated that parents were found to be the primary sex educators for their children and children that found a strong sense of attachment to their families were less likely to engage in risky sexual behaviour (Resnick, et al. 1997). Family structure is important as it influences female adolescents greatly. In informal settlements, 27% of females sustain a single female headed household, thus single female headed household arrangement is seen as contributing to early sexual initiation and pregnancy amongst adolescents as well as lack of parenting (Marx and Charlton 2003; Macleod 2003). According to Zulu et al (2002), young women living in female headed household tend to have multiple sexual partners rather than those who lived in male headed household. Familial arrangements are considered to be highly significant since the support, comfort, advice, and knowledge received from the household can greatly influence the outcome of early childbearing. Families establish social networks of support and care for their children, and these structures are important roles in their upbringing and care of them

(Branson, et al. 2008). In addition, adolescents that reside with both parents are less likely to engage in early sexual activities since both parents provide the support, supervision and behavioural control that is needed for adolescents (Blum 2007). Therefore communication and the relationship developed between parents and adolescents are fundamental in guiding adolescents' sexual and reproductive behaviours. Parents play an important role, particularly for girls, by supporting them to resist peer pressure, setting boundaries for their actions and behaviour, and thus ultimately influencing their decision of engaging in early unsafe sex (Macintyre, et al. 2003).

Household structure is also an important element in determining adolescents' sexual behaviour. For instance, in households which the mother had died, adolescents tended to drop out of school for a non pregnancy related reason, as compared to households that had their mother's alive, adolescents of these households tended to drop out due to a pregnancy related reason (Hallman and Grant 2008). Consequently a mother's absence is significantly associated with higher risk of becoming pregnant while attending school (Hallman and Grant 2008).

Although South Africa is one of the few countries that allow pregnant school goers to attend school during and after pregnancy (Kaufman, et al. 2001), many teenage mothers are faced with other catastrophic problems mentioned earlier which limit and take priority to them completing their schooling. Many South African girls complete their schooling after bearing a child and the return to school reflects familial support (Marteleto, et al. 2008). However this may not always be the outcome of an early childbirth experience. In many instances teenage mothers are abandoned by their partners and family and have to survive on their own.

2.3.2. Educational attainment

2.3.2.1. Role of educational attainment in delaying childbearing

In most instances education can be positively associated with delaying the experience of sexual activity and early childbearing, particularly with South African adolescents. The effect and relation that education has on young adolescents can be viewed as a fundamental determinant which is invariably linked with adolescents' socio-economic status (Grant and Hallman 2008; Bongaarts 2003; Bongaarts 2010). Therefore, the access and availability to basic schools are an integral and crucial phase of a teenager's life. In general young adolescents that attend educational institutions (schools, technikons, colleges, university) are fundamentally equipped with specific skills, knowledge about their reproductive and sexual activity risks, awareness of dual contraception methods, and the consequences of engaging in early sexual behaviour. It must be noted that the adolescent phase is a transition encompassed with many emotional, physical and psychological changes, therefore obtaining good health is highly dependent on receiving good education (Lloyd 2007).

The information with regards to sexual activity is transferred to school going learners through sex education programmes or Life Science subjects which in more recent years have become compulsory and examinable for all students. As a result, the relationship between fertility and level of education varies across South Africa, since female's education directly has an impact on their reproductive patterns. Data presented in all DHS and WFS shows that women who attend and achieve a primary education level have substantially lower fertility rates than women who have no educational experience (Bongaarts 2003).

The goal of sex education programmes, which are relative and present in the South Africa schooling system, is to delay the onset of sexual intercourse and to promote consistent condom usage and other forms of safe sex among adolescents who have had sexual intercourse or are considering it (Manzini 2001). Therefore, it can be highlighted that adolescents who attain the

highest form of education are most likely to make informed and rational decisions regarding their sexual and reproductive career.

A study conducted by Manzini (2001), who researched sexual initiation and childbearing amongst adolescent girls in KZN, highlighted that introducing sexual education to school going learners before they reach puberty (between 9-10 years of age) would significantly benefit young girls by placing them in a better position to make informed decisions. This notion of introducing sex education programmes at younger years; however, can be disputed since there are, in many instances, teenage adolescents that have achieved higher levels of education and still managed to follow and experience this pattern of early childbearing. As a result, introducing these sex education programs to school going learners at earlier ages can be beneficial to an extent, but it is also important to consider and examine how these messages of sex education are being conveyed to young adolescents.

It must be noted that schools are seen as institutions that promote socialisation amongst students. The majority of an adolescent's life is spent in an educational institution and therefore close social networks are established between teachers and students, and as well as amongst other fellow students. Teachers as role players have the ability to influence and encourage adolescents to avoid engaging in unprotected sex, keep them from dropping out of school, and motivating them to resume schooling for completion of their education (Lloyd 2007). Schools also have the ability to provide adolescents with the necessary tools with which to nurture and negotiate healthy relationships, and to avoid compromising their own wellbeing (Kaufman, et al. 2004). As a result, educational opportunities tend to decrease the odds of sexual activity for girls, therefore delaying the likelihood of early childbearing (Kaufman, et al. 2004). The opportunity of receiving primary, secondary, and tertiary education has resulted in women experiencing lower fertility levels, and delayed the onset of their childbearing experience (Bongaarts 2010). For instance, women that receive higher education tend to have lower fertility and desired family sizes as compared to women with primary or no education at all (Bongaarts 2010).

Additionally, in certain regions of Sub Saharan Africa, decline in fertility rates are attributed to rising age at first birth as a result of an increased proportion of young females' educational attainment (Gyimah 2003). Educational attainment is also seen to be positively associated with contraceptive demand and usage. Adolescents that attend educational institutions are more likely to be aware of modern contraceptive methods, risks and benefits and therefore able to postpone early childbearing (Bongaarts 2010).

2.3.2.2. Effect of childbearing in delaying education

I. School drop-outs and repetitions

The experience of early childbearing in most instances has an adverse effect on educational attainment. Teenage mothers often view their pregnancy as a barrier towards them completing their schooling and future educational opportunities. Under these circumstances, but in relation to early childbearing, the role and impact of education then becomes uncertain as to when and at what age should school going learners be introduced to topics of sexual behaviour and activities.

The statistics have shown that at least four out of ten girls become pregnant once before the age of 20 years, moreover, that the issue of teenage pregnancy has presented a barrier against the educational success of girls in South Africa (Chigona and Chetty 2007). This can further be validated by Hallman and Grant's (2003;2004) study on pregnancy-related school dropout and prior school performance in KZN which strongly highlighted that most schooling disruptions are attributed to economic constraints, however one fourth attributed their disruption to a pregnancy. The South Africa Department of Health (SADOH) 2007 also reported that 30% of non-enrolled and non-matriculated 15-18 year old females regarded pregnancy as the primary reason for them not returning to school. Preston-Whyte (1990) had reason to believe that although having a child may not be stigmatized and even be welcomed culturally within specific environments, pregnancy itself can impede a mother's educational progress. Furthermore Chigona and Chetty (2007) revealed that in South Africa 61% of the

uneducated population are women; and that by the age of 18 years more than 30% of teens have given birth at least once therefore hindering the educational success of girls. In addition teen mothers find it difficult to cope with the challenge of having a new-born coupled with the academic pressure of school. Chigona and Chetty (2007) indicated some of the reasons as to why young adolescents fail to complete their education: lack of time to finish homework, missing classes due to motherhood, fear and loneliness at school, lack of acceptance by some teachers and students, poverty, lack of professional counselling, and so forth.

Acquiring the highest form of education is highly important for women in South Africa. In view of the fact that this inherently has a direct impact on their opportunities as well as the outcome of these situations, the social issue of teenage pregnancy has become problematic since it disrupts the educational attainment for women and youth at large. We have already recognized that young female adolescents are more susceptible and vulnerable to engaging in risky sexual behaviour (Mensch, et al. 2001), hence it is of absolute importance that young female adolescents receive the necessary educational qualifications and opportunities to become economically active and independent, but also to break away from the cycle of experiencing early childbirth and poverty. Educational attainment is also undoubtedly related to the type of household structure that an adolescent inhabits. For instance, Hallman and Grant's (2008) study on pregnancy related school dropout and prior school performance in KZN highlighted that the same household and family characteristics that influence a young woman's likelihood of dropping out of school in response to her pregnancy, also influence her likelihood of resuming school to complete her education. In some instances the pregnancy experience and motherhood may not necessary interrupt an adolescent's education, but it does introduce a new set of challenges and circumstances that have the ability to influence a teenage mother's choice of resuming to school (Hallman and Grant 2008). It is also important to consider the gender disparity that may be experienced at schools. Hallman and Grant (2004) also argue that girls develop and

advance through primary school at a much faster rate as compared to boys; however, they begin to falter predominantly at secondary level. These could possibly be due to physiological, developmental, and emotional changes that adolescents' experience. Alternatively teenage pregnancy could also be due to performing poorly in academics, which then results in teenagers becoming rebellious and lower motivation to abstain from sexual activities (Kirby 2001). In a case study that focused on adolescents' sexual activity in Kenya, Mensch et al (2001) found that gender disparity does have a significant impact on young girls particularly. Schools that include a gender neutral atmosphere in due course actually reduce the risk of young females engaging in risky sexual activity; whereas in schools that favoured a gender based atmosphere, girls were more likely to drop out of school. The fundamental difference of this population is that pregnancy followed drop out and was not merely the cause of it (Mensch, et al. 2001). Despite South Africa achieving high levels of school enrolment, there is still a significant discrepancy in racial educational attainment, both in terms of quality and quantity. On average the coloured and African race groups are the least likely to finish their schooling and therefore can possibly account for the occurrence of high teenage fertility rates within these defined race groups (Marteleto, et al. 2008).

2.3.3. Socioeconomic status

Adverse socioeconomic conditions often influence families the living conditions. This research focuses on teenage pregnancy particularly amongst urban informal dwellers. The probability of a teenager experiencing the same life difficulties, obstacles and challenges which her mother endured is significantly high. The Zulu et al (2002) study on sexual risk taking in the slums highlighted that deteriorating economic conditions and poverty increase the likelihood that adolescents engage in risky sexual behaviour. Families that reside under these specific conditions are vulnerable to acute health problems including STIs and HIV. These problems are further intensified by poor access to health and family planning services as a result of geographic isolation, and low income (Zulu,

et al. 2002). The experience of extreme poverty and deprivation in informal settlements is what makes young women engage in risky sexual behaviour and maintain multiple sexual partners (Zulu, et al. 2002). More importantly the situation under these conditions enables men to exploit females' desperation and vulnerabilities by offering money in exchange for sexual activities (Zulu, et al. 2002).

2.3.4. Peer influence

The formation of an intimate relationship between couples is essentially important, as aspects of trust, power, authority, negotiation and so forth can inherently influence the outcome of experiencing early childbearing and engaging in risky sexual behaviour at early ages. Many researchers have suggested that there is a 'fertility conundrum' which actually captures the sense of conflict experienced by adolescents of deciding whether or not to use condoms, abstain from sexual activities, become pregnant (Rutenberg, et al. 2003). For instance in Maharaj's (2001) study on obstacles to negotiating dual protection, perspectives of men and women highlighted that couples who consider their relationship to be stable do not view condom usage as necessary if there is another effective method of pregnancy prevention in their ongoing sexual relationship. Additionally, condom usage maybe seen as a sign of infidelity and is used predominantly at the beginning of their relationship (Maharaj 2001). This clearly illustrates the nature of a relationship created and in most cases women are positioned at the lower end of the bargaining scale. From a South African perspective, the concern of these relationships can definitely account for the high inconsistent condom usage amongst teenagers, and hence the occurrence of early childbearing, infection of STIs, and HIV/AIDS that tend to affect youth disproportionally. Another factor that seems to be influencing this situation is the lack of communication between partners which in some instances is non-existent. In some cases women believe that by engaging in safer sex they are protecting themselves against unwanted pregnancies, infection of STI's and HIV/AIDS, however the authority of deciding when and how is concentrated amongst the dominate male figure (Maharaj 2001). Women are

also not in such positions to negotiate safer sex due to physical threat, violence, desertion, and economic hardships, and this also affects the access to family planning services (Maharaj 2001). The perception of engaging in sexual activity in a relationship highlights two important aspects: firstly, that sexual activity benefits both the girl and boy, in the sense that girls are offered financial support and gifts, and boys are perceived to been given their manhood (Rutenberg, et al. 2003). As a result, the initiation of these types of relationships can inherently affect the health outcome of adolescents as well as determine later life opportunities. Varga's (2003) study suggests that adolescents' relationships are driven by peer pressure and young females tend to engage in unprotected and unsafe sex as a marker of trust, showing their commitment and loyalty to their partners.

2.3.5. Rising age of marriage

According to Kaufman et al. (2001) in rural areas a girl's marriage represents a potential economic safety net, especially for those lacking their own familial networks of support. Traditionally marriage was considered to be a universal phenomenon; however we notice a change in women's perception and attitudes towards this process and as a result, "first marriage is now being delayed and proportions of never married women are increasing due to increasing levels of urbanization and economic opportunities and increasing levels of educational attainment" (Garenne, et al. 2001: 277). Consequently, there is pattern that can be established: "with late first marriage, there is relatively high adolescents fertility associated with low contraceptive usage, and relatively low fertility associated with higher contraceptive usage amongst older women" (Garenne, et al. 2001: 284).

In a Sub Saharan context a similar pattern of teenage childbearing can be observed. Literature on African family formations illustrates that age at first marriage is increasing, and therefore premarital adolescents' sexual activity is increasing (Meekers 1994). Although teenage childbearing was common in Sub Saharan African societies, it usually occurred within a marital union

which was seen as acceptable, and it was the norm for married women to bear children despite their young ages (Meekers 1994). However, it is evident that there is a substantial proportion of adolescent childbearing that is occurring to never married girls, thus indicating first marriage for females in particular is occurring much later in their lives and it is not necessarily indicative of earlier sexual initiation. In addition, the longer a female takes to get married the longer she exposes herself to experiencing an early pregnancy (Meekers 1994). These percentages of high premarital fertility clearly demonstrate the rising age of first marriage, consistent contraception subsequent to first child birth, and higher educational attainment which ultimately impacts a better standard of living, aspiring to have higher economic goals and reducing the desired family size. In summary this chapter highlights literature that is relevant to understanding the severity of the phenomena been studied.

Chapter three: Methodology

3.1 Introduction

This chapter gives explanations for the type of research design and methods used, as well as the data collection analysis techniques chosen. The study aims to investigate the nature of teenage pregnancy within an informal settlement and furthermore to examine these young females' reproductive patterns and sexual behaviour under their specific living conditions. The primary objective of the study was to identify factors and issues that initiate teenage pregnancy. The study also aims to determine the types of sexual practices around adolescence engagement and to examine teenage females' experience of childbearing. Thus, a qualitative research is the most appropriate method to explore the wide range of views, perceptions and experiences of teenagers with incidents of early childbearing. This study was designed as a case study of teenage pregnancy in the informal settlement of Siyanda, Durban. A total of 16 in depth, face to face interviews were conducted, of which six participants for the 16-17 and 18-19 age categories were interviewed. The age category of 14-15 had only four participants. The 14- 15 aged females comprised the first category, 16- 17 aged females were the second category and 18-19 aged females were the third category. A further two focus group discussions were conducted, with six participants each. Groups discussed the sexual behaviour and reproductive patterns of young females ranging between 14 and 19 years of age.

3.2 Study design and research methodology

The study design was immensely influenced by the nature of the social issue being explored. Teenage pregnancy as a social issue has the propensity to be sensitive in nature; therefore, in order to gain an in depth understanding of the phenomenon being studied, a qualitative research was adopted and applied. A qualitative method allows the researcher to understand participants on a more personal level by focusing on specific details (Silverman 2001) and further enables the nature of the study to explore and understand meanings that individuals may reference in relation to the social problems and phenomenon being studied (Creswell 2009).

3.2.1 Case study

A case study according to Creswell (2009:13) "is a strategy of qualitative inquiry in which the researcher explores in depth a program, event, activity, process, or one or more individuals". In addition a "case study as a design is employed to gain in depth understanding of the situation and meaning for those involved" (Merriam 1999 cited in Henning, et al. 2004:41). Similarly, Welman argues that case studies in particular pertain to a limited number of unit analyses and are directed towards understanding the uniqueness and the peculiarity of a particular case in all of its complexity (2005:198). This approach places emphasis on the social context when understanding the social world. It is believed that the meaning of social actions, events or phenomenon is derived from the context in which it occurs (Neuman 1997; Denzin and Lincoln 1998). The research at large also focused on natural settings and placed emphasis on the participants living experiences. This is essential for understanding the meanings people place on events, occurrences, structures and processes in their life; these meanings help to connect them to the social world in which they live (Miles & Huberman 1994). The case study approach was considered appropriate for studying a relatively small number of people and being able to illustrate complete description and understanding of the issue being studied (Struwig and Stead 2001). Furthermore, the case study was isolated to factors that were not so common in the general group of adolescents, but common to certain sub-group, i.e. adolescents who live under adverse socio-economic conditions, are exposed to sexual activity at young ages, have a low contraceptive usage, experience substance abuse and other conditions that may have a negative impact on their lives. Hence the case study as a descriptive methodology approach was the most suitable.

3.3. Choice of informal settlement

Figure 1: Map showing the location of Siyanda Informal Settlement near KwaMashu

Source: http://maps.google.co.za/

It has been widely established that variations in fertility levels between South African provinces are partly a result of the different types of socio economic, political, and health challenges that the race groups endure.

Despite Durban being the largest city in the province, its population in particular illustrates a demographic trend: approximately 33% of its total 67% metropolitan African population resides in urban informal settlements (Marx and Charlton 2003). The Siyanda informal settlement is situated near KwaMashu, north of Durban, and is a predominantly African township with 25% of its residents having below subsistence level[3] and an unemployment rate of 30% (eThekwini 2009). Approximately 627 household structures make up the Siyanda informal settlement; though there is no accurate figures of how many residents are currently living within the settlement. The Siyanda informal settlement is very close to the KwaMashu Township which is surrounded with basic necessities such as shopping centres, clinics, local

[3] In this case study below subsistence level referred to the household income comprising to an amount below R1500. In these households, income was obtained by a single member of the family through causal jobs or pension grants. These households comprised of at least four to five household members.

schools, and municipal transport. Nevertheless, the residents of the informal settlement have to either walk a distance or obtain municipal transport to access these facilities from the nearby township.

Although there is support of these facilities around the settlement, the living conditions of the informal residents are quiet unfavourable and are significantly affected by urban challenges such as high population density, poverty, crime, and unemployment, all of which govern the risk of exposure to experiencing early sexual initiation and childbearing. Despite the geographical location of the settlement being within an urban terrain, these residents have social service delivery of poor quality, lack resources, have small or non existing governmental initiatives and programs, and lack basic necessity such as sanitation, running water, and electricity. The major challenge that these residents encounter is the lack of sufficient electricity, and this therefore results in illegal electricity connections. Over the past year, this has become a serious concern as many of the illegal connections are submerged in dirty water and these areas are playgrounds to many children and toddlers within the settlement, pedestrian areas, as well as roads for vehicles (eThekwini 2011).

The Siyanda informal settlement community has very few government institutions that ultimately aim to improve their living conditions and lifestyle behaviours. Many residents are engaged in the informal sector and work in shops, markets, building construction sites, and as domestic labor (eThekwini 2009). Others run *shebeen* (liquor) or *spaza* (small convenience) shops in the settlement. As a result the experience of extreme socioeconomic conditions ultimately seems to have influenced young teenager's choices in life, behavior, and lifestyle, and the likelihood of experiencing teenage pregnancy.

In addition there are a vast proportion of the households that are female-headed and therefore these women in particular are left with the burden of household chores, generation of income, and the responsibility and safety of their children. For instance, on average a gender breakdown for selected

informal settlements presented a population as 44% male and 56% female; furthermore, 27.9% of those females tended to sustain female headed households (Marx and Charlton 2003). Thus, a single female-headed family household is seen as contributing to early sexual initiation and pregnancy amongst adolescents as well as lack of parenting (Macleod 2003).

Due to such extreme conditions, many children are faced without strong familial support or social structures to guide them. Despite the presence of many local government schools in the area of research, absenteeism from school on a daily basis is common for children and adolescents within this environment. Socioeconomic constraints, responsibility of younger siblings, and teenage pregnancies were the rationale for lack of attendance at school.

It was therefore accepted that studying a relatively small number of residents under such adverse conditions provided an opportunity to explore the essential research questions, and at the same time be able to develop an understanding of the social, economic, political and environmental factors that may contribute to the high prevalence of early childbearing. The patterns of the females' reproductive experience, their lifestyle choices, and sexual behaviour are crucial and need to be studied and analyzed to attend to the social issue of teenage pregnancy.

Figure 2: Precise Location of Siyanda Informal Settlement

Source: http://maps.google.co.za/

3.4. The study participants

The study participants were a combination of young females from the informal settlement between the ages of 14 and 19. The study was conducted in two phases which included in depth interviews and focus group discussions. The participants varied according to their age, their experience of early childbearing, teenage motherhood, sexual initiation, educational attainment, and particularly their reproductive and sexual behaviours. A total of 16 adolescents between the ages of 14 and 19 created the sample of this study and were selected on the basis of their childbearing experiences. These varied from participants who were sexually active but had not experienced child birth, to those participants who were currently pregnant, and to those that had already experienced their first child birth.

Due to the research and data collection being conducted within the social setting, the snowball sampling technique was used to select the study participants. Snowball sampling is a non probability sampling method defined by Mcneill and Chapman (2005:50) as "identifying certain key individuals in a population, interviewing them, and then asking them to suggest others who might also be interviewed". It is also considered useful when researching community studies whereby respondents may not be visible and routine sampling procedure may be impractical (Bailey 1987). Similarly, snowball sampling can be done in three distinct stages. The first stage involves identifying a few persons who have prerequisite for the study; these individuals are then used to help identify others who qualify for the inclusion of the sample. The second stage is interviewing the respondents who then refer more individuals and are interviewed in the third stage (Bailey 1987; Welman 2005). Moreover, by adopting this multistage sampling technique, the units of sample are then interconnected; it follows that the unit of text ultimately forms an actual network within their natural boundaries (Krippendorff 2004). Participants are bound by the experience of a mutual event.

The limitation of adopting a technique of this nature is that snowball sampling may lack rigidity for the study.

3.5. Data collection methods

In qualitative studies, researchers get to know the participants on a personal level and as an outcome are able to identify with the concerns that participants raise and are able to completely understand important and relevant points. This can only be obtained through conducting interviews. Data collection for this study was accomplished in two phases; in depth interviews and focus group discussions, each of which have their own strengths. Interviews are a natural way of interacting with people on an intimate level which allows interviewers to understand respondents' beliefs, perceptions and attitudes (Durrheim and Terre Blanche 2004; Krippendorff, 1998). Similarly interviews in general are beneficial to the researcher particularly when historical information is crucial to understanding the current context, and also allows the researcher to be in control over the line of questioning (Creswell 2009). Thus, in depth face to face interviews and focus group discussions were the primarily source for data collection. Prior to the interviews, all participants were informed of the aim and objectives of the study and asked to sign consent forms for participation of the study. This further allowed me to use the information gathered for the research report. Phase one and two participants were assured of their confidentiality and anonymity and they all had given permission and declined reviewing and editing the transcripts of their interviews. Furthermore all participants were asked for their names and addresses if they wished to receive a final copy of the research conducted.

3.5.1. In depth interviews

Face-to-face in depth interviews were utilised for obtaining data in the first phase. Semi structured interviews, like the face to face in depth interviews, provide flexibility, ease, and allow unanticipated responses (Bailey 1987). It also provides a more personal way of collecting data because it involves face-to-face interactions with the participants, and this result in the researcher being aware of non-verbal cues and gestures which at first are seen as trivial, but are crucial to the understanding and meaning placed on what the respondent is saying (Durrheim and Terre Blanche 1998). In semi

structured interviews, “the research has a list of themes and questions (not specific questions) to be covered, although these may vary from one interview to the next” therefore, interview guides are used while conducting this particular type of interview (Welman 2005:167). An interview guide is the crucial element for these types of interviews as they provide an overview of the topics and areas of interest for the researcher to consider. The researcher varies with the questions asked depending on the respondents, knowledge level, and educational understanding, as well as to fit the background of the respondents. In most instances, the questions that are asked are formulated and adapted to the respondents, allowing the interview to develop naturally (Welman 2005).

The research questions required personal information regarding participant’s sexual and reproductive behaviours, therefore by applying a data collection method of this nature; we were able to explore the topic being studied through guiding questions. It also provided a platform for the participants to open up and engage in conversation. The majority of the face to face in depth interview questions were semi structured and context specific, directed towards each participant’s individual experience. These questions were structured to gain information on sexual patterns and behaviour, attitude towards contraceptive usage, perceptions on childbearing, educational challenges, and conditions of health and socioeconomic status. Ultimately each in depth interview conducted was intrinsically shaped and influenced by the respondent’s personal characteristics and experience of the event.

For the first phase of data collection, the face-to-face in depth interviews were conducted by selecting and interviewing participants according to their age category. Three distinct age categories were identified and applied: 14 to 15 years (age category one), 16 to 17 years (age category two), and lastly 18 to 19 years (age category three). Six participants were interviewed for the 16-17 and 18-19 age category and four participants interviewed for the 14-15 age category. These participants consisted of currently pregnant teens, those teenagers that had already experienced child birth and those teenagers

some of whom were sexually active, but had not experienced child birth. Although there was semi structured questions developed for the participants in the interview, their responses to questions were constantly a discovery of emerging ideas and understanding their perspectives on the world, perceptions and notions of the current situation, and the extent of that situation. Therefore, if new information emerged during the interview, questions were revised and modified for the other participants.

The majority of the participants' first language was isiZulu, therefore a translator was provided to help convey questions and translate responses whereby participants had difficulty. The interviewer was present in all interviews to be able to explore emerging ideas and misunderstandings from the responses, and help navigate the overall interview. Each interview ranged between 40 and 60 minutes, not exceeding an hour. Each interview was audio taped and recorded, and transcribed soon after the interview was conducted, in addition to reviewing short notes taken and observation made during the interview.

3.5.2. Focus group discussion

The second phase of data collection was conducted using two focus group discussions. Each of these groups consisted of six participants, and was composed based on, firstly, teenagers who had already become mothers and their experience of childbearing, and secondly, current pregnant teenagers and their experience thus far. The six participants for each focus group varied by their age, educational attainment, and experience of childbearing. Thus the rationale for selecting those participants in particular for the focus group discussions was to observe the differences in their experience of teenage life and pregnancy within the specific environment and identify factors according to their different age categories that may or may not have had an influence on their current situation.

Focus groups refer to interviews with a relatively small number of individuals drawn together to express their opinions, and perceptions on a specific set of open questions (Welman 2005). In conducting focus group the

researcher serves as a moderator; in other words, the researcher facilities the group discussion by posing certain questions to get participants to interact with each other and provide their responses (Silverman 2011). In doing so the researcher not only guides the interview, and encourages interaction between group members, but also elicits responses among the members of the groups. As a result, a consensus of opinion regarding the research problem can be reached. According to Welman (2005: 203) "focus group discussions allow participants to share their opinion because it may lead to new ideas amongst the different respondents, allowing them to reconsider their initial responses".

Like the in depth interview, respondents for the focus group were briefed on the aims and objectives of the study, however a different predetermined set of questions, areas of interest and topics were considered for the focus group discussion. A translator was also present due to the language barrier. Each focus group discussion ranged between an hour to an hour and 30 minutes. Each group discussion was recorded and transcribed with additional noted taken during the discussion.

3.6. Data analysis

Data analysis is the process of bringing order, structure and meaning to the mass of collected data (Rossman and Rallis 1998). As a result analysing data is fundamentally the most critical aspect of the qualitative research process. Despite qualitative research being very time consuming and costly, it is extremely rewarding with rich, in depth, and valuable explanatory data. Each interview and focus group discussion was audio taped and transcribed with additional notes and observations made during the process. Transcribing the interviews was extensive and time consuming, however these transcriptions were then used extensively to illustrate particular findings. Once the data obtained from the key interviews and discussions was transcribed, thematic analysing was then applied for analysis of the study findings.

According to Ryan and Bernard, “themes can be described as *umbrella constructs* which are usually identified by the researcher before, after and during the data collection” (citied in Welman 2005:211). Similarly in the process of thematic analysis, “the analysts looks for themes which are present in whole set or sub set of interviews and create a framework of these for making comparisons and contrasts between the different respondents” (Gomm 2008:244). It is during this process whereby researchers have to identify salient themes, recurring ideas, or language that helps to understand the research problem (Rossman and Rallis 1998). Although some themes may have been predetermined prior to the interview and transcription, illustrations from the study findings were used to relate to particular themes. Themes were generated from the conceptual framework, from the research questions, and from the study findings. Subsequently the next stage of data analysis was using these themes to actually code the data. Coding refers to tags or labels that attach meaning to the data collected, and these are then used to retrieve and organise chunks of texts in order to categorise it according to theme (Welman 2005). The purpose of coding data is to analyse and make sense of the data that is already collected. It also provides reasons, explanation and, in some instances, motives that are behind the factual information, to which the researcher can interpret, explain and relate to (Welman 2005). By coding data we are further able to identify common elements, factors, and experiences amongst the respondents which otherwise we would have not been able to illustrate.

The categorizing and structuring of data was extensive and time consuming, however it was done with extreme caution to maintain the true and honest data and to prevent data from being lost. Each theme and category was allocated a symbol to which the findings were classified within. Interpretation of the respondents’ data for the research was attempted without personal judgement of my own assumptions and beliefs but rather interpreted within the context of the harsh reality of adverse socioeconomic conditions, limited resources, and poor sexual and health care decisions.

3.7. Limitations of the study

The process of conducting qualitative research, particularly for a sensitive topic such as teenage pregnancy, raises many ethical issues and questions, some of which constitute limitations to the study.

Firstly, due to the study being qualitative in nature and relying extensively on data to be collected through in depth and focus group discussions, the information provided through self reporting could prove to have some errors. Secondly, the study covered a limited geographical space in just one of KwaZulu Natal's informal settlements; thus generalisation of the results to the province and broader country has to be cautioned. Thirdly, the data collection of semi structured and focus group discussions also prove to be a limitation. These types of techniques are time consuming; furthermore they are open to participants' interpretations, and responses to the questions. Researchers often have to redirect respondents to question of interest. Furthermore the phase of focus group discussions may have created an environment in which not all respondents were honest, or disclosed the essential information for the study. Hence this could have contributed to social desirability. Some respondents may have reported in a manner that is seen by other respondents as favourable. Respondents' behaviour could have been portrayed to bring social approval from other respondents. Fourthly, dealing with adolescents' sexual behaviour and patterns seems to be challenging. Many adolescents were sceptical of revealing such initiate and personal details of their sexual behaviour and health. Some may have distorted and altered their opinions to questions as a way of avoiding being stigmatised. In this way, true data may have not been achieved, and this proves to be a limitation.

Despite these limitations, the methods and techniques employed were carefully chosen and considered to obtain the necessary objectives of the study. These inherently provided the structure for exploration and the required in depth information.

3.8. Theoretical framework

3.8.1. Hallman holistic framework

Hallman framework is a model of external influences of society, community, and household onto individual proximate determinants, and on the study outcomes of interest. This framework recognises that knowledge interacts with skills, experience, confidence, and self esteem, and that the livelihood options and school attendance can affect sexual reproductive health behaviours. Even with awareness and knowledge of risk factors, other proximate determinants, many influenced by common independent factors, may affect sexual behaviour (Hallman 2004). The framework includes social, economic, psychological and demographic factors that may influence the risk of adolescents engaging in risky sexual behaviours and the result of early childbearing.

Hallman's framework is relative to understanding adolescent childbearing within South African context. It shows how imperatively social and economic status influences the sexual behaviours and experiences of young women and men aged between 14 and 24 years of age (Hallman 2004). Adolescents that reside in informal settlements are exposed to conditions of poverty, unemployment, crime, and low educational attainment. As a result, these environments predispose adolescents in engaging in risky sexual behaviours. Thus, the conceptual framework of Hallman provides a detailed description of the experience of a high prevalence of adolescent childbearing within adverse socioeconomic living conditions of informal settlements.

When economic factors were re-examined according to Hallman's framework, it was found that relative economic disadvantage significantly increases the risk of unsafe sexual behaviours and experiences (Hallman 2004). Furthermore, the experience of low socioeconomic conditions not only influenced and increased females decisions to exchange sex for money and goods, but also essentially raised the chances of young females experiencing coerced sex and engaging in multiple sexual partners (Hallman 2004; Hallman 2003). Under these conditions, poverty and lack of parental

support were identified as the primary source of young females engaging in risky sexual behaviours for financial support (Hallman 2004).

In addition, the lack of social livelihood alternatives may force young adolescents to engage in behaviours that put them at risk of experiencing early childbearing, but also at risk of sexual transmitted diseases (Hallman 2004). Household and family characteristics play vital roles in adolescents' choices to engage in risky sexual behaviour. While household poverty was seen to be significantly associated with increased early sexual debut among 15 and 19 year females, the characteristics of the household formation, such as the presence or absence of older male and female figures, inherently affected the experience of early childbearing, dropping out of school, and thereafter resuming to attain education qualification (Hallman 2004; Hallman 2008). Moreover, women who attend and achieve a primary education level have substantially lower fertility rates than women who have no educational experience (Bongaarts 2003).

As a result Hallman's conceptual framework provides extensive, multifaceted explanations for the high prevalence and consistent pattern of early childbearing within informal settlements. By incorporating these reasons explaining adolescents' challenges such as unsafe sex, early sexual activity, the experience of early childbearing and low contraceptive usage, we are able to fully understand the social phenomena of adolescent pregnancy through a holistic theoretical lens.

Chapter four: Findings

This chapter presents the findings of the study. It will discuss the information received from the respondents of Siyanda informal settlement[4]. The responses will be examined in relation to identified themes of these young females' reproductive and sexual patterns, realities of early childbearing experiences, and perceptions of contraceptive methods. A total of 16 in-depth interviews and two focus group discussions were conducted over a period of four weeks at Siyanda informal settlement. The sample consisted of 16 female participants between 14-19 years of age.

4.1 Demographic distribution of participants in Siyanda

Before providing a description of the findings, it is important to have a holistic understanding of the distribution of the young adolescents that were part of the study. All 16 females that participated ranged between 14 and 19 years of age. This included teenagers who have experienced their first child birth, are currently pregnant, and those who are sexually active but had not experienced any pregnancy. Given that most of the participants were in school going ages, those adolescents that had experienced early childbearing had a relatively low level of education, with none of them having completed grade 12. The majority of the girls had completed only grade 10 and some grade 11. It was found that most of the teenagers had dropped out of school due their pregnancy, and had never resumed school as a result of lack of financial and emotional support from their families. Furthermore, most of the adolescents were unemployed and never married. Those who were employed either obtained temporary or informal jobs as domestic workers or cashiers. All participants obtained for this study were currently living in Siyanda informal settlement with either their parents, extended family members such as their aunts and grandmother's or in some cases residing with their partners' family.

[4] In order to protect the identity of the participants, for citations of adolescents that had in-depth interviews conducted, IDI# (1-16) is used to represent these respondents. Focus group discussion participants will be identified as FGD #1 (already teen mothers) and FGD # 2 (currently pregnant).

Interviews were collected for 16 female participants between ages 14 and 19. It was apparent that 10 out of 16 females had engaged in sex before the age of 15 years and had experienced their first child birth before the age of 17 years. The total of eight teen mothers and pregnant teenagers had attained an average of eight schooling years. The highest grade completed was grade 9. Only two out of the ten adolescents that experienced pregnancies were completing grade 11 and 12. Five out of ten females lived with extended family. However the four out of the six respondents that resided with both parents had never experienced a pregnancy. Five out of ten respondents reported that their pregnancy was a result of inconsistent contraceptive usage. An increase in the frequency of contraceptive usage subsequent to child birth was noted. Seven out of ten respondents reported to have been consistent with contraceptives after their first child. Only three respondents reported to have had multiple sexual relationships.

4.2 Sexual patterns and reproductive behaviour

4.2.1. Timing of first sexual intercourse

Almost all the girls had engaged in sexual activity and intercourse by 15 years of age. From the participants interviewed, there were only 3 respondents who had not experienced any form of sexual activity or intercourse and were currently 14 years of age. All of the respondents interviewed for this study had basic knowledge of what is sex and often talked about it with their partners, peers and in some cases their siblings. They knew that practising in unsafe sex exposes them to unplanned and unwanted pregnancies, and STI's including and HIV/AIDs. For some of the adolescents, sexual consent was given from both parties to engage and experience sexual intercourse. Under these circumstances, both partners had talked about having sex and the decision was rather mutual. The following quotations highlight how some of these respondents perceived their relationship and timing of first sexual activity with their partners:

I fell pregnant at 16 years, but I started having sex at 14 years. (IDI# 5)

I started having sex at 15 years but my partner was 18 years. (IDI# 4)

I started when I was quite young, around 15 years, and my partner was 19 years. (IDI# 1)

I was 15 years when I had my first sex and by 16 years I was pregnant. (IDI# 3)

These quotations illustrate that sexual initiation begins at early ages for adolescents. The mean age for first sexual encounter of these adolescents was 15 years of age. Within two years of the first sexual intercourse, most of the girls had experienced their first child birth. It follows that, there are various factors, such as relationship with older partners, inadequate knowledge, inexperience and immaturity, which influence adolescents to engage in early sexual activities.

4.2.2. Consent with first sexual intercourse

The comments below reveal that only a few adolescents have the ability to communicate and negotiate with their sexual partners when to begin and experience sexual activities. Despite engaging in sexual activities at extremely young ages, according to these respondents, their power to talk and communicate with their partners makes the experience of sexual intercourse less irrational and unsafe. It is also important to mention that adolescents' relationship dynamics of trust, love, commitment, and decision-making authority is highly influential on the timing of first sexual intercourse and the control of consenting to sexual activities.

There was no kind of pressure or forcefulness, we both decided to have sex, but then it just happened. (IDI # 7)

We both talked about it and decided that we love each other and then we decided to have sex. (IDI# 1)

There was no pressure, we first talked about it, we talked about the advantages and disadvantages, we talked about going to have the blood test done, and then we did that and then we spoke to the counsellor, and she told use to use condoms and then we decided to have sex. (IDI # 13)

Conversely there were adolescents whereby their first sexual intercourse was rather coerced and extremely influenced by their sexual partners. The decision to engage in sexual activity was relatively forced upon the female adolescent. The respondents underlined that, irrespective of them being in current relationships with their boyfriends, the issue of having sex and when to have sex was often pressured upon them. Under these circumstances many of the respondents felt that they had no choice but to engage in sexual intercourse; their power and communication within the relationship was exceptionally limited, and often felt they were put in a position which compromised their actions.

He forced the issue because I told him that I don't want it and that people told me it will hurt and then he told me that it will not hurt, so I did have pressure on his part. (IDI # 2)

He decided to have sex, it wasn't my choice. But then we talked about it and decided to have sex. (IDI # 8)

4.2.3. Peer influence

Some respondents revealed that the pressure to engage in sexual activities did not necessarily come from their partners but rather from fellow peers and friends. Respondents felt pressure from the peers who were already sexually active to at least begin sexual activities with their boyfriends. Many respondents felt that as young adolescents, there is a great deal of pressure especially of their sexual lifestyle, with regards to who and how many sexual partners, frequency of sexual activity, whether there is usage of condoms or not, and to sometimes just gain the experience of it. These quotations emphasise some of the pressures that young adolescents felt that they had to endure to with regards to their peers:

It was just for fun with friends. We were both young and didn't know what we were doing and we wanted to experience it together, being teenagers, they don't know anything, and in the heat of the moment we did. (IDI # 3)

Okay I can say my friends peer pressured me into doing it, I mean like if something is addictive and everyone is doing it, they say I must do it too, and it will be okay. (IDI # 4)

In schools, I know boys used to force boys to have sex with their girlfriends skin to skin. The boys get pressure from their friends to do that, there are a lot of gangs in school and if you want to be part of that gang you have to sleep with the girl without a condom. (FGD # 2)

Some others use condoms and when they talk to their friends their friends tell them you are so stupid because you are having sex with the condom, me I'm just doing it like that. (FGD # 2)

While each of these respondents indicated knowledge of sexual practices and activities, it was not always apparent if these respondents had a clear idea of the ramifications of practising sex at such young ages. It is important to note that the timing of first sexual activity for these respondents was highly dependent on the adolescents' dynamics of the relationship, which either resulted in consensual sex occurring between both parties, or sexual activities taking place as an outcome of pressure and influence. The incidence and timing of experiencing first sexual activity was within the first and second year of high school, and this was consistent from the respondents of this study.

4.2.4. Types of sexual partners

Partnerships with older men[5] were common among respondents. Respondents who were sexually active reported being involved or had encountered at some point their first sexual intercourse with a male three to five years older than them. One participant however did have her first sexual encounter with a boy two years her junior; however, this was very uncommon within the sample frame. According to the respondents, many

[5] For the study, *an older man was* commonly used to refer to males who were two to five years older than the respondents. In addition older men were also associated with financial stability i.e. ability to afford their own cars, have a good job and be able to purchase clothes, airtime, and groceries for the respondents.

girls engaged in relationships with older men because they felt much more comfortable and regarded older men as being mature and experienced. They also reported that older men tended to listen and understand their needs better than boys in their own age group. Furthermore, single sexual relations were the most common type of partnership established. Respondents usually experienced their sexual relationships with the father of the child. Many of these young females were more likely to continue their sexual relations with the same partner subsequent to child birth.

He listens to me; that's why I choose the older men because they listen to me....if I talk to older men like my partner they listen to me and that's why I prefer older men. (IDI #4)

I have just one boyfriend, the father of my child and I only sleep with him. (IDI# 9)

I slept with him about four times and he is the father of this baby. (IDI# 7)

Girls like men that can dress and look at style and what they were and they like to have men that can buy them lots of things, that why they go for older men. (FGD# 1)

Some girls have relationships with older men, the sugar daddies with more money. He can support her with everything. (FGD# 2)

4.2.5. Multiple sexual relationships

Despite the differences in the adolescents' sexual activities and childbearing experiences, all respondents had knowledge of what constitutes multiple sexual partners and the repercussions of engaging in it. These were some of their perceptions of multiple sexual partners:

Well it's not good because some people in the relationship may be HIV positive and they won't abstain, they would just keep quiet and a lot of people will get infected with this disease. (IDI # 14)

I feel bad because when you have another partner, you can't trust your partner, it shows that you don't have love for your partner, like you want to

give it to someone else. I know of people that have 2 partners and then they get infected with HIV/AIDS and they feel like they can't keep it to them and they need to spread it. (IDI # 2)

I don't think it's good because you can fall pregnant and you won't know who the baby father is and secondly you can get some infection and you won't know who gave you this infection. (IDI # 7)

Conversely there were incidents in which a few adolescents engaged in multiple relationships with other boys outside their current relationship. The reasons for engaging in multiple sexual relations differed greatly. Some respondents engaged in additional relationships for sexual motives, as opposed to girls that established relationships with other men for receiving gifts, money, emotional support and comfort; it was mostly material gain. Accordingly, these were not necessarily sexual relations sustained with multiple partners by the respondents. In addition some girls were in relationships with partners who were the father's of their children. The following quotations highlight the adolescents' who are currently involved in multiple sexual relationships perceptions:

I have 3 partners, but I only sleep with 2 of them. The first boy I used a condom and the last boy I didn't use a condom and them I fell pregnant. (IDI # 1)

Now I have 2 partners and two babies, my children have different fathers and I sleep with both partners but condoms are not used every time. (IDI # 8)

I have 1 sexual partner but 2 boyfriends. I only sleep with the father of my baby and the other 2 boys are my boyfriends but we don't sleep together. (IDI # 3)

Many of the adolescents in particular who are involved in multiple sexual relationships resort to these types of sexual practices and behaviour on the basis of receiving material gain. Many of the girls who did engage in multiple sexual relations perceived this type of relationship as tolerable provided that sleeping with other partners required usage of a condom, whereas there was

no condom used when sleeping with the father of their children. All of the respondents that indulge in these particularly relationships had mentioned that their current stable boyfriend had no knowledge of other partnerships being experienced.

4.2.6. Sex for financial gain

Most of the relationships, according to the females, are exclusively sustained for the benefit of themselves due to their lack of financial support. Ideally the father of child provides minimal financial support which is used for the livelihood of the child, whereas the money received from the other partners are used on the adolescent's personal necessities. Some of the reasons for these adolescents engaging in multiple sexual relationships according to respondents are:

Some of them feel bored with this boy, they say he is boring, not to fast and he is quiet. Sometimes they engage because of money because some their parents maybe drinking and use the money on drugs and they may want something and then have sex with someone and get the money. (IDI # 14)

Some people say that they are stressed, they don't feel the love that they need, and it's also because of money, girls get money. (IDI # 2)

On the part of the girls, I think they want more money; maybe others take money from their partners because of low support from their families. (IDI # 5)

Some of them have sugar daddies with more money, some of them have relationships with married men and he can support her with everything. (FGD # 2)

I think some of them engage because they are poor; girls don't think that they can get money by working; they think that if they sleep with other boys they will give you money. (IDI # 7)

Some girls go and make love for money so they can buy expensive things and its usually older men that can pay them. (IDI # 16)

As a result many of the respondents indicated that engaging in multiple sexual partners was rather a choice made by these adolescents due to lack of financial support from parents as a result of their low socio economic status. By engaging in sex for financial gain adolescents are usually able to satisfy their different needs through the financial support received by their sexual partners.

4.2.7. Patterns of contraceptive use

The findings revealed that all adolescents had basic knowledge of contraceptive methods such as the injection, oral pill, and condom. However there was no evidence of the adolescents being sufficiently educated with regards to how the different methods of contraceptives can be used as dual protection[6]. Many of the young females had misconceptions especially around the injection and pill as contraceptive methods.

Majority of the respondents have never been introduced or aware of family planning programmes until the birth of their first child.

I heard about it from the clinics when I went there to take my baby for the injections. They had boards on the walls that told you about protection and family planning, so I asked the nurse to help me because I have one baby and don't want another baby. (IDI # 2)

Only after the baby, then I decided to go for the injection by clinic and the nurses told me about family planning. (IDI # 1)

I went four times after the birth of the baby to the clinic for baby vaccinations and blood testing because I am breast feeding and then I learnt about family planning. (IDI # 4)

As a result of the insufficient knowledge that the adolescents received with regards to protection and sexual activity, the condom was found to be the most common and effective method of contraception used by these young females in the study. It is important to mention at this point that the

[6] According to Morroni et al (2003) dual protection refers to the promotion of simultaneous protection against sexually transmitted diseases (STI) and unintended pregnancies.

injection or the oral pill as a precaution during sexual activity was the least preferred method of contraceptive to be used. These respondents had no knowledge of being able to use two types of contraceptive methods (i.e. a condom and oral pill or injection) simultaneously which would protect them more effectively, thus reducing their likelihood of unplanned and unwanted pregnancies and protecting themselves against STIs and HIV/AIDS in the occurrence of the condom bursting during sexual activity.

When they were questioned regarding these issues, almost all sexually active respondents were surprised to learn that such outcomes of being able to use two methods of protection simultaneously were possible. In addition, it was apparent that respondents had realised the usage and reliance only on the condom was not necessarily the safest and most responsible option. Actually, there was only one respondent who had thought about these circumstances and chose to have dual protection with the condom and oral pill. This highlights the implications of these adolescents' misconceptions and misunderstanding regarding sexual activities and protection, which contributes to their risky sexual practices.

I used the condom because it protects everything from HIV to pregnancy and a lot of sickness and condoms are great because if I do the injection, I have to sleep without a condom and I won't fall pregnant but I can still get HIV. (IDI # 3)

I didn't use the condom for the first time because he told me that when you have sex for the first time and use the condom it hurts. (IDI # 2)

The condom can burst at any time and then you can fall pregnant, but if you going to use the injection but not use the condom then you can get the sexual diseases so its not good and it doesn't help all the time. (FGD# 2)

One of the other aspects explored was the inconsistency with condom usage amongst the teenagers. Despite the young females being knowledgeable about condom usage, the results showed great differences in their pattern of condom usage amongst all adolescents. Many of the sexually active females

demonstrated that there was inconsistent condom usage before their first birth. It was apparent that many adolescents used a condom for their first sexual intercourse, however failed to be consistent thereafter which in most situations resulted in their first pregnancy. In addition other adolescents emphasised that consistency with condom usage was only experienced after their first child birth and strongly suggested by the young females. These quotations highlight the inconsistency of condom usage experienced by the adolescents:

Actually after having my baby I realised that I had to use protection, so I have to say that I am using protection now as in condoms.... Every time I have sex since the baby was born but before the baby was born I didn't use any protection, the first time we had sex I didn't use and that's how I fell pregnant. (IDI # 3)

Yes I used condoms but not all the time. (IDI # 1)

We didn't use it every time; we used the condom once and then didn't use it. It depends we use it sometimes. (IDI # 5)

We used it for the first time and not afterwards, it was my choice not to use it afterwards...because we checked after we had sex for the first time to do a blood test and then I told him we both don't have to use the condom because we are clean. (IDI # 7)

Many of the teenagers that were sexually active had the perception that by getting tested for HIV/AIDS, it provided the basis for them being inconsistent with condom usage. Although it is always beneficial to know your health status, this proved to be problematic since the results of the test determined whether protection during sexual activities should be used. According to the respondents with their test results being negative, it was acceptable for their partner as well as themselves to choose not to use any form of protection during sexual intercourse.

Another aspect that was explored was the ability of these young females to make informed decisions within the relationship regarding their sexual life.

It was apparent that a few adolescents felt that the decisions whether to use any form of contraception was often imposed upon them by their sexual partners. Under these circumstances, the adolescents expressed their concern regarding their limited choice and power to make informed decisions in their relationship, furthermore indicating that if they had to ask their partners to use some form of contraception, their trust, love, and commitment to the relationship is then questioned.

These quotations emphasise the power struggle experienced in the relationship by these young females regarding their sexual activity:

I decided to use protection, he said it's okay if it will help, because he was angry with using the condom but I told him for the sake of myself and my child I have to protect myself. (IDI # 2)

The first time we had sex I didn't use a condom because he told me that it hurts when you use the condom and I didn't know anything because it was my first, so I listen to him. (IDI # 9)

It was my boyfriend's decision; I could talk to him but then he would say there is no disease because no one is cheating then why must you use condom. (IDI # 5)

This highlights the fact that many teenagers both male and female experience immense pressure to conform to specific roles and norms within their everyday lives. Young female adolescents especially feel pressure to satisfy their partners' sexual desires and needs, since they fear rejection and abandonment by their partners. For this reason many teenagers feel that they have to adhere to these demands and as a result believe that they have no other alternative.

I feel it's like abusing a person, if you are with someone that abuses you and he wants to do it without a condom, you just have to accept it whether you like it or not. (FGD # 1)

It might be the boyfriend is forcing the girl not to use or want to use a condom, some boys who love having children don't like using the condoms, they ask you why you want to use the condom because I'm not HIV positive. (IDI # 2)

It is also an issue of trust because if you can talk and trust your boyfriend and he can understand and love you then why you are still using a condom. (FDG # 2)

4.2.8. Knowledge and attitudes towards contraception

It was evident throughout all interviews that the respondents felt strongly about protecting themselves during sexual activities. They emphasized the importance of being knowledgeable about the types of contraceptive methods, taking precautions during sexual activity, and being aware of each other's HIV status. This however was not always the case due to discrepancies and inconsistencies with contraception usage. All respondents acknowledged that at some point they had encountered a source of information regarding sexual contraception.

Respondents revealed that they had obtained this information from their peers, teachers, and health facilities, but most importantly from the sex education programme (Life Orientation) taught at school.

I learnt about sex from LO in school, it teaches us that getting pregnant at an early age is very dangerous and may lead to some bad things and secondly how to protect yourself when you are sleeping with boys, they also advise us. (IDI # 14)

I heard about the different types of contraception methods from the clinic, they had boards on the wall that told you about protection and family planning. (IDI # 2)

I received this information from the clinics, and in school the teachers talk to us about things like this. We talk about it as friends and we share each other's problems. (IDI # 7)

The most common source of receiving information regarding sexual information, according to the respondents, was through school and in the

form of sex education programmes such as Life Orientation (LO). In contrast, a few respondents underlined that the best way they found to receive such information was through forms of media such as magazines and radio. Respondents who were currently pregnant found the health care facilities and clinics to be the most effective method of receiving information. One respondent felt that LO taught in school primarily focused on equipping young females with the experience of their menstrual cycle and not necessarily taught them about their sexual activity.

They did teach us in primary school and in LO, but it was more with girls' period and stuff, not much about engaging in early sexual activity. (IDI # 3)

All respondents accentuated that these sex education programmes were introduced to them in the course of their primary education, referring to grade 6 and grade 7.

However, from the responses of the adolescents' it can be ascertained that, despite these programmes being introduced at extremely early ages to the teenagers, the essential content of knowing when and at what age to engage in sexual intercourse, implications of unsafe and risky sexual behaviours, practising safe sex, or consequences of early childbearing and so forth, may not necessarily be covered in school. As a result this may have detrimental implications on the adolescent's choices of their sexual patterns and reproductive behaviour. Furthermore sex education introduced at early years of young females schooling career does not necessarily result in the likelihood of delaying the onset of adolescents' sexual activity.

Another aspect explored was the adolescents' attitudes and perceptions on condoms. Regardless of condoms being the most common and safest method of contraception according to the young females, some of the girls had great concerns about where the condoms were acquired from. Many teenagers highlighted their apprehension especially around condoms from the local clinic. They believed that since the condoms were widely and freely available at the clinic, it had defects and was not up to standard and quality. As a result these adolescents chose to buy condoms from the pharmacy and

nearby local shopping centres. These quotations underline the adolescent's perceptions on the local clinic condoms:

We use condoms, I even buy it myself. We buy it from the pharmacy. There are in the clinics but I don't use and like those condoms because they can tear and burst easily. (IDI # 13)

I don't go to the clinic, I buy the condoms from the tuck-shop and I don't take condoms from the clinic. I feel embarrassed to go to the clinic and take the condoms, but I am also scared of what the nurses will say. (IDI # 15)

My boyfriend buys it, we don't take it from the clinic and the condoms from the clinic are not that protective so we buy ours from the shops. (IDI # 10)

We buy it because some girls tell me that the condom from the clinic it's not perfect, not good and makes me sick and he buys the condom. (IDI # 7)

Despite condoms being widely accessible and available in local clinics around Siyanda informal settlement, many adolescents chose to buy their condoms due to the stigma and assumptions that they have regarding the quality of condoms at the clinic. Thus it is crucial to educate and provide adolescents across all sexual experiences with accurate information. Many respondents from the study were misguided and had the incorrect information regarding condoms obtained from the clinic. Subsequently the misguided information can then be preserved through network of friends.

4.3 Educational attainment and experience of the adolescents

4.3.1 Highest grade completed by adolescents

As mentioned, many adolescents that had already experienced childbirth and those that were currently pregnant found it extremely difficult to continue in their schooling career while pregnant. The stigmatization around pregnancy at school, general difficulties, and challenges encountered while being pregnant were the primarily reasons for these young females failing to resume and complete their schooling. Given that many of the young girls began exploring sexual activities principally in their first and second year of

secondary high school, grade 9 and grade 10 was the highest grade completed for the majority of the girls.

I left school in grade 9, standard 7. I stayed at home and had the baby. I thought I could go back to school but I couldn't. (IDI # 1)

I fell pregnant in grade 10, I was 16 years, and after I gave birth I left school. In grade 11 and 12, I left school, I skipped those years. (IDI # 4)

I will say grade 9 because in grade 10 I fell pregnant and left school in September and I didn't complete grade 10. (IDI # 9)

I am 4 months pregnant but attending a college and doing grade 11 (IDI # 10)

I am going to school now but it's not that hard because their are other girls that are pregnant. (IDI # 7)

These quotations above emphasize the extent of school drop out due to pregnancy, and more so the implications of early childbearing on a female's educational attainment. The majority of the girls that had already experienced childbirth did not resume school, and as a result the highest grade completed was grade 9 or grade 10. For those females that are currently pregnant and are still attending school are doing so in Further Education and Training (FET) colleges with the highest grade being grade 11. From all adolescents interviewed there was only one respondent who is currently completing grade 12; however, she had to interrupt school for two years to take care of the child. Therefore it is apparent that early sexual initiation has rippling effects on these young females' life opportunities thereafter. Many respondents revealed that they intended to resume to school once they gave birth, however circumstances afterwards did not permit them to do so.

4.3.2 Behaviour of students and teachers towards pregnant adolescents

Another aspect that was explored was the reactions that pregnant adolescents received from their fellow students and teachers at school. Many respondents elaborated that they did attend school for a few months while pregnant until their pregnancy became visible. It is important to note that

the respondents attended different schools and it was evident from their reactions that there were different ways in which their friends, teachers and other students perceived teenage pregnancy within the school.

Hence for some adolescents, the issue of being pregnant and attending school was more acceptable by the norms of their friends, other students, teachers and the principal. These quotations underline experiences of pregnant teenagers that have support structure within schools:

Yes I am attending school now, it's an FET college, the teachers and students don't say much. I have supportive friends. I have a friend who is similar to me, we both pregnant and support each other. (IDI # 10)

Yes I did attend school while being pregnant, the experience was okay. The teachers keep quiet and they didn't treat me badly. There were two teachers who had helped me and protected me, and there was one teacher who I could talk to. (IDI # 4)

I am attending school while being pregnant but it's not hard because there are some other girls in school that are pregnant as well and now its like a fashion to be pregnant in my school. They treat me like all other girls and the teachers even ask how the baby is. (IDI # 7)

It can be highlighted from the above demonstrations that these young pregnant females feel at ease when attending school especially when there are support structures of friends and teachers. It is apparent that they feel accepted and well integrated within their schooling composition. Respondents also emphasised that in schools where teenage pregnancy was common, it was easier to be understood and to relate to other pregnant teenagers. They provided support for each other. Thus it is crucial to establish such support systems within schools as adolescents are constantly faced with difficult choices and challenges in their lives. In low income areas such as Siyanda, the obvious assumption with regards to teenage pregnancy is that adolescents have a modest amount of support and supervision.

Authority figures such as principals and teachers should be approachable and understanding, creating an atmosphere where pregnant mothers are further motivated to continue and resume to school, thus believing there is an array of options provided to them.

This, however, was not always the situation in the study and many adolescents viewed their concerns regarding teenage pregnancy specifically at their schools. These adolescents often expressed the difficulties and challenges they had to endure while attending school and being pregnant. A few adolescents felt that there were conventional norms and values within their families and schools which determined what was considered to be acceptable or not amongst the pupils. Furthermore, they elaborated that authority figures such as parents, teachers, principals and diligent students reinforced these types of behaviours amongst teenagers who were pregnant. They often felt pressure and difficulty to conform to these types of behaviour. The following quotations underline many of the challenges that are often experienced by pregnant teenagers:

Yes I did attend while being pregnant, other students didn't like me much, they said I just wanted to sleep around and sometimes put my desk in the corner. But the teachers were supporting me; she told me not to leave school because this happens and I must stay in school and continue. (IDI # 5)

No, we weren't allowed to attend. It wasn't the teachers but because of other students and what they would say so I left before anyone could say anything. Actually in the school I went to, the girls especially pregnant girls came up with this rule of not attending while being pregnant, so you just had to drop out. We are embarrassed and ashamed of ourselves because we are pregnant and don't want to be the fools so we drop out. (IDI # 3)

It was hard, the teachers and students used to talk about me and laugh at me, sometimes they used to ask me question. They treated me very badly and they used to pick on me, always me as an example... the teachers will say don't be like that girl... its bullshit. (IDI # 11)

At home they told me to leave school before I get a bad name.(IDI # 2)

The teachers scold us, if a girl is pregnant and the teachers finds out, then they write a letter and call your parents to school, they say that school is not a maternity ward and that our parents must control us. (IDI # 13)

These were primarily the reasons for adolescents choosing to drop out of school. Despite South Africa having an educational curriculum that enables and allows pregnant teenagers to attend school during and after their pregnancy, the majority of the respondents strongly emphasised their challenges; the stigma and labelling at schools due to being pregnant, as well as lack of communication and support on the part of teachers and principals.

4.4. Household structure and influence of adolescents behaviour

The findings revealed that the household composition greatly influenced the young female's decisions and choices with regards to their sexual behaviour. The household structures at Siyanda consisted of adolescents residing in homes that were either comprised of both parents, a single parent, containing the young girl's mother and siblings, or, in extreme cases, some of the adolescents were orphans but resided with their guardians or a close relatives such as grandmother or aunts. In the most common cases, single parenthood was the result of abandonment or death of the other parent. There were a few incidents whereby the adolescent's immediate family resided in the rural farms or in other cities, and they currently were living with close relatives to attend school or, to seek job opportunities subsequent to child birth.

Many girls who resided in single parent households revealed that their mothers were extremely supportive. They further expressed that despite their mothers being exceptionally angry at first due to the pregnancy, they were often able to reconcile and gain support and trust.

I had support from my mother, I stay with her now. She helped my even after the baby was born; she bought clothes and take of me and my baby now. (IDI # 4)

I live with just my mother *and brother. We are very close, my mother is like my friend and we can talk about anything, she understands me and is very open. (IDI # 10)*

I live with just my mother, my father passed away. I have a very good relationship with her; she teaches me everything, so even when I was going to have sex I asked her about it. She gave me good advice. (IDI # 13)

From the above quotations it can be highlighted that adolescents who reside in single parent household develop a sympathetic relationship with their mothers. It is apparent that communication between parent and adolescent does occur and thus ultimately influences the choices that adolescents make. Under these circumstances, adolescents that have experienced childbirth seem to be more appreciative of the support received by their mothers.

Adolescents who resided with either both parents or close relatives demonstrated that they received very little support regarding their situation. Many of the young females revealed that their parents' reactions towards the pregnancy were rather harsh and in some instances these girls were forced to leave home and live with their partners. There was minimal support provided to the adolescents and often made them feel unworthy, lonely and abandoned.

I don't have family support, my parents died and my granny chased me out of the house when she found out that I was pregnant and so she doesn't talk to me. Now I live with my boyfriend and his family. (IDI # 8)

Now I stay with my parents but before my parents were upset and my grandmother said I must just go and stay with my boyfriend until I give birth, my parents did not accept me when I fell pregnant so I had to go stay with him. (IDI # 5)

4.5. Barriers to teen parent communication

Parental involvement in the adolescent's sexual life was considered beneficial to those teenagers that did receive support and valuable information. Across all young girls interviewed those teenagers that were able to communicate and establish relationships with their parents perceived their childbearing experiences to be less unfavourable. They emphasised that communication between child and parent is of absolute importance, and this greatly helped them to make informed and safe choices regarding their sexual behaviour and reproductive patterns. Under these circumstances, it was found that these young females valued the advice received from their mothers, especially because she had already experienced child birth and since the girls trusted that their mothers would offer the most guidance.

Nevertheless not all adolescents were fortunate enough to have either their parent or parents being actively involved in their lives. Despite peer pressure from friends, most of the teenagers attributed their early sexual initiation was due to the lack of parental education and involvement. It is commonly known that sexual education begins at home. In such cases parents have the responsible of talking to their children, addressing issues that are appropriate to their age and most importantly informing them to make the correct and safe choice.

However this is not always the case. There are constant communication barriers between adolescents and their parents which often lead them to engage in risky and treacherous activities such as practicing unsafe sex, substance abuse, or criminal activities. In communities such as Siyanda informal settlement, teenagers often grow up and live their lives with very little guidance and supervision from parents. It was apparent that close relationships with parents were rare and this was seen as a cultural norm amongst the respondents. Mothers and elderly women particularly in the community were considered to be figures of authority that should be shown respect at all times. Communication with mothers and elderly women regarding teenagers' sexual choices was seen as highly inappropriate and

disrespectful, and therefore poses as a communication barrier for the adolescents. Furthermore, daily conversations between parent and adolescents about their problems being experienced, issues at school, and relationships were not common.

Many girls revealed that if their parents showed concerned and were more involved in their lives the outcome of the situation would be much different. They further elaborated that these existing communication barriers were fixable if only parents were less authoritative and were keen to discuss issues such as sex, relationships and boyfriends. A common finding was that the majority of the adolescents found it difficult to communicate and discuss sexual matters with their parents, especially their mothers. They revealed that their mothers were extremely strict and did not feel comfortable enough to talk to her. Rather friends and older siblings were their choice of confidante.

These illustrations explain some of the communication problems experienced by the adolescents:

I speak with my friends. I don't feel comfortable speaking to any of my family members about things like that. (IDI # 3)

It's very important because some of the teenagers they just fall pregnant, they don't talk to their mother because they are scared of their mothers. (IDI # 13)

Sometimes parents are too strict, you can't just go and talk to them about sex, so it's your choice to talk to your mother. (FGD # 2)

As a result the majority of the girls who lacked communication with their parents suggested that if their mother especially was accepting and less strict the likelihood of experiencing early sexual activity and possibly of child bearing will be much lower.

4.6. Older women perceptions and stigma with teenage pregnancy

Young females who had already experienced child birth, currently pregnant teenagers and those that had never experience child bearing had similar views regarding older women in the community. These older women are not necessarily the mothers of the teenagers, but extended relatives such as their aunty and neighbours. This perhaps best illustrated their divergent views on the phenomena of teenage pregnancy within the informal settlement of Siyanda. Most of the girls articulated perceptions that older women in the community had towards teenage pregnancy, further discussing the stigma that is very much in existence amongst the elder women. In most of the interviews the girls detailed how elder women would categorise, label, and in extreme cases disown pregnant teenagers. These women in particular isolated and often treated pregnant teenagers unfairly. These quotations highlight some of the views of teenage pregnancy by elder women in the community:

Especially older women and mothers, they shout at us, the others tell the teenagers that they are disgusting and they hate them, they behave badly towards teenage mothers and pregnant girls. Like sometimes they call you names and when you don't have parents they call you homeless child, useless person, who is going to support you and your baby. (IDI # 2)

Sometime they tell us that our boyfriend will do all the wrong things now because we have babies now, they say shame on you, and they laugh and talk about us. (IDI # 11)

Yes there is stigma especially if we are in school. They shout at us for getting pregnant. There are some girls now in the community that are pregnant now and older women get especially angry. (IDI # 15)

These quotes demonstrate how elder women in the community view teenage pregnancy as problematic. It is apparent that experiencing early childbirth is of great concern to these elder women however instead of providing some sort of support system for single teenage mothers; it often becomes an

additional challenge for these adolescents to be accepted and integrated within the community.

Across all adolescents that did experience stigmatization amongst the elder women in the community, they often explained that the men were more accepting, understanding, and supportive regarding their current situation. In some instances men encouraged these young girls to resume school and complete their education, whereas older women often isolated them by calling them names and often making them feel unworthy and useless.

The older men in the community tell me about life, they don't say much to us and they encourage us to have a life after the baby and to go back to school. (IDI # 11)

Other respondents felt that elder women expressed more disgust and concern regarding teenagers that were HIV positive as opposed to adolescent that experienced teenage pregnancy.

I think with just having HIV/AIDS there is a stigma but not with teenage pregnancy. Now teenage pregnancy is usual, something that happens everyday, people having HIV is different to being pregnant and I think people talk about HIV/ADIS and not pregnancy, in this community you can't find a teenager that doesn't have a baby, so I think it's serious. (IDI # 3)

4.7. Accessing health care facilities

The same kind of reaction was found to be discussed by many adolescents regarding older nurses in the clinic and health facilities that they had attended. The often expressed how older nurses in particular were more likely to scold and make them feel uncomfortable during their visits. The behaviours and attitudes of such health workers highlight the adolescent's challenges in attaining adequate and sufficient knowledge about her sexual lifestyle. Younger nurses were more likely to understand and accommodate the adolescent's problems without being judgemental towards them.

They treat us badly because we pregnant, the nurses and the people look at us, I don't use the clinics, and I go the doctor because the older nurses especially scold us. (IDI # 7)

The older women react badly towards the teenage mothers because they are young and instead of being in school they are at the clinics. (IDI # 13)

The young nurses understand but the old ones, they scream and shout at us. They young nurse helped me and told me about contraceptives after the baby. (IDI # 2)

It is apparent that this may have been the reason for the young girls shying away from the clinics. From other research studies conducted, nurses' attitudes towards young teenage mothers and early pregnancy is primarily the reason for the barriers of communication. This further hinders the ability of adolescents receiving accurate and adequate information for their sexual behaviour and patterns.

4.8. Perceptions on Social welfare grant and teenage pregnancy

It is apparent that the majority of adolescents felt that the Child Support Grant (CSG) did have an influence on teenagers becoming pregnant. The link between the grant and teenage pregnancy was the provision of opportunity in receiving money. Adolescents that never experienced teenage pregnancy also had the same perception towards the grant. These quotations below illustrate majority of the adolescents' perceptions towards the child grant and teenage pregnancy:

I definitely think it has an influence of teenage pregnancy, that's why girls get pregnant and chose to have the baby because they feel they can get some money. (FGD # 1)

Some girls have no money to support themselves and when they have the baby they get at least some money. (FGD # 1)

I think some girls don't have support from their families with money, and they think that by having a baby they can get money, but it gets worse after the baby. (FGD # 2)

According to the adolescents, teenagers rather take advantage of the grant provided once they get pregnant. Despite existing literature showing that the child grant has a no influence on teenage pregnancy, the findings of this study suggests otherwise. These adolescents are constantly exposed to economic constraints, and therefore may see the child grant as an opportunity of receiving a minimal amount of money every month. Adolescents that had never experienced childbirth also had the same perceptions that the child grant did have an impact on teenage pregnancy.

Chapter five: Discussion and conclusion

5.1. Introduction

The purpose of the study was to understand the nature of teenage pregnancy specifically with an interest in teen mothers within the informal settlement of Siyanda. The living condition of informal residents is quite unfavourable and is affected by urban challenges such as high population density, unemployment, crime, poverty, and low service delivery. As a result, the factors mentioned above drive the risk of exposure to experiencing early sexual initiation and the likelihood of early childbearing.

The data obtained was from a limited geographical space, was just one of KwaZulu Natal's many urban informal settlements. The study provides insight into adolescent's experience of childbearing and their sexual patterns and reproductive behaviour. Factors that once initiated teenage pregnancy such inadequate sex education, lack of access to contraceptives, and low availability of sexual health facilities, have shifted and socio economic and cultural factors have become predominant as factors that increase the likelihood of teenage pregnancy instead. The findings of the study indicate that gender roles, peer influence, socio economic conditions, lack of knowledge, and attitudes towards contraceptives were behavioural norms that inherently shaped and underlined adolescents' sexual behaviours and patterns.

5.1.2. Patterns and attitudes towards contraceptives

Contraceptive knowledge and usage will vary according to a woman's background characteristics. Several studies have reported to have found contraceptive usage to be higher amongst educated women as compared to uneducated women, higher amongst urban women than rural women, and a higher usage as womens' ages increase (Chimere-Dan 1996; Garenne, et al. 2001; Bongaarts 2003; Bongaarts 2010). Despite contraceptive knowledge being highest among women below 30 years of age, the usage of contraceptives peaks particularly among women aged between 20-34 years (Chimere-Dan 1996). This could be due to women having already experienced their first child birth and be using contraceptives to delay their

second pregnancy. Younger women are less likely to be consistent with preventative measures prior to their first child birth. Hence they are exposed to unplanned and unwanted pregnancies, STIs and HIV.

The adolescents from the study reinforced this pattern and attitude towards preventative measures. Some of the adolescents reported none or inconsistent contraceptive usage. As a result, many of the young females engaging in unsafe and unprotected sex with their partners. It is important to emphasise at this point that the young females' relationships with their boyfriends determined whether or not contraceptives were used. For instance, if the status of a relationship is considered as serious and stable, non usage and inconsistency use of condoms was more common. Adolescents felt no need for preventative measures to be used when their relationship exhibited love, loyalty, and commitment between partners.

Among the participants of the study a few adolescents had explained that usage of contraception was decided upon by the partner. In most scenarios, young females felt they were not in a position to negotiate sexual choices with their partners. Young females comply with these conditions to avoid physical violence, feelings of abandonment and rejection as well as economic hardships. However by doing so, they are exposed to practising unsafe sex and the possibility of unwanted and unplanned pregnancies, HIV/AIDS (Maharaj 2001; Varga 2003; Machel 2001). This is further confirmed by studies which support that an adolescent's relationship status does inherently influence their sexual and reproductive behaviours. Relationship dynamics of trust, commitment, decision making power, and respect are characteristics that influence and in some instances control adolescent's choices in sexual activities (Rutenberg, et al. 2003; Maharaj 2001; Varga 2003; Harrison, et al. 2006).

This rationale highlights the importance of relationship dynamics and gender roles in understanding the conditions that predispose adolescents to unsafe and risky sexual behaviours.

Another likely factor in low adolescent contraceptive usage was testing for HIV/AIDS. The test results especially been HIV negative prompted adolescents lack of usage and consistency with condoms. Adolescents believe that by being HIV negative, they are not at risk of contracting the disease. In addition they reported that been in a relationship and getting tested for HIV/AIDS proves that no infidelity has taken place. Hence these adolescents perceived condoms to be less important during sexual intercourse. Although adolescents are regularly advised to get tested, this provided the motive for the adolescents in being inconsistent with condom usage. It can be detrimental since many adolescents in the study justified their lack of contraceptive usage as a result of getting tested. In an era where HIV/AIDS epidemic is rife, practicing unsafe and unprotected sex can be the reason to the high the prevalence of HIV infection amongst adolescents (Manzini 2001; Rutenberg, et al. 2003; Hallman 2004). Despite adolescents showing awareness of HIV/AIDS, especially how they can contract and transmit the disease, there is little that can be substantiated by their actions. More than 15% of under 20 year old females are HIV positive, indicating a high prevalence rate amongst adolescents engaging in unsafe sexual activities (Bankole, et al. 2007; Rutenberg, et al. 2003; Manzini 2001; Kaufman, et al. 2004; Varga 1997; Hallman 2004; Macintyre, et al. 2003). This is so because teenagers can never be completely assured of their partner's faithfulness and loyalty.

The study results also illustrate the increased pattern of contraceptive usage subsequent to child birth. Adolescents realise that by engaging in unprotected sex, the experience of early childbearing is possible. The attitudes and patterns towards contraceptives may also be influenced by adolescents attending health facilities during their pregnancy. The knowledge received during antenatal checkups allows adolescents to explore family planning programmes and alternate forms of contraceptive methods. This therefore explains the increase in contraceptives after first birth.

Adolescents often refer to immaturity, lack of experience, and inadequate knowledge as the reasons for experiencing an early childbirth. This is

consistent with literature that shows a low incidence of contraceptive usage before the first birth and an increase amongst adolescents that have attended antenatal clinics during and after their pregnancies (Mqhayi, et al. 2004; Garenne, et al. 2004; Wood and Jewkes 2006). Perhaps these young females examine the reality of their situation and the impacts that early childbearing has on their schooling careers, economic opportunities, social and physical wellbeing. Therefore, to avoid repetition, adolescents illustrate more responsible behaviour by making use of family planning programmes and contraceptives. Many adolescents have shown to have a change of perception and attitudes towards contraceptive methods after the first child birth.

It is evident from the study that adolescents recognize the importance of having safer sex and using contraceptives consistently so that it is efficient.

5.1.3. Teenage pregnancy and educational attainment

Schools are seen as preventative resources in which adolescents receive skills, support, and knowledge about sexual matters that influence them in making informed decisions (Lloyd 2007; Hallman and Grant 2008; Marteleto, et al. 2008; Mensch, et al. 2001). The introduction of sex education in schools was meant to delay the onset of sexual intercourse and to promote safer sex among adolescents (Manzini 2001). The study by Manzini (2001) highlights that introducing sex education to school going learners before they reach puberty places young females in better positions to make informed choices. This, however, is not always the case. Although sex education is taught at schools, there is no guarantee that the content and messages about sexual life are being conveyed to the young learners in the most appropriate and effective manner. This can provide an explanation as to why some adolescents from the study found sex education to only be efficient when dealing with puberty issues. It was apparent that some adolescents felt it lacked content regarding sexual matters. For instance, when and at what age should first sexual intercourse occur, contraceptives, dangers of engaging in risky and unsafe sex, implications of early pregnancy, and HIV and AIDS. The possibility that sex education taught at

schools does not necessarily cover adequate sexual content inherently affects adolescents' sexual choices and patterns. The lack of adequate knowledge does have an impact on adolescents engaging in unsafe and risky sexual behaviours. These include being exposed to the vulnerability of unplanned, unwanted pregnancies, likelihood of multiple sexual relations, STIs, and HIV. Although the experience of an early childbirth has an impact on teen mothers attaining lower education, there are other contributing factors.

South Africa is one of a few countries that accommodate pregnant school going learners to attend and resume school. In spite of the initiatives made, not much progress has been made on teen mothers resuming school to complete their education. Majority of the adolescents never resumed school due to their pregnancy and lack of financial and familial support. Several studies confirm that teenage mothers view their pregnancy as barriers towards completion of schooling and future educational opportunities (Chigona and Chetty 2007; Hallman and Grant 2008; Mensch, et al. 2001). Teenage pregnancy and motherhood introduces a new set of circumstances that influence future decisions (Hallman and Grant 2008). For most of the adolescents, grade 10 was the highest completed and many adolescents had left school due to their physical condition. They had reported experiencing difficultly between balancing motherhood and their studies. Teen mothers lacked time to complete homework and missed classes regularly. In addition there was lack of support to deal with the stigma that is attached to experiencing an early childbirth in their schools and community. Despite the high prevalence of teenage pregnancy there is still immense stigmatization that is associated with it. Teenage mothers are judged by their peers and society and are viewed as girls with low morals, fostering promiscuous behaviour. Adolescents that reside in communities as such tend to be less motivated to complete their education and generally have lower self esteem.

Hallman's conceptual framework illustrates how the psychological and social aspects of society influence adolescents' sexual and reproductive behaviours (Hallman 2004). It must be noted that knowledge influences

skills, self esteem, confidence, and livelihood options. Hence adolescents internalise how people behave, perceive and interact towards them, which definitely has an impact on their sexual and reproductive behaviours (Hallman 2004; Hofferth, et al. 1979). This is further supported in the study in which teen mothers explained how often they were labelled, treated differently and isolated, but especially viewed in a negative way as compared to teenagers that have never experienced a pregnancy. Many adolescents find it hard as there is a lack of emotional and financial support from their families and partners. In order for these young women to be successful academically, they need to be provided with the adequate support that ultimately equips them for early motherhood.

One of the main reasons for the adolescents' not resuming school was lack of financial support from parents and partners. Teen mothers reported that they had no familial support with taking care of the child and therefore could not return to school. Unfortunately teen mothers are not in positions where they can afford to pay for day care facilities while attending school. Hence, in order to address the large percentage of teenage pregnancy school drop-outs, adequate support should be made available to these young women. For instance the education system should consider introducing programmes that will enable adolescents to at least complete their secondary schooling. These programmes should include additional and extra academic classes that not only cater to the needs of the teenager but also to her responsibility as a teenage mother. These programmes should be flexible and at the same time equip teenage mothers with the skill of balancing both schooling and motherhood. In doing so, adolescents are able to balance both motherhood and their studies. The completion of basic secondary education ensures that adolescents are provided with economic opportunities and reduces the likelihood of a life of poverty.

Many adolescents often have to face the difficulties and challenges of motherhood alone. Barriers towards communication between parent and adolescents are primarily the reason as to why adolescents lack familial support. The link between parent and adolescent is that, parents are

considered to be primary sex educators, providing emotional support and reassurance of correct and appropriate behaviour during an adolescent's transition from childhood to early adulthood (Resnick, et al. 1997; Meschke, et al. 2000; Macintyre, et al. 2003; Marteleto, et al. 2008). Hence, establishing communication between parent and adolescent is fundamental in guiding an adolescent's sexual choices and behaviour. Parents play an important role particularly for girls by supporting them to resist peer pressure, setting boundaries for their actions, and behaviours which influence their choices (Macintyre, et al. 2003).

Adolescents living under adverse socio economic conditions often lack counselling, support, and guidance from their parents. These parents are rather overwhelmed with financial problems, therefore participating as the primary sex educator is not a high priority. The study also illustrates adolescents' uncertainty of communicating with their parents regarding sexual matters. This included fear of their parents' reactions and behaviours towards the subject of sex, and apprehension of parents being aware of their sexual engagement, while some adolescents regard discussions with parents about sex as inappropriate and disrespectful. It is apparent that communication between parent and adolescent is a rare experience for these young women. In light of this, the importance of communication between both parties is fundamental to adolescents making informed decision about sexual behaviour and patterns.

5.1.4. Household structure and teenage pregnancy

The household composition for adolescents is an important aspect to consider when analysing the prevalence of teenage pregnancy. In most instances the household structure has influence on the adolescent's choices with sexual behaviour. Household and family formations are inevitably linked to teenage pregnancy. This is so because characteristics that influence a young female's likelihood of dropping out of school in response to her pregnancy also influence her chances of resuming school (Hallman and Grant 2008). Many adolescents from the study highlight the pressure that their households had on them to drop out of school due to the

embarrassment of their pregnancy. These households comprised of parents that were conventional in their thinking and actions. They preferred their pregnant teenage daughters to rather drop-out of school in order to avoid feelings of shame, embarrassed, and stigmatization.

Another likely factor with household structure and teenage pregnancy is that it can facilitate the onset of sexual initiation, particularly within these environments. For instance 27% of females within informal settlements sustain single female headed households (Marx and Charlton 2003; Macleod 2003; DHS 1998; Meschke 2000). It is often difficult for single parent mothers to provide adolescents with the care and assistance that they need. Perhaps this contributes to the likelihood of adolescents engaging in risky sexual activities as a result of a lack of supervision and guidance. The majority of the adolescents from the study resided in single parent households or were living with extend family. This perhaps explains their behaviour due to insufficient support, guidance, and supervision from adults. Youth who live with both parents are less likely to engage in risky sex activities as compared to those who live with just a single parent (Blum 2007). As a result family and living arrangements of adolescents has the possibility of influencing their sexual activities.

Informal settlements provide conditions for female-headed low economic household structures. In addition, adolescents are predisposed to adverse socio economic conditions. Economic disadvantage is found to increase the likelihood of a variety of unsafe sexual behaviours and experiences for adolescents (Hallman 2004; Zulu, et al. 2007; McCulloch 2001; Makiwane 2010; Blum 2007). However, more extreme effects take place for females' sexual behaviours than males. This is so because low economic status not only increases females' chances of exchanging sex for material gain but also increases their likelihood of experiencing coerced sex and engaging in multiple sexual partnerships (Hallman 2004). Thus, an explanation for the adolescent's engagement in multiple sexual relationships and having sex for material gain is provided. It is understood that lack of livelihood alternatives may compel the poor to engage in behaviours that put them at risk (Hallman

2004). Teen mothers from the study explained that their reason for involvement with multiple partners was purely for material gain. Several of their partners provided for their material necessity such as money, clothes and jewellery.

5.1.5. The role of community and teenage pregnancy

Although clinics were available and accessible by public transport, many adolescents encountered difficulty attending these clinics due to youth's unfriendly services. Adolescents reported that elderly nurses pose a challenge for them in accessing adequate assistance in health services. However they found younger nurses to be more considerate and understanding. Perhaps the change in attitudes amongst the younger nurses is result of the younger generation being more open mined and less traditional. In addition younger nurses recognize early childbearing to be a difficult experience for teenagers and therefore provide the support and assistance that they need. Many young females avoided attending these clinics for advice on sexual matters because of the attitudes of the older nurses. It was apparent that the clinics were only used for antenatal checkups, child birth immunization and family planning. Findings suggest that elderly nurses in particular were less considerate towards pregnant teenagers and behaved rather unfairly. For instance, many older nurses scolded them and used them as examples for irresponsible behaviour.

The study by Wood and Jewkes (2006) confirms this by discussing the difficulty that adolescents face with accessing health care services. It illustrates the attitudes of nurses as preventing teenagers from receiving accurate information to make informed decisions. In addition nurses failed to identify their actions as contributions to the reinforcement of the stigma associated with early childbearing (Wood and Jewkes 2006). Perhaps this provides explanation as to why none of the adolescents sought counselling or advice prior to first sexual intercourse. The fear of being stigmatized and judged prevented these young females from receiving crucial information.

Many respondents highlighted the need for youth to be integrated within the community intervention programmes. They underlined that existing social initiatives and outreach programmes were unsuccessful in integrating the youth's perception and concerns. This proved to be highly problematic particularly for addressing the phenomena of teenage pregnancy. Being able ascertains firsthand knowledge and understanding of adolescents' challenges and problems is essential for providing the most suitable solution. For instance, the young females suggested that an essential improvement can be made by establishing a youth committee that will address their concerns and issues. Perhaps the high incidence of early childbearing within this community can best be explained as a measure of low levels of among parents, community leaders, and adolescents. This information also leading one to conclude that there is a lack of involvement in adolescents' lives regarding their physical, social and emotional wellbeing.

5.1.6. Social welfare grant influence on teenage pregnancy

Despite Makiwane (2010) indicating that there was no significant positive association between the grant and trend in teenage childbearing, the findings of this study suggested otherwise. Participants who had never experienced childbearing expressed that the social welfare grant was significant on the girl's experience of early childbearing. These young females conceptualised the fact that many teen receive the grant, so therefore it must be a provision of opportunity in receiving money. Similarly adolescents that did experience teenage pregnancy also agreed that child grant does have an influence on young female's reproductive patterns and behaviour. Many teenagers perceived that reasons for girls becoming pregnant at young ages were to receive the minimal amount every month. The monthly income also provided the basis of financial security for those adolescents that were abandoned by their families and partners.

South Africa implemented the Child Support Grant (CSG) as an alleviation strategy for child poverty. However, adolescents' perceptions from the study suggest that the CSG impacts on teenage pregnancy. It does not necessarily initiate their onset of sexual activity but it was found to have an impact on

their reproductive patters. Informal settlements are environments that experience high levels of unemployment and poverty, hence relative economic disadvantage predisposes adolescents to engaging in early sexual activity and the possibility of experiencing early childbirth. Adolescents' perceptions were that the grant was seen as a way of escaping their poverty stricken lifestyles. Consequently adolescents are ignorant of the greater costs attached to having a child at a young age. It is apparent that adolescents relate to the CSG as a means of attaining a minimal amount of money every month. The CSG also provides conditions for adolescents failing to delay their second pregnancy. It also contributes to adolescents failing to consider alternate options such as abortion or adoption. Relatively abortion was never considered as an option amongst these girls. The majority of them were strongly against having an abortion. Due to the provision of money provided every month, adolescents believe the grant will be sufficient in taking care of the child; however this is not usually true. Teenagers that get pregnant as a means of attaining the CSG oftentimes perpetuate the cycle of poverty.

5.2 Conclusion

The sexual and reproductive behaviours of adolescents in an informal settlement were examined as a result of the high prevalence of teenage childbearing in South Africa. The deteriorating economic conditions, lack of basic necessities and services, and other experiences of poverty have become the reality and livelihood of many informal dwellers. Low economic status and economic disadvantage is found to have an effect on unsafe sexual behaviours (Zulu, et al. 2002; WHO 2004; Hallman 2004). Thus if the factors contributing to adolescents engaging in early sexual activities are identified and addressed, the probability would be that prevalence of teenage pregnancies, STIs and HIV infection amongst adolescents will be substantially reduced. Practising unsafe sex exposes adolescents to an array of consequences. For instance the likelihood of unplanned and unwanted pregnancies, possible STI and HIV infection, schooling disruption, are all likely to reduce economic stability and increase adolescents' risk to a

lifetime of poverty. The experience of an early childbirth has found to have social, economic, personal, and physical ramifications (Mensch, et al. 2001; Singh 1998).

By gathering information about the nature of teenage pregnancy in informal settlements such as Siyanda, the present study was able to examine these young females' reproductive patterns and behaviour under these specific living conditions. One of the main objectives for the study was to identify factors and issues that initiate early sexual debut and the possibility of experiencing childbirth. It was apparent from the study's findings that social demographic characteristics such as age, gender, and place of residence were influential in adolescents experiments with sexual activities at young ages. This is illustrated in the studies done by Zulu et al. (2002), WHO (2004), and Hallman (2004) that suggest adolescents whom reside in low economic conditions have a much younger median age for first sexual encounter.

The study findings suggest that by 15 years of age, almost all girls in this informal settlement had their first sexual intercourse. The participants had varied experiences with their first sexual activity. Factors that facilitated the onset of adolescent's sexual activity were influence from their sexual partner, peer pressure from friends, and having older sexual partners. The majority of the respondents described their first sexual experience as less of a mutual decision, rather they explained how they were coerced some cases forced to engage in sex. Many adolescents felt that the idea of having sex was imposed by their sexual partners. The status of a relationship was influential in adolescents experiencing sex at early ages. Many of the participant's sexual partners used the relationships dynamics of commitment, loyalty, and trust to entice the young girls to engage in sex at an early age.

Several girls believed that teenage pregnancy was common in their community, although they reported that drugs were also a problem. Thus suggesting the phenomena of teenage pregnancy is a social norm and part of

everyday life. According to some adolescents, teenage pregnancy was seen to be a 'fashion'. These adolescents explained that they at least knew two to three girls in their community or in school that were currently pregnant or had already become teen mothers. Under these adverse socio economic conditions, the experience of early childbearing is influenced by economic stability, peer pressure, and familial environment.

Lack of communication between parent and adolescent was identified as an imperative factor contributing to teenagers' risky sexual behaviours. Many adolescents revealed that sex education from their parents was nonexistent. The primary reason for this was identified to be fear of talking about sex with parents. Parents were often portrayed as being too strict, inconsiderate, and failing to understanding adolescents concerns. Thus, the findings suggest that other siblings and close friends were the most likely individuals that teenagers feel comfortable to confide in and trust.

The second objective for the study was to determine the type of practices around adolescent's sexual behaviour and engagement. Single sexual partnerships were the most prevailing characteristic of the adolescent's relationship. The teenagers engaged in sex frequently with the father of their child. These males were particularly three to four years older than the girls. However there were a few adolescents that had the tendency of engaging in sexual activities with more than one partner. According to these teenagers, whether or not they had intercourse with their multiple boyfriends, depended on several aspects. These included being the father of the child, money, and status. For instance condoms were not used during sexual intercourse with the father of the child however were preferred with either one or more of the boyfriends.

The results show that the most common method of contraception amongst the adolescents was the male condom. There was no evidence of these girls using the oral pill. In fact many girls preferred the male condom as the safest and most comfortable method of protection. On the other hand there were a few girls who considered the injection as an alternative method of

protection. It should be noted that lack of counselling and ability to acquire the necessary information regarding sexual behaviour leads to adolescents being uncertain about health risks. The findings propose that the teenagers of Siyanda found counselling to be insufficient. They reported the nearby health clinics and elderly nurses to be less accommodating with their early sexual choices and pregnancies.

The last objective explored in the study was the overall childbearing experience for these young females. Findings showed that for those adolescents who had already experienced childbearing, the main concern and challenge was the lack of financial and emotional support from the father of the child and their families. Early childbearing does hinder a female's level of education and the chances of her resuming school to complete her education. This is consistent with existing literature discussing the impact that early childbearing has on females' educational attainment. None of the teen mothers surveyed had completed their education, and this was largely a result of the lack of emotional and financial support from their families. In contrast, currently pregnant teens were seen as being more content with their situation. They perceived their pregnancies to be appropriate and revealed that they had immense support from their families and the father of the child.

Another unexpected but rather important finding was the relationship between teenage pregnancy and child welfare grant. Makiwane 2010 study shows a negative association with early childbearing and the grant, the adolescents perceived the grant having influence on young females' reproductive patterns. The majority of the teenagers, irrespective of their childbearing experience, perceived teenage pregnancy to be connected with the child grant.

It is important to note that while each of the adolescents interviewed had distinct individual traits and personal histories that did contribute to their initiation of early sexual intercourse and the likelihood of experiencing early childbearing, the experiences which they related with regards to sexual

intercourse, influence and power in the relationship of partners, and the usage of contraceptives, were astonishingly consistent, irrespective of their background.

5.3 Future research

The reality for any action to take advantage of any opportunity for change firmly depends on the priority given to teenage pregnancy in South Africa. Such priority is undermined by the insufficient data available on variation in early childbearing experiences within formal and informal settlements. Hence more questions need to be raised regarding adolescents' perceptions of early childbearing, sexual behaviours and reproductive patterns, and their social and emotional pressures under these adverse socio economic conditions.

The study was small in scope due to limitation in time and resources. As a result more questions need to be raised around early sexual initiation, particularly within informal settlements. Firstly, we need to examine the perceptions and experiences of early childbearing and decide if they are similar to other informal settlements and the wider area. If not, what are some of the reasons for disparity in the experience?

Secondly there were differences in terms of childbearing experiences. Teen mothers had different views regarding their experience as compared to currently pregnant teens and how they perceived their pregnancy. It would be useful to look at the perceptions of early childbirth once they had gone through the experience. This could an analysis of their attitudes and perceptions before and after pregnancy.

Thirdly this study focused on the Siyanda informal settlement that is mainly comprised of the African population. Another interesting aspect to explore would be other population group's early childbearing experience, such as Indian and coloured, under the same adverse socio economic conditions. Do they display similar sexual behaviours and reproductive patterns? What

factors influence the experience of early childbearing? Do they have the same challenges and difficulties? How do they perceive early childbearing?

In addition more studies of this nature should be conducted not only in informal settlements and KwaZulu Natal but in various other parts of the country and other countries. Further investigation can also be done on the relationship of child grant and teenage pregnancies. There is always a need to gain men and parents views on adolescents reproductive health issues in general and teenage pregnancy in particular, therefore this should be considered for future research.

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Appendix I: Interview Schedule and Questionnaire

Questions for in-depth and focus group research conducted on 'Experiences of teenage mothers in the informal settlements: An analysis of young female's reproductive health and challenges, a case study of Siyanda informal settlement'. These questions proposed below are purposely designed to obtain the main objectives of the interviews.

Discussion: In-depth Interview Questions

Firstly participants should introduce themselves by their name's and also stating the current age and age at which they experienced their first pregnancy.

General Questions:

1. What is your current age?
2. When did you fall pregnant? At what age?
3. How many children do you currently have?
4. What are you doing now? E.g. studying, stay at home mother, working etc.

Sexual behaviour

1. When did you start engaging in sexual activities?
2. Was it coerced or a mutual decision to engage in sexual intercourse? Any pressure?
3. At what age did you encounter your first sexual intercourse?
4. How old was your first sexual partner?
5. Was it a mutual decision to experience sexual intercourse?
6. How many times have you engage in sexual intercourse?
7. How many sexual partners do you have?

Contraceptive Usage

1. What are some of the contraceptive methods that you are aware of?
2. How did you hear and receive this information? E.g. friends, media, school, health facilities
3. Have you or your partner used any method of contraception during sexual intercourse? What were they?
4. How often/frequent do you use contraception?
5. Where do you get it from?
6. What method of contraceptive do you prefer?
7. Was contraception used before your first child birth/ pregnancy?
8. Who suggested the use of contraception in the relationship?
9. Have you used condoms during sexual intercourse?

10. Are condoms frequently used in your sexual activities?
11. Are you able to negotiate condom usage with your partner?

Education

1. Are you in school?
2. What is your highest grade completed?
3. Did you attend school while being pregnant?
4. What was the experience like?
5. What are some of the challenges and difficulties that you have encountered?
6. How did other students and teachers react to your situation? Why do you think they behaved this way?
7. Were your friends supportive? How did they feel?
8. Do you have any friends that are in a similar situation like you?
9. At what age did you start learning about sexual matters in school? Do you think it is important, if so why?
   Have you returned to school since the birth of your child? If so, who takes care of the baby?
   How do your fellow students, friends and teaches behaviour towards you?

Community and Household

1. Who are you living with at the moment?
2. How would you describe your household?
3. How do you provide for the baby? Does the father offer support?
4. What resources are in the community to help pregnant teenagers?
5. How do people in the community behave towards pregnant teenagers?
6. Is there any stigma attached to falling pregnant as a teenager from elderly men and women in the community?
7. Who takes care of the child?
8. Describe the family support that you received?
9. Did you speak to any household members regarding your sexual life?
   How important you think it is for mothers and daughters to talk about sexual behaviour and birth control etc?
   How would describe the health care facilities in the area? Are there any challenges in accessing them?

Relationships

1. Are you in a relationship?
2. How would you describe your relationship?
3. How long have you been in this relationship?
4. Have you heard about multiple sexual partners?
5. What do you think is multiple sexual relations?
6. What is your personal opinion on multiple sexual partners?
7. Why do you think people engage in these types of relationships?
8. Who do you think is the best person that adolescents can talk to? E.g. friends, siblings, parents, teachers, spiritual leaders?

Childbearing Experiences

1. Who did you tell when you first found out that you were pregnant?
2. How did they react towards you?
3. What was the baby's father reaction towards the pregnancy?
4. Did you use any contraceptive method before your first birth?
5. What was the outcome of the pregnancy? E.g. Live birth, miscarriage, stillborn, multiple births etc
6. Have you experienced a second pregnancy?
7. Did you use contraceptives before the second pregnancy?
8. Did you seek medical care during your pregnancy?
9. How many times did you go to clinics?
   What are some so the challenges/ difficulties that you experienced during your pregnancy?
   Where there any of your friends pregnant at the same time as you?

Focus Group Interview Questions:

What age do you think people should start having sex?

Why do think teenagers engage in sexual activities?

What are your feelings towards teenage pregnancy?

What are your views on premarital sex?

What are the opinions of other friends and family on engaging in premarital sex?

Do teenagers know about contraceptives?

Do you think teenagers use contraceptives?

Which are the most common contraceptive methods that teenagers use?

What are your opinions on contraceptives?

Are condoms frequently used? Why, why not?

Are contraceptives accessible and available?

What are some of the reasons for teenagers not being consistent or not using contraceptives at all?

What are some of the meanings attached to using contraceptives?

Do teenagers have more than one sexual partner at a time? Why?

What are your views on multiple sexual partners?

Why do teenagers engage in these types of relationships?

Do you know of sex education classes taught at school?

What are your attitudes towards sex education in schools?

What is greatest concern to you regarding teenage pregnancy? Why?

Are teenagers getting pregnant more or less?

Why do teenagers fall pregnant?

What do you think maybe some of the options for teenagers that do fall pregnant? And Why?

What role can parents play to prevent teenage pregnancies?

What is the most effective way for adults to talk to their children about pregnancy, STI's, drug abuse, contraceptive usage?

What are the most serious problems facing the youth people in your community?

What can groups or agencies in community do to prevent future cases of teenage pregnancy?

Do you think the child support grant has an influence on teen childbearing?

Appendix II: Informed Consent

(To be read out by researcher before the beginning of the interview. One copy of the form is to be left with the respondent; one copy is to be signed by the respondent and kept by the researcher.)

My name is Carminee Govender (student number 206501197). I am doing research on a project entitled 'Experiences of teenage mothers in informal settlements: An analysis of young female's reproductive health and challenges, a case study of Siyanda Road informal settlement'. **This project is supervised by Ms Nompumelo Nzimande at the School of Development Studies, University of KwaZulu-Natal.** I am managing the project and should you have any questions my contact details are:

School of Development Studies, University of KwaZulu-Natal, Durban.

Cell: 0828691959. Email: 206501197@ukzn.ac.za

Thank you for agreeing to take part in the project. Before we start I would like to emphasize that:

-your participation is entirely voluntary;

-you are free to refuse to answer any question;

-you are free to withdraw at any time.

The interview will be kept strictly confidential and will be available only to members of the research team. Excerpts from the interview may be made part of the final research report. Do you give your consent for: *(please tick one of the options below)*

Your name, position and organisation, or	
Your position and organisation, or	
Your organisation or type of organisation *(please specify),* or	
None of the above	

Please sign this form to show that I have read the contents to you.

---------- (Signed) ---------- (date)

---------- (print name)