

**FACTORS ASSOCIATED WITH TEENAGE PREGNANCY AT DWARSLOOP LOCAL  
AREA CLINICS, BUSHBUCKRIDGE SUB-DISTRICT, MPUMALANGA PROVINCE**

By

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**DECLARATION**

I declare that “**factors associated with teenage pregnancy at Dwarsloop Local Area Clinics, Bushbuckridge Sub-District, Mpumalanga Province**” is my own work in design and in execution and that all the sources that I have quoted have been indicated and acknowledged by complete referencing and that the work has not been submitted before for any other degree at any other institution.

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Signature-----

Date-----13/09/2021

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## **DEDICATIONS**

*I dedicate this study to my mother, my children Marcia, Pinky, Tshifhiwa, my son-in-law, Lebogang, my grandchildren Tshiamo, Tshenolo, Alakhe, Andile, my brothers and sisters, sisters-in-laws, brothers-in-laws and my husband for support and encouragement.*

## **ABSTRACT**

**Background:** The South African policy environment creates a relatively progressive space around teenage sexuality. A teenager's right to access sexual and reproductive health care is guaranteed in the South African Constitution of 1996, and a series of laws thereafter enable teenagers to access contraceptives, terminate pregnancies and access sexual and reproductive health services (Willan, 2013:6). Despite the South African government's efforts in ensuring access to sexual and reproductive health care services, the Bushbuckridge Sub-District is still confronted with a high rate in teenage pregnancy. The purpose of the study was to describe factors associated with teenage pregnancy.

### **Methods**

A quantitative descriptive study design was chosen. Population consisted of all pregnant teenagers attending antenatal clinic at five clinics in Bushbuckridge Sub District, Mpumalanga Province. Simple random probability sampling was used to include 70 pregnant teenagers who satisfied the inclusion criteria. Data were collected through structured self-administered questionnaires. Data was analysed using statistical package for social sciences (SPSS). Ethical consideration was ensured.

### **Results**

The study findings revealed that girls start engaging into sexual intercourse at an early age, 14 years and younger, as some of the respondents were both 14 years old and pregnant. The study further revealed that 69% of respondents did not use protection during the first time they engaged in sexual intercourse. Though the participants had knowledge about family planning methods, this knowledge did not influence teenagers in preventing pregnancy. The study also found that parents do not communicate with their teenagers about sexuality.

### **Key concepts**

Teenage, contraceptive, contraception, teenage pregnancy, access

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## **LIST OF ABBREVIATIONS**

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
DoH	Department of Health
HIV	Human Immunodeficiency Virus
SA	South Africa
STI	Sexual transmitted Infections
SADHS	South Africa Demographic Health Survey
SRHS	Sexual Reproductive Health Services
TOP	Termination of Pregnancy
WHO	World Health Organization

## **Definition of Concepts**

**Access:** The means or opportunity to enter or approach a place, the right or opportunity to use something or see someone (South African Concise Oxford Dictionary, 2007:6). For the purpose of this study, access is defined as the ability of a teenager to access contraceptives at a convenient time and to receive relevant information regarding reproductive health.

**Teenager:** Is a person aged between 13 and 19 years (South African Concise Oxford Dictionary, 2007:1204). For the purpose of this study, teenager is referred to as a person who is 19 years of age and younger.

**Contraceptive:** Is a device or drug that serves to prevent pregnancy (Paperback Oxford Dictionary, 2006).

**Contraception:** The practice of preventing a woman from becoming pregnant (Oxford Advanced Learners Dictionary, 2010). The use of artificial methods or other techniques to prevent pregnancy.

**Young:** Having lived or existed for only a short time not far advanced in life (South African Concise Oxford Dictionary, 2007:1364). The Department of Health (DoH, 2003) defines young as a person who is aged 19 years and younger.

**Teenage pregnancy:** A pregnant person who is 19 years and younger.

**Termination of pregnancy:** The premature expulsion of an embryo or foetus, either spontaneously or induced.

## **1. CHAPTER ONE**

### **1.1 INTRODUCTION AND BACKGROUND**

In the past few decades, South Africa has seen a decline in teenage fertility and yet teenage pregnancy rates still remain high, with around 30% of 15 to 19 years old who report having ever been pregnant. The majority of pregnancies occur among 18 and 19 years old young women (William 2013). Teenage pregnancy is a marker of unprotected sex and, therefore, high rates of teenage pregnancies alert us to the high-risk nature of many sexual encounters involving teenage girls. This phenomenon is of particular concern as South Africa has one of the highest human immune virus (HIV) prevalence figures globally, among both women and men (SADHS2016). HIV prevalence increases with age, reaching a peak at 35 to 44 years, at which age 40% of women and 27% of men are HIV positive. Twelve percent of young women age 15 to 24 are HIV positive, more than 15% of young women in Kwa- Zulu Natal, Mpumalanga and Eastern Cape are positive. (SADHS, 2016). A significant number of these pregnancies is unplanned which raises certain population challenges (Ramulumo & Pitsoe, 2013). Teenage pregnancies are considered problematic because complications from pregnancy and childbirth are the leading causes of death in teenage girls aging between 15 and 19 years in developing countries (Yasmin, Kumar and Parhar, 2014). Furthermore, young girls between the ages of 10 and 14 are five times more likely to die during delivery than mothers who are between 20 and 24 (Willan, 2013). Teenage mothers are more likely to experience adverse pregnancy outcomes and are more constrained in their ability to pursue educational opportunities than young women who delay childbearing.

Adolescence and early adulthood are considered the healthiest stages of life. Yet young people contribute substantively to the burden of disease profile in South Africa. While deaths from HIV and injuries peak in the younger age categories, the risk factors for death from non-communicable diseases are also initiated during adolescence and early adulthood. In fact, unsafe sex/sexually transmitted infections (31.5%), interpersonal violence (8.4%), alcohol use (7%) – the vast majority of which are initiated during adolescence, are leading risk factors for the burden of disease in South Africa (MRC, 2008, cited by Panday, Makiwane, Ranchod & Letsoalo,2009). HIV is a critical threat to

the health and overall wellbeing of youth in South Africa. There is strong association between pregnancy and HIV infection in South Africa. Antenatal data shows that 12.9% of 15 to 19-year-old pregnant women are HIV positive (DoH, 2008). This proportion suggests that girls should be taught how to prevent sexually transmitted infections and avoid pregnancy during their adolescence. Pregnancy before 18 years of age is therefore, a matter of national priority and political will. Dealing with this issue requires an effective legal framework that protects the rights of the children involved and the enforcement of laws in compliance with human rights standards, (UNFPA,2013). Therefore, South Africa, and all African countries should invest more in the health of teenagers, not only to improve the health of teenagers, but also to ensure that the next generation is healthier.

## **1.2 RESEARCH PROBLEM**

### *1.2.1 Source and background of the problem*

According to Brink, van der Walt and van Rensburg (2018), a research problem is described as an area of concern in which there is a gap; or as a situation in need of solution, improvement or alteration; or a situation in which there is discrepancy between the way things are and the way they ought to be. The South African policy environment creates a relatively progressive space around teenage sexuality. A teenager's right to access sexual and reproductive health care is guaranteed in the South African Constitution of 1996. A series of laws enacted thereafter enable teenagers to access contraceptives, terminate pregnancies and access sexual and reproductive health services (Willan, 2013). Despite the South African government's efforts to ensure access to sexual and reproductive health care, there is still high rate of teenage pregnancy (Willan, 2013).

The World Health Organization's (WHO) (2014) statistics indicate that the average global birth rate among 15 and 19 year olds is 49 per 1 000 girls. Pregnancy and childbirth complications are the second highest cause of death globally in this age group. Some 3 million unsafe abortions involving girls aged 15 to 19 are performed each year, contributing to maternal deaths and lasting health problems. Early childbearing increases the risk of lasting health problems both mother and their newborns. In low- and middle-

income countries, babies born to mothers under 20 years of age face a 5% higher risk of being stillborn or dying in the first weeks, versus those born to mothers aged 20 to 29. Newborns born to adolescent mothers are also more likely to have low birth weight, with the risk of long term effects. The younger the mother the greater the risk to the baby. The researcher in this study used adolescent and teenagers interchangeable.

### *1.2.1 Statement of the research problems*

The increasing rate of teenage pregnancy in Dwarsloop local area clinic with patients as young as 14 years old presenting for care. In the year 2018 of the 13785 deliveries in the Sub District, 2305 deliveries were from teenage girls of 19 years and younger contributing 17% of deliveries. The researcher was interested in studying factors associated with high rates in teenage pregnancy among young girls visiting the Dwarsloop local area clinics, Bushbuckridge Sub-District.

## **1.3 PURPOSE OF THE STUDY**

### *1.3.1 Aim*

The aim of the study was to describe factors associated with teenage pregnancies with special focus on the Dwarsloop local area clinics.

### *1.3.2 OBJECTIVES*

The objectives of this study were:

- To describe demographic characteristics of teenagers who were pregnant in the Bushbuckridge Sub-District at the Dwarsloop local area clinics.
- To determine factors associated with teenage pregnancy in the Bushbuckridge Sub-District at the Dwarsloop local area clinics.

## **1.4 RESEARCH QUESTION**

What are the factors associated with teenage pregnancy at the Dwarsloop local area clinics?

## **1.5 SIGNIFICANCE OF THE STUDY**

The result of this study will, to a large extent, be useful to improve the quality of life of teenagers. It will assist in designing appropriate intervention programs. The study will further equip teenagers with information in regard to the laws that protect their rights in South Africa. The study will assist health care providers to come up with strategies on how to improve reproductive health services, so that these services are accessible, acceptable, equitable and appropriate.

### **Conclusion**

This chapter explained the source and background of the research problem, explained statement of research problem, purpose of the study, research objectives and significance of the study. Chapter Two will discuss the literature review.

## **2 CHAPTER TWO: LITERATURE REVIEW**

### **2.1 Definition**

A literature review is a systematic and explicit approach to the identification, retrieval and bibliographical management of independent studies, usually drawn from published sources, for the purpose of locating information on a topic, synthesising conclusions, identifying areas for future studies, and developing guidelines for clinical practice, Brink, Van der Walt and Van Rensburg (2018).

### **2.2 INTRODUCTION**

The literature highlights that the South African environment creates a relatively progressive space around teenage sexuality, teenage pregnancy and motherhood. Teenagers' right to access sexual and reproductive healthcare are guaranteed in the South African Constitution (1996) and a series of laws enacted thereafter enable teenagers to access contraceptive, termination of pregnancies and sexual and reproductive health services (Savage-Oyekunle & Nienaber, 2015).

Teenagers are also protected from sexual violation by equally strong laws. However, implementation of these laws presents a severe obstacle. Teenage pregnancy is a public concern in both developed and developing countries (Acharya, Bhattarai, Poobalan, Teijlingen & Chapman, 2014). The study by Dev, Acharya, Bhattarai, Pooblan, Van Teijlingen and Chapman (2010) states that 16 million young women aged 15 to 19 years give birth each year, which is about 11% of all births worldwide. This figure does not include births among girls aged younger than 15 years. Teenage pregnancy in South Africa is driven by many factors, including gender inequalities, gender expectations of how boys and girls should act, sexual taboos, poverty, poor access to contraceptives and termination of pregnancy, inaccurate and inconsistent contraceptive use, the judgmental attitudes of many health workers towards teenage pregnancy and poor sex education (Willan, 2013).

In South Africa, more than 30% of teenage girls fall pregnant and between 65% and 71% of the pregnancies are unplanned (Odimegwu, Amoo & De Wet 2018).

The literature further points to the fact that teenage girls are not always in control of if and how they have sex. In South Africa, studies cite unequal decision making about sex between partners, where girls lacked autonomy. This power difference hinders the practice of safe sex (Willan, 2013). Teenage pregnancy is a health issue that affects all of us. A child having a baby as a teenager is more likely to face critical social issues, such as poverty, poor education and risky behaviours, which will lead to poor health and child welfare issues.

## **2.3 CAUSES OF TEENAGE PREGNANCY**

For several decades, teenage pregnancy has posed a serious challenge, both internationally and locally. Teenage pregnancy has generally been linked to adolescent sexual activities and risk-taking behaviour and factors increasing teenage pregnancy are numerous, and may vary between populations. In developed countries teenage pregnancy usually occurs outside marriage, and, in many communities and cultures, it carries a social stigma (Papri, Khanam, Ara, & Panna, 2016).

### *2.3.1 Sexual debut*

Early sexual debut remains an area of concern in adolescent sexual behavior in South Africa. A study conducted in Mpumalanga Province by Muloongo and Tshuma (2012) shows that sexual debut in Mpumalanga is below the national age of consent in all districts except for the Nkangala District. The mean age at sexual debut among teenagers in Mpumalanga was 15.5 years. The district with the highest mean age at sexual debut was Nkangala, at 16.3 years, followed by the Ehlanzeni District, at 15.4 years. The district with the lowest mean age at sexual debut was Gert Sibande, at 14.1 years. The study further reported that the mean age at first pregnancy among teenage mothers in the Mpumalanga Province was 16.9 years, and that 70.4% of first pregnancies were unwanted. The South Africa Demographic Health Survey (2016) indicates that the mean age at sexual debut in the country is between 14 to 19 years among young girls in rural areas.



The results of a research study conducted by Gwido and Fekadu (2015) about factors contributing to, and the effects of, teenage pregnancy in Juba in South Sudan, show that, among the respondents, 8% of the girl's' sexual debut was between 11 and 13 years of age. Mothiba and Maputle, (2012) conducted study on the factors contributing to teenage pregnancies in the Capricorn District of the Limpopo Province, where a quantitative descriptive approach was chosen. The findings of this study revealed that 60% of the respondents started to engage in sex at between 13 and 15 years of age. The study conducted by Mkhantshwa (2014) indicate that girls of 14 years and younger are sexually active as is evident by the fact that 4% were already pregnant during the study. The study further revealed that 19% of the participants started to have sexual intercourse when they were 14 years old or younger, and 56% were 15 to 16 years old.

The study conducted at Makhado municipality of Limpopo Province in South Africa by Miriri, Ramathuba and Mangena-Netshikweta (2014) findings revealed that teenagers were falling pregnant at an early age 47% of the respondents were between the ages of 14 to 16 years. Statistics regarding sexual behaviour show that 25.7% of the respondents had sex before the age of 15.

### *2.3.2 Cultural Factors*

A study conducted in Mpumalanga Province by Muloongo and Tshuma, (2012) indicated that one of the cultural practices that encourage girls into sex is school functions, which include the matric dance, school bashes, Valentines balls and parties, which allow teenagers to engage in sex because there is little supervision from teachers and parents. The study further indicated that other Nguni cultural factors exposing girls into sexual relationship are reed dance (Umhlanga), umemulo (21<sup>st</sup> Birthday), ritual ceremonies and ukuthwala.

Thobejane (2015), in his study conducted in the Matjitjileng village in Limpopo, states that 90% of teenage mothers indicated that they stay with their parents, and 70% of them reported not discussing sexual matters with their parents. A lack of parental guidance has a major impact on teenage pregnancy because most parents have a misconception that topics on sex and relationship are taboo and should not be discussed with children

(Thobejane, 2015). A study conducted by Gwido and Fekadu (2015) shows the lack of supervision and parent-child communication as one of factors contributing to teenage pregnancy.

### *2.3.3 Economic Factors*

Biyase (2005), cited in the study conducted in Mpumalanga Province by the Research and Population Unit, revealed that financial constraints contribute towards teenage pregnancy among most families. In South Africa, however, an unknown percentage of teenagers are falling pregnant in order to obtain financial support from the government, so as to be financially secure. The WHO (2014) reports that adolescent pregnancies are more likely in poor, uneducated and rural communities. A study conducted in Limpopo by Mothiba et al., (2012) showed that 44% of the participants depended on their single mother's income, where most mothers were domestic workers. It was evident from the study that most pregnant teenagers were dependent on single mother income.

A study conducted by Akella and Jordan (2016) reported that poverty has a negative effect on the entire household, the community, our nation and the global economy. Children coming from a poor environment may be affected by a multitude of social factors. These social factors do not include teenage pregnancy alone, but also include community violence, gang membership involvement, alcohol and substance abuse and a high incidence of illiteracy. There is a direct relationship between teenage pregnancy and poverty (Jewkes, Morrell and Christofides, 2009).

### *2.3.4 Rape and coercion*

Research indicates that gender-based violence and coercion in a sexual relationship are significant factors in explaining early unwanted pregnancy. Data from a study undertaken by Macleod and Tracey (2010) indicate that earlier first intercourse is likely to be forced and that teenagers are exposed to high levels of sexual coercion. A study conducted by Alabi and Oluwafeni (2017) in Nigeria indicates that teenagers can become pregnant as a result of sexual abuse or rape.

Many studies have reported a strong link between early childhood, sexual abuse and subsequent teenage pregnancy (Madigan, Wade, Tarabulsky, Jenkins and Shouldice, 2014; Harner, 2016; Marino, Lewis, Bateson, Hickey and Skinner; Abajobir et al., 2017). In a paper on the epidemiology of rape and sexual coercion in South Africa, Jewkes and Abrahams (2002), cited in the study conducted by Muloongo & Tshuma (2012) reported that: "Forced sexual initiation is reported by almost a third of adolescent girls." The plethora of data from a variety of sources indicates that earlier first intercourse is likely to be forced and that female teenagers are exposed to high levels of sexual coercion (De Vries, Eggers, Jinabhai, Meyer-Weitz, Sathiparsad and Taylor, 2014; Decker, Miller, McCauley, Tancredi, Anderson, Levenson and Silverman, 2014; Choi, Van Ouystel and Temple, 2016; Yeater, Montanaro and Bryan, 2015; Lee, Yuen Loke. Hung and Sobel 2018).

#### *2.3.5 Substance abuse*

Several studies have shown a connection between substance use and sexual activity. By using drugs or alcohol the risk of engaging in unprotected activities increases, resulting in an unplanned pregnancy (Morrison, Smith and Akers, 2014; Derese, Seme and Misganaw 2014; Ritchwood, Ford, DeCoster, Sutton and Lochman, 2015; Dariotis and Johnson, 2015). A study conducted by Alabi and Oni (2017) indicated that teenage alcohol drinking can cause unexpected pregnancies and drinking alcohol can lower a teenager's ability to control impulses, contributing to 75% of all pregnancies that occur between the ages of 14 and 21. Approximately 91% of pregnant teenager`s reported that, although they were drinking at the time, they did not originally plan to have sex when they conceived (Alabi and Oni, 2017(2),

A study conducted by Madondo (2013) revealed that substance use was significantly associated with teenage pregnancy. Using a substance, or being under the influence of a substance, may influence the adolescent to unrealistically appraise the situation. Substance abuse also impairs their verbal as well as physical resistance against unprotected sexual intercourse, hence the risk of teenage pregnancy. Substance use is a gateway for risky sexual behaviours among adolescents which results in teenage

pregnancy with consequent health and social implications (Mathewos and Mekuria, 2018). The study further revealed that about 29.8% of sexually active teenagers reported that they used substances.

### *2.3.6 Household Factors*

Household factors are also likely to affect adolescent sexual behaviour. The study conducted by National Population Unit (2014) found that dual orphans were more likely to experience an unwanted pregnancy before the age of 16 compared to paternal to paternal orphans and those with both parents alive. The study further showed that girls living in permanent housing, instead of traditional housing, were 50% more likely to use condoms. A study conducted on the factors associated with teenage pregnancy by the Research and Population Unit at Mpumalanga Province in 2012 found that a father's absence, in itself, seemed to put their daughters at risk of having children early (Makiwane, Makoe, Botsis and Vawda; 2015).

Girls whose fathers left the household, either before they were born or up to the age of five, were seven to eight times more at risk of becoming pregnant compared to girls living with their fathers. A study conducted in Limpopo shows that 57.8% of teenage mothers with an unwanted pregnancy said that were pregnant because they were seeking for love, compared to 41.0% among teenage mothers with wanted pregnancies (Mushwana, Monareng, Richter and Muller;2015). This study further shows that the larger the household size, the more likely a teenager would want to become pregnant.

The study conducted by Miriri, Ramathuba and Mangena-Netshikweta (2014) indicates that parent child communication can be difficult, especially in black communities, moreover during transition to adolescence as parents find it difficult to discuss the subject of sexuality. The study further revealed that approximately 30.8% of the participants received information about sexuality and reproduction from friends compared to 20% who got information from parents.

Studies have revealed that teenage girls are more likely to get pregnant if they have limited or no guidance from their parents (Ayalew, Mengistie and Semahegn (2014); Svanemyr, Amin, Robles and Greene 2015; Müller, Rohrs, Hoffman-Wanderer and Moul, 2016). When a teenager does not feel that she can talk to her parents about sex, either because they forbid sex talks or because they are not around, she will more than likely turn to friends for direction on whether or not to have sex. This results in the passing on of misinformation and possible teenage pregnancy. Studies further indicate that a lack of attention and affection from the family causes depression and pushes girls to look for love and attention from others, especially from members of the opposite sex.

According to Jackie (2012), low self-esteem is among the major causes of teenage pregnancy. Children who are not shown love and affection from parents will seek it out from within their peer group. Many adolescents report feeling pressured by their peers to have sex before they are married. A study conducted in Ethiopia by Mathewos and Mekuria, (2018) revealed that adolescents who were living in conditions characterised by poor parent-daughter interaction regarding issues of love and pregnancy were 3.7 times more likely to experience pregnancy, compared to those who lived under conditions characterised by good parent-daughter interaction.

## Conclusion

This chapter discussed the literature review undertaken on the factors contributing to teenage pregnancy by various studies. Chapter Three deals with methodology used.

### **3 CHAPTER: RESEARCH METHODOLOGY**

#### **3.1 Introduction**

This chapter describes the research design and methodology used in the study. The setting in which the research was conducted; population, data collection and data analysis, measures to ensure validity and reliability as well as ethical considerations are discussed.

#### **3.2 Research design**

According to Leedy and Ormord (2012), research is a systemic process of collecting, analysing and interpreting information in order to increase our understanding of phenomena of interest. Research methodology informs the reader of how investigation was carried out and what the researcher did in order to solve, or answer, the research question (Brink, Van der Walt and Van Rensburg 2018). The selection of research methodology or strategy is at the core of a research and must include research design, definition and selection of the population of interest, variables (characteristics of the individuals in the population group), their status and relationships to one another, the instruments for data collection and procedures used for data analysis (Mkhantshwa, 2014).

Research design is the set of logical steps taken by the researcher to answer a question. It is the blueprint of the study and determines the methodology used by the researcher to obtain sources of information, such as participants, elements and units of analysis to collect and analyse the data and to interpret results (Brink et al., 2018). The current study followed a quantitative descriptive study designed to investigate the factors associated with teenage pregnancy among young girls.

##### *3.2.1 Quantitative design*

Quantitative research is a process that is systematic and objective in its ways of using numerical data from a selected subgroup of a universe in order to generalise the findings to the universe that is being studied (Creswell, Ebersohn, Ellof, Ferreira, Ivankova, Jansen, Nieuwenhuis, Pietersen, Plano Clark and Van der Westhuizen 2010).

Quantitative research is conducted to describe new situations, events or concepts in the world. In this study the researcher chose quantitative descriptive research in order to describe factors contributing to teenage pregnancy.

### 3.2.2 Descriptive studies

According to Brink et al. (2018), descriptive designs are used in studies where more information is required in a particular field about certain characteristics in order to provide a picture of the phenomenon in certain situations as it occurs naturally. Descriptive designs are concerned with gathering information from a representative sample of a population. The emphasis in the collection of data in descriptive studies is on structured observation, questionnaires and interviews or surveys. In this study, a descriptive cross-sectional design used a questionnaire in order to describe the factors that lead teenagers to unsafe sexual practices resulting in teenage pregnancy.

### 3.3 Study site

Dwarsloop local area clinics are situated in Bushbuckridge in the Mpumalanga Province and fall under the Thulamahashe Circuit, the Dwarsloop Circuit and the Casteel Circuit. The area has five primary health care clinics; three clinics (Orinocco, Arthurstone and Casteel) are situated in a rural setting. The other two clinics (Dwarsloop and Shatale) serve both rural and urban communities.

Table 3.1 Number of pregnant teenagers in schools

	Number of pregnant teenagers
Thulamahashe circuit	37
Dwarsloop circuit	35
Casteel circuit	25
<b>Total</b>	<b>97</b>

(Source: Education Management Information System: 2018)

### **3.4 POPULATION**

A population is the entire group of persons or objects that are of interest to a researcher in other words, this means the phenomena that the researcher is interested in studying (Brink et al., 2012:131). The population in this study was all pregnant teenagers aged 19 and younger attending the antenatal clinic at any of five clinics in the Dwarsloop local area.

#### *3.4.1 Sample and Sampling*

A sample is a part or fraction of a whole, or a subset of a larger set selected by the researcher to participate in a research study. A sample therefore consists of a selected group of the elements or units of analysis from a defined population (Brink et al., 2012). In this study the sample was drawn from all pregnant teenagers aged 19 and younger attending the antenatal clinic in any of the five Dwarsloop local area clinics.

Sampling refers to the researcher's process of selecting the sample from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest (Brink et al., 2012). According to De Vos, Strydom, Fouche` and Delport (2012), sampling means taking a portion or a smaller number of units of a population as a representative or having a particular characteristic of that population. In this study the researcher used simple random probability. Probability implies that all elements in the population have an equal chance of being included in the sample. Simple random probability was used to ensure that all subjects had an equal chance of being included. The fishbowl technique was used to select the subjects randomly; fourteen girls were selected randomly at each clinic using antenatal clinic register. The researcher wrote the clinic file numbers of the pregnant girls on pieces of papers then these were put in a bowl. The papers were rolled up and shuffled in the bowl then the researcher took the rolled papers from the bowl until the sample size was reached.



### *3.4.2 Sample size*

In the second quarter of 2018, at least 97 pregnant teenagers were recorded in schools in the study area (Table 3.1). Therefore, this study included 70 pregnant teenagers, given a response rate of 72% (70/97).

### **3.5 Data Collection**

Data collection is the precise and, systematic gathering of information relevant to the research sub problems, using methods such as interviews, participant observation, focus group discussion, narratives and case histories (Burns & Grove,2011).Data collection describes the way in which the researcher approaches answering the research question. Data collection provides an audit trail which includes a clear and specific explanation of how data were collected, how the results or findings were derived, as well as the rationale for the method selected (Brink et al., 2018). Data was collected using structured self-administered questionnaires. The questionnaire consisted of 24 questions that were divided into three parts namely: demographic data, sexual behaviour and factors contributing to teenage pregnancy. The questionnaire was translated in two local languages, Xitsonga and Sotho and the questionnaire was back translated to English to see if translation was correct. The statements in the questionnaire were constructed to obtain objective data from the respondents who met the inclusion criteria. The researcher hand-delivered the questionnaires to pregnant teenagers who gave their consent to participate. The researcher was present when the participants completed the questionnaires in order to clarify misunderstandings and to answer any questions.

### **3.6 Data Analysis**

According to de Vos et al. (2012), data analysis is a process of inductive reasoning, thinking and theorising, which certainly is far removed from structured, mechanical and technical procedures, to make inferences from empirical data of social life. Data analysis entails categorising, ordering, manipulating and summarising the data and describing them in meaningful terms (Brink et al., 2018). Descriptive statistics are used to explain and summarise data, and thus indicate what the data set looks like. These statistics convert and condense a collection of data into an organised visual representation in a

variety of ways, so that the data can have some meaning (Brink et al., 2018). For the purposes of this research, descriptive statistical analysis was used and included frequency distribution tables and percentage of respondents according to the selected characteristics. Statistical Package for Social Sciences (SPSS) was used.

### **3.7 Validity and Reliability**

#### *3.7.1 Validity*

The validity of an instrument refers to the extent to which the instrument measures what it is supposed to measure. Instrument validity seeks to ascertain whether an instrument provides accurate measures, given the context in which is applied (Brink et al., 2018). The researcher will focus on face validity and content validity.

#### *3.7.2 Face validity*

Face validity is defined by Polit and Beck as the extent to which a measuring instrument looks as though it is measuring what it purports to measure. Brink et al define face validity as the instrument that appears to measure what it is supposed to measure. Face validity is based on intuitive judgement made by experts in the field (Brink et al 2018).

#### *3.7.3 Content validity*

Content validity is an assessment of how well an instrument represents all components of the variable to be measured (Brink et al., 2018).

The questionnaire was administered to experienced staff working in the obstetrics unit and in the antenatal care unit in order for them to validate the content and provide input. Face validity of the self-structured questionnaire was checked by colleagues who were experts in reproductive health care and experienced midwives with clinical experience in obstetrics and who were working in reproductive health care and antenatal care units.

#### *3.7.4 Reliability*

Reliability refers to the degree to which an instrument can be depended upon to yield consistent results if used repeatedly over time on the same person, or if used by two

researchers (Brink et al., 2018). According to Creswell, Ebersohn, Ellof, Ferreira, Ivankova, Jansen, Nieuwenhuis, Jansen, Pietersen, Plano Clark and Van der Westhuizen (2010) reliability of an instrument means that, if the same instrument is used at different times or administered to different subjects from the same population, the findings should be the same.

The researcher ensured reliability by accurate and careful phrasing of each question to avoid ambiguity and lead respondents to particular answers.

### **3.8 ETHICAL CONSIDERATION**

Ethical principles in research are defined in Burkhardt and Nathaniel (2008) as norms which are concerned with the study of social and philosophical reflection on society's norms and practice. Ethical consideration is the application of moral philosophy, as cited by (Mkhantshwa, 2014).

#### *3.8.1 Ethical clearance*

The proposal was presented to the Department of Public Health, School of Healthcare Sciences and Faculty of Health Sciences at the University of Limpopo and was then sent to the Turfloop Research Ethics Committee (TREC) at the University of Limpopo for ethical clearance. A clearance certificate (Ref: TREC/05/2017: PG) was obtained from the TREC before commencing the study. The approval to conduct the study was received from the Research and Ethics Committee of the Mpumalanga Province, the Deputy Director of the Bushbuckridge Sub-district and the Primary Health Care Supervisor of the Dwarsloop local area clinics.

#### *3.8.2 Confidentiality, anonymity and privacy*

The collected data was coded and did not contain participants' names, therefore, the anonymity and confidentiality of individual participants, and their personal information, was protected. The data was treated as strictly confidential and used solely for the purposes of the current study.

### *3.8.3 Informed consent*

The principle of Informed consent was applied, as some of the participants in this study were minors, by the researcher adhering to the guidelines in the National Health Act No 61 of 2003 (as amended) and Children Act, Act 42 of 2005. The following principle was adhered to: informed consent was obtained from research participants and from parents of research participants younger than 18 years before data was collected.

### *3.8.4 Respect for persons as autonomous individual*

Individuals are autonomous and, therefore, they have the right to self-determination and the right to withdraw from a study anytime, or to refuse to give information and to ask clarification about the purpose of the study (Brink et al., 2018:29). The researcher did adhere to the principle of respect by avoiding any form of coercion.

### *3.8.5 Principle of Beneficence*

The principle of beneficence imposes a duty on researchers to minimise harm and to maximise benefit, a participant in research has the right to be protected from discomfort and harm, whether physical or emotional.

In this study respondents participated voluntarily, they were not pressured and were assured that they could withdraw from the study at any time without being penalised if they felt that this right had been violated

### *3.8.6 Principle of Privacy and Confidentiality*

The process of ensuring confidentiality refers to a researcher's responsibility to prevent data from being linked to participants, or being divulged for purposes other than research (Brink et al., 2018:30). Privacy rights are violated when a researcher shares information without the knowledge of the participants or against the will of the participants. The researcher informed participants that the information will be published and assured them that their anonymity would be maintained. The teenagers remained anonymous to observe the ethics of research and to honour the promise between researcher and respondents.

## Conclusion

This chapter has provided an overview of the research design and methods that were followed. Data collection methods and a brief summary of issues related to ethics consideration were also discussed. The next chapter discusses the data analysis and the results in detail.

## 4 CHAPTER FOUR: PRESENTATION AND INTERPRETATION OF THE FINDINGS

### 4.8 Introduction

The data analysis and findings of the study are discussed in this chapter. The data collection tool used in this study was analysed to ensure that the data gathered were presented clearly with the aid of graphs, tables and percentages.

This chapter presents the results as per the study objectives outlined earlier, which were:

- To describe demographic characteristics of teenagers who were pregnant in the Bushbuckridge Sub-District in the Dwarssloop local area clinics.
- To determine factors associated with teenage pregnancy in the Bushbuckridge Sub-District in the Dwarssloop local area clinics.

### 4.9 Demographic characteristics of teenagers who were pregnant

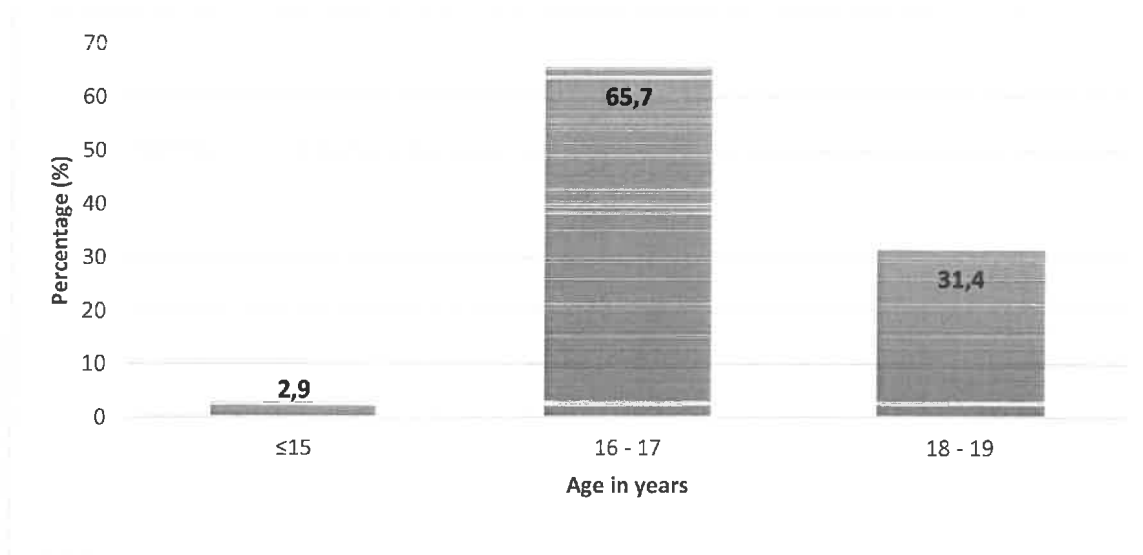


Figure 4.1: Age distribution of participants

Figure 4.1 above presents the age distribution of the participants and shows that majority of the participants were in the age group 16 – 17 years (65.7%), followed by 18 – 19 years (31.4%) and less than 15 years (2.9%).

Table 4:1 Selected demographic information of the participants by age

	Total	Age (years)			p-value
		≤15	16–17	18–19	
		n (%)	n (%)	n (%)	
<b>Marital status</b>					
Single	67 (95.7)	2 (2.9)	44 (65.7)	21 (31.3)	0.954
Married	3 (4.3)	0 (0.0)	2 (66.7)	1 (33.33)	
<b>Age at sex debut</b>					
≤14 years	21 (30)	2 (9.5)	17 (81.0)	2 (9.5)	<0.001
15 years	20 (28.6)	0 (0.0)	19 (95.0)	1 (5.0)	
16 years	18 (25.7)	0 (0.0)	9 (50.0)	9 (50.0)	
17 years	7 (10.0)	0 (0.0)	0 (0.0)	7 (100.0)	
18 years	4 (5.7)	0 (0.0)	1 (25.0)	3 (75.0)	
<b>Religion</b>					
Christian	58 (82.9)	2 (3.5)	39 (67.2)	17 (29.3)	0.601
Non-Christian	12 (17.1)	0 (0.0)	7 (58.3)	5 (41.7)	
<b>Level of education</b>					
Grade ≤9	11 (18.6)	2 (18.18)	9 (81.82)	0 (0.0)	0.007
Grade 10	17 (28.8)	0	14 (82.4)	3 (17.7)	
Grade 11	18 (30.5)	0	13 (72.2)	5 (27.8)	
Grade 12	9 (15.3)	0	4 (44.4)	5 (55.6)	
Tertiary	4 (6.8)	0	1 (25.0)	3 (75.0)	
<b>Staying with both parents</b>					
Yes	24 (34.8)	0 (0.0)	15 (62.5)	9 (37.5)	0.479
No	46 (65.2)	2 (4.4)	30 (66.7)	13 (28.9)	
<b>Source of income</b>					
Working	2 (2.9)	0 (0.0)	1 (50.0)	1 (50.0)	0.946
Social Grant	66 (94.3)	2 (3.0)	44 (66.7)	20 (30.3)	
Partner	2 (2.9)	0 (0.0)	1 (50.0)	1 (50.0)	

Table 4.1 shows that of the majority of the participants were single (95.7%; n=63). Of those participants who were at school, (30.5%; n=18) had completed their education as far as Grade 11, followed by those who completed Grade 10, Grade 9 or below, at (28.8%;

n=17), (18.6%; n=11), respectively. Participants who had completed Grade 12 and tertiary educational level were at (15.3%; n=9) and (6.8%; n=4) respectively. There was a statistically significant difference between the participants with regard age at sex debut ( $p<0.001$ ) and level of education ( $p=0.007$ ). Approximately (65%; n=46) of the participants were not staying with both parents and the majority of participants were Christians (82.9%; n=58). Approximately (94%; n=66) of the teenagers were using a child support grant as their source of income.

#### 4.10 Factors contributing to high teenage pregnancy

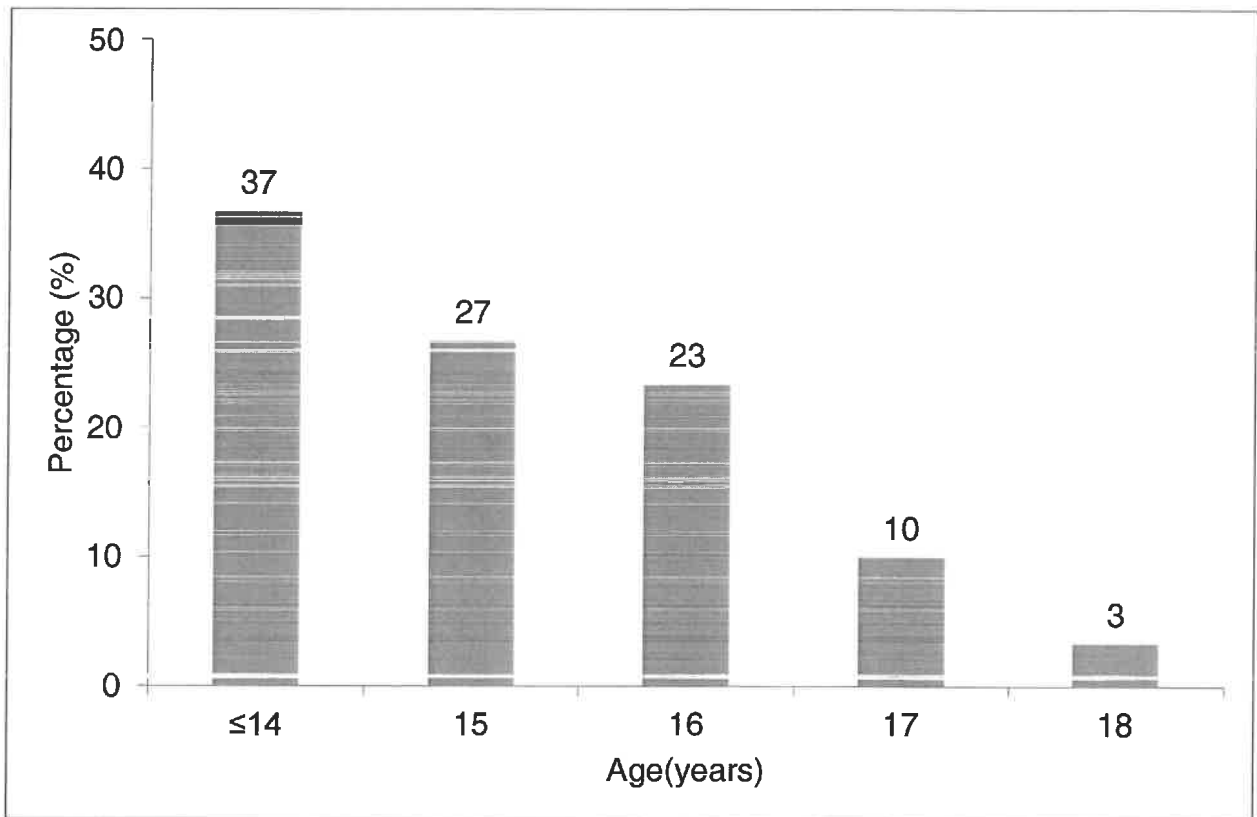


Figure 4.2: Distribution of age at sex debut

The proportion of age at first sex decreased with decreasing years from 37% at age of 14 years or below followed by 27%, 23%, 10% and 3% at age 15 years, 16 years, 17 years and 18 years respectively, as presented in Figure 4.2 above.



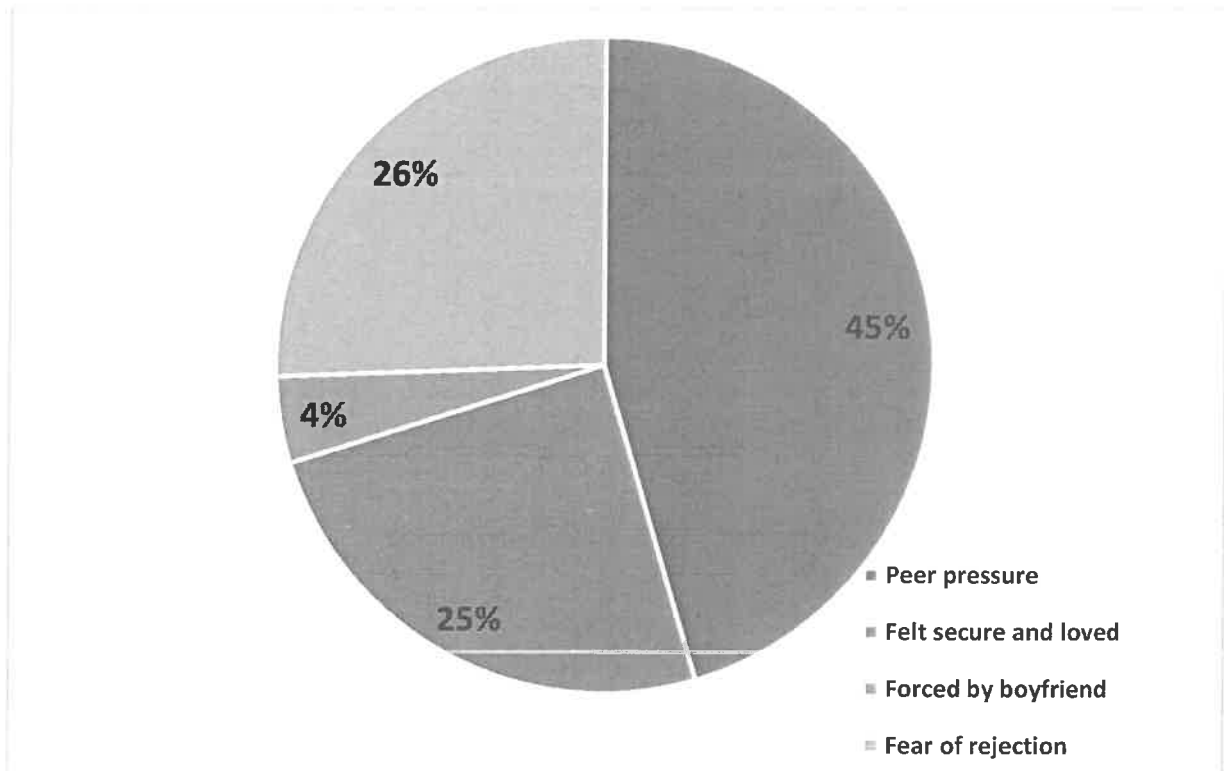


Figure 4.3: Reasons for sexual intercourse for the first time

The reasons for having sex at first time ranged from peer pressure at (45%), followed by those teenagers who feared rejection by their boyfriends (26%), those who felt secured and loved by their boyfriends (25%) and, lastly, those who were forced by their boyfriends (4%) as presented in Figure 4.3 above.

Table 4:2 Reasons for sexual intercourse for the first time stratified by age of participants

	Age (Years)			P value
	≥15 years	16–17 years	18–19 years	
	n (%)	n (%)	n (%)	

Peer pressure	1 (3.1)	21 (65.6)	10 (31.3)	0.977
Felt secure and loved	0 (0.0)	12 (70.6)	5 (29.4)	
Forced by boyfriend	0 (0.0)	2 (66.7)	1 (33.3)	
Fear of rejection by boyfriend	1 (5.6)	11 (61.1)	6 (33.3)	

According to the findings presented in Table 4.2 above, a high proportion (70.6%; n=12) of teenagers which was in the age group 16 – 17 years reported that their reasons have sexual intercourse at first time was that they felt secure and loved by their boyfriends. Participants who had sex for the first time were influenced by the fact that they felt secure and loved by the boyfriends (70.6%; n=12) in age group 16 – 17 years, followed by those who were forced by boyfriends (66.7%; n=2), and peer pressure (65.5%; n=21), both in age group 16 – 17 years. In age group 18 – 19 years, the number of participants who feared rejection by their boyfriends and those who were forced to have sex by boyfriends were both at (33.3%; n=1) followed by peer pressure, at (31.3%; n=10) and, lastly, participants who felt secure and loved by boyfriends, at (29.4%; n=5).

Table 4.3 Proportion of teenagers staying with parents stratified by age at sex debut

Staying with both parents	Age at sex debut in years						P value
	Overall	≤14 years	15 years	16 years	17 years	18 years	
Yes	24 (34.8)	1 (4.2)	10 (41.7)	6 (25.0)	5 (20.8)	2 (8.3)	0.006
No	45 (65.2)	19 (42.2)	10 (22.2)	12 (26.7)	2 (4.4)	2 (4.4)	

Table 4.3 above shows that approximately (65%; n=45) of participants were not staying with both parents. The highest proportion of participants not staying with both parents who had their sex debut were in age group 14 years and below, at (42.2%; n=19) followed by (26.7%; n=12) whose age at sex debut was 16 years and (22.2%; n=10) whose age at sex debut was 15 years. Approximately (4.4%; n=2) was recorded an age at sex debut of 17 years and 18 years.

Table 4.4 Reasons for frequently having unprotected sex

	Age (Years)				P value
	≥15 years	16 – 17 years	18 – 19 years		
	n (%)	n (%)	n (%)		
<b>Do you frequently engage in unprotected sex</b>					
Yes	22 (31.4)	14 (63.6)	8 (36.4)		0.553
No	48 (68.6)	32 (66.7)	14 (29.2)		
<b>Reasons for frequently engage in unprotected sex</b>					
Peer pressure and to please my boyfriend	32 (66.7)	20 (62.5)	11 (34.4)		0.489
Forced by boyfriend	9 (18.8)	7 (77.8)	2 (22.2)		
Under influence of drugs and alcohol	7 (14.6)	5 (71.4)	1 (14.3)		

The participants in the current study were asked about the reasons why are they involved in unprotected sex and (68.6%; n=48) of the participants reported to frequently be engaged in unprotected sex, with the highest proportion reported in age group 16 – 17 years, at (66.7%; n=32) followed by age group 18 – 19 years and age group 15 years and below at (29.2%; n=14) and (4.2%, n=2) respectively. The most reported reason for engaging in unprotected sex was peer pressure and to please their boyfriend (66.7%; n=32), followed by those who were forced to have sex by boyfriends (18.8%; n=9), and those who frequently engaged in unprotected sex due the influence of drugs and alcohol (14.3%; n=7), as presented in Table 4.4 above.

Table 4.5 below presents the reported communication between teenagers and their parents about issues related to sexuality, love and friendship. It was found that approximately (65%; n=46) of the participants did not communicate with parents about issues related to sexuality, love and friendships openly. The highest proportion of participants who did not communicate with parents was in age group 16 – 17 years (67.4%; n=31), followed by age group 18 – 19 years (28.3%; n=13). Of the participants who communicated openly with parents about issues related to sexuality, love and friendship, (66.7%; n=16) frequently engaged in unprotected sex. The highest proportion of participants who communicated with parents but did not frequently engage in unprotected sex was in the age group 16 – 17 years (75%; n=12), followed by (25%; n=4) in age group 18 – 19 years. In approximately 63% of the cases where participants communicated with parents, their parents knew about their sexual partners, with the highest proportion in age group 16 – 17 years (73.3%, n=11), followed by (26.7%, n=4) in the age group 18 – 19 years. Of the participants who did not communicate openly with parents about issues related to sexuality, love and friendship, approximately (70%; n=32) were frequently engaged in unprotected sex. However, of the participants who did not communicate openly with parents, (30.4%; n=14) were frequently engaged in protected sex, with the highest proportion in the age group 16 – 17 years, (78.6%; n=11), followed by age group 18 – 19 years (21.4%; n=3). Furthermore, among those participants who did not communicate openly with parents, approximately (26%; n=12) reported that their parents knew about their teenager's sexual partners, with the highest proportion was in

age group 16 – 17 years, at (66.7%; n=8), and followed by (33.3%; n=4) in the 18 – 19 year age group as illustrated in Table 4.5 below.

Table 4.5: Communication with parents about issues related to sexuality, love and friendship openly

	Age (Years)					P value
		≥15 years	16 – 17 years	18 – 19 years		
	n (%)	n (%)	n (%)	n (%)		
Do you communicate with parents						
Yes	24 (34.3)	0 (0.0)	15 (62.5)	9 (37.5)		0.466
No	46 (65.7)	2 (4.4)	31 (67.4)	13 (28.3)		
Teenagers communicate with parents						
Frequently engaged in protected sex	8 (33.3)	0 (0.0)	3 (37.5)	5 (62.5)		0.489
Frequently engaged in unprotected sex	16 (66.7)	0 (0.0)	12 (75.0)	4 (25.0)		
Teenagers do not communicate with parents						
Frequently engaged in protected sex	14 (30.4)	0 (0.0)	11 (78.6)	3 (21.4)		0.498
Frequently engaged in unprotected sex	32 (69.6)	2 (6.3)	20 (62.5)	10 (31.3)		
Teenagers communicate with parents						
Parents know their sexual partners	15 (62.5)	0 (0.0)	11 (73.3)	4 (26.7)		0.706
Parents do not know their sexual partners	9 (37.5)	0 (0.0)	4 (44.4)	5 (55.6)		
Teenagers do not communicate with parents						
Parents know their sexual partners	12 (26.1)	0 (0.0)	8 (66.7)	4 (33.3)		0.224
Parents do not know their sexual partners	34 (73.9)	2 (5.9)	23 (67.7)	9 (26.5)		

Table 4.6 below presents the association between participants who heard of family planning and selected demographic information about the participants. The age of participants was found to be significantly associated with knowing about family planning ( $p=0.040$ ). Of all age groups, more participants (67.9%) had heard of family planning in the age group 16 – 17 years, followed by 32.1% in age group 18 – 19 years. More participants who had not heard about family planning were also in the age group 16 – 17 years, at 58.8%, followed by 29.4% in age group 18 – 19 years. Marital status, age at sex debut and staying with both parents was not significantly associated with knowing about family planning.

Table 4.6: Association between knowledge on family planning and teenager's demographics

	Total	Have you heard of family planning		p-value
		Yes (n=53, 75.7%)	No (n=17, 24.3%)	
<b>Teenager's age</b>		n (%)	n (%)	
≥15 years	2 (2.9)	0 (0.0)	2 (11.8)	0.040
16 – 17 years	46 (65.7)	36 (67.9)	10 (58.8)	
18 – 19 years	22 (31.4)	17 (32.1)	5 (29.4)	
<b>Marital status</b>				
Married	3 (4.3)	1 (33.3)	2 (66.7)	0.080
Never married	67 (95.7)	52 (77.6)	15 (22.4)	
<b>Age at sex debut</b>				
≤14 years	21 (30.0)	15 (71.4)	6 (28.6)	0.496
15 years	20 (28.6)	15 (75.0)	5 (25.0)	
16 years	18 (25.7)	15 (83.3)	3 (16.7)	
17 years	7 (10.0)	4 (57.1)	3 (42.9)	
18 years	4 (5.7)	4 (100.0)	0 (0.0)	
<b>Staying with parents</b>				
Yes	24 (34.8)	18 (75.0)	6 (25.0)	0.959
No	45 (65.2)	34 (75.6)	11 (24.4)	
No	9 (6.2)	0 (0.0)	9 (100)	

The majority of participants (75.7%) in the current study had heard of family planning. Approximately 59% of the participants had heard about family planning from health facilities, while 28.6% had heard about family planning from peers and only 12.9% heard about family planning from parents. Table 4.7 below presents the univariate logistics regression undertaken to determine predictors of frequently regarding being engaged in protected sex. Participants who did not hear about family planning were 0.3 times less likely to frequently engage in protected sex ( $p<0.05$ ).

Table 4.7: Univariate logistic regression to determine predictors of condom use by teenagers

Variables		Predictors
Marital status	Married	Reference (1)
	Never married	0.02 (-0.53 – 0.57)
Staying with parents	Yes	Reference (1)
	No	0.02 (-0.22 – 0.26)
Heard of family planning	Yes	Reference (1)
	No	0.3 (0.07 – 0.5) *
Communicate with parents about sexuality	Yes	Reference (1)
	No	0.03 (-0.21 – 0.27)
Parents know your partner	Yes	Reference (1)
	No	0.05 (-0.13 – 0.23)

Values are reported as odds ratios (95%CI); \*significant at  $p<0.05$ ; \*\* significant at  $p<0.005$ ; \*\*\* significant at  $p<0.001$   
a= Not significant in univariate model then dropped

## Conclusion

In this chapter, the results of the study were presented and interpreted. The next chapter discusses these findings and compares the findings of this study to the relevant literature.



## **5 CHAPTER 5: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS**

### **5.8 DISCUSSIONS**

#### *5.8.3 Demographic factors of study participants*

The current findings revealed that teenage pregnant mothers were aged between 14 years and 19 years, with majority in the age group 16–17 years, at 66.7%. The findings of this study differ from findings from Miriri et al., (2014), which reported that the largest group of the respondents were aged between 18 and 19 years at 47%. This is also in disagreement with the World Fertility Survey, which indicates that over half of all teenagers aged 14-19 years had their first birth before the age of 15 years (Miriri et al., 2014). The findings of the current study might be a reflection of the fact that teenagers in Mpumalanga may be aware of sexual education and the risks associated with teenage pregnancy. The religious affiliation of the participants was mostly Christians, which concurs with findings of Miriri et al. (2014) and Mkhantshwa, (2014).

In the current study, there were teenagers who fell pregnant before completion of schooling and this has significant implications for contemporary society, especially if pregnancy occurs before the completion of schooling and predates the commencement of gainful employment. Teenagers with matric or a higher level of education were found to significantly less likely to be pregnant than teenagers with a measure of lower education ( $p < 0.007$ ) which concurs with a study by Udjo (2014). Globally, teenage pregnancy is more common among young people who have been disadvantaged in childhood and who have low expectations of education or opportunities in the job market (Makiwane et al., 2018). The study findings further show that a greater proportion (65%) of the participants were not staying with the both parents and, among the participants who were 14 years and younger, all of them were not staying with both parents. The findings concur with the findings of a study by (Alabi & Oni, 2017) that children of single parents are more vulnerable to teenage pregnancy than those with both parents. The majority of the teenagers from the current study were accessing a child support grant (CSG) as their source of income, . The government of South Africa often provide some form of social assistance to vulnerable groups. The right to social security is enshrined in the South

African Constitution and the Social Assistance Act 13 of 2004. The country provides for a child support grant to single parents or caregivers who are low-income earners. The impact of the child support grant on teenage pregnancy in South Africa has aroused interest in the last couple of years, sparking debate that it may be encouraging teenage pregnancy. However, no empirical evidence has been produced to confirm this relationship (Udjo, 2014).

#### *5.8.4 Age at sex debut*

The findings of the study show that more than one-third (37%) of the teenagers started having sexual intercourse at the age of 14 years and younger. These findings concur with the findings of a study done by Odimegwu, Amoo, De Wet (2018) who found that statistics regarding sexual behaviour show that 25.7% of the respondents had sex for the first time before the age of 15 years. The current study findings suggest that focused sexual and reproductive health educational programs to change adolescent attitudes about early sexual debut and sexual risk behaviour are required to reduce teenage pregnancies.

#### *5.8.5 Reasons for sexual intercourse for the first time*

According to the current study findings, in the case of approximately 24% of the participants, their reason of engaging to sexual intercourse for the first time was due to peer pressure. The findings concur with a study done by Alabi and Oni (2017) which found that, during adolescence, teenagers often feel pressured to make friends and fit in with their peers. Similarly, to a study conducted in Ethiopia by Kebede, Nahusenay, Birhane and Tesfaye, (2015) sexual debut was associated with peer pressure. A study conducted in Limpopo in 2012 reported that, of the participants, 58% stated peer pressure as the reason of engaging in sexual intercourse and 56% stated that they engaged in sexual intercourse because fear of rejection. This study confirms that peer pressure and fear of rejection had an influence on teenage pregnancy (Mothiba & Maputle, 2012).

#### *5.8.6 Usage of protection*

The study revealed that 69% of the respondents did not use protection when engaging in sexual intercourse, as compared to 31% who used protection. The results of this study concur with the results of a study conducted by Abdulai (2012) on factors influencing condom use, where older participants (20 to 29 years) showed the highest proportion of condom use, at 28.8%, while the age group 15 to 19 years were the least likely to use condoms, at only 3.5%. It is evident from these findings that girls of ages 19 years and younger do not use protection when they engage in sexual activities. The study further highlights the fact that women emphasised non-usage of condom or protection because their partners disliked condoms and, when asked why, the women said that find it difficult to ask their partners to use protection/condoms. It is evident that the confidence to negotiate condom use is a significant predictor of actual condom use, which calls for the empowering of our youth with such negotiation skills in order to increase use of condoms which, in turn will improve their sexual and reproductive health.

The study findings are of great concern if young girls are engaging in unprotected sex, because findings by STATS SA (2018) indicate that the leading causes of death for female adolescents in 2015 was tuberculosis at (8.2%), followed by HIV at (6.2%). UNICEF data indicates that adolescent and young people represent a growing number of people living with HIV worldwide. The South African data suggests that new HIV infections are occurring among adolescent girls below 15 years of age, however, the prevalence is substantially higher in the age group 15 to 24 (UNAIDS, 2016).

#### *5.8.7 Reasons for unprotected sex*

The findings of the study reveal that, of the participants who did not use protection, 44.8% wanted to please their boyfriend, with highest proportion (19%), in the age group 15 to 16 years. Eighteen-point-seven percent of the participants were forced by their boyfriend not to use protection with the highest proportion, at 10.45%, in the 15 to 16 age group, compared to participants in the 17 to 18 year age group (4.1%). The study findings concur with the findings of a study undertaken by Alabi and Oni (2017), which cited findings of a study undertaken by the Kaiser Family Foundation which stated that more than 29% of

pregnant teens reported that they felt pressured to have unprotected sex and 33% feared rejection. A study conducted by Mabaso and Sokhela (2018) on the determinants of HIV infection among adolescent girls and young women in South Africa highlighted that factors that contribute to the high prevalence of HIV among young girls. These factors are varied and include the fact that the vulnerability of young girls to HIV is affected by societal norms which are supportive of male superiority and sexual entitlement. Evidence shows that this leads to gender inequality and unequal power dynamics which causes females not to negotiate safe sex, leading them to engage in risky sexual behaviours. It is evident from these findings that there is gender inequality.

#### *5.8.8 Communication with parents about sexuality*

The findings in this study reveal that 66% of the respondents did not communicate with parents about sexuality, which supports the findings of a study by Mathewos et al (2018) which reported that most teens (63.2%) of them reported that they had poor parent daughter interaction concerning issues of sexuality, love and pregnancy. A study conducted by Alabi and Oni (2017) indicated that victims of teenage pregnancy lacked information or were probably not adequately educated on safe sex by parents. This study further found that teen girls were more likely to get pregnant if they have limited or no guidance from their parents. The findings of this study are consistent with the study conducted by Mothiba and Maputle (2012) which found that participants perceived discussing sex with their parents as a cultural taboo. The findings of this study concur with the findings of a study undertaken by Wamoyi, Wight, Plummer, Mshana and Ross (2010) conducted in Tanzania on parent-child communication about sexual reproductive health. The study found that parents believed that it was culturally unacceptable to have discussions about sex with their children. The findings further support the study conducted in the Matjitjileng village in Limpopo by Thobejane (2015) where 70% of the respondents indicated that they did not discuss any sexual matters with their parents. It is evident that the lack of parental guidance does have a major impact on teenage pregnancy because parents have the misconception that the topic of sex and relationships are taboo and should not be discussed with children.

#### *5.8.9 Communication with parents about sexuality as compared to parents knowing their children sexual partners*

The study reveals that the sexual partners of 61.43% of respondents were not known to their parents. The majority of the parents of adolescents practice an authoritarian parenting style and apply physical and psychological methods to support teenagers (UNICEF, 2018). It is possible that adolescents in this study were afraid to introduce their partners to their parents because of possible negative consequences. The recent history of sexuality in South Africa has been one characterised by a competition and interplay between two discourses that have had a profound influence on sexual practices and teenage pregnancy rates. The first discourse, rooted historically in African culture, is characterised by openness towards sex and a view of sex as a healthy and normal feature at all stages of life, including childhood (Jewkes, Morrell & Christofides, 2009). In accordance with this notion, there are various ways in which the sexuality of teenage girls is both acknowledged and celebrated. However, in the current study, the majority of the parents did not communicate with their teenage daughters. Therefore, the increased risk of teenage pregnancy found in this study, and the relative lack of success of standard interventions to reduce rates of teenage pregnancy in this group, point to the need to develop new interventions to address this problem. This can be achieved by mentoring teenagers with an aim to develop a trusting relationship between an older, more experienced person and a younger, less experienced person over an extended period of time, with the aim of providing social support (Mezey et al., 2017).

#### *5.8.10 Knowledge about contraceptives*

The study shows that the greater proportion of the respondents (75.71%) had heard of family planning. The findings also show that young girls receive information from health facilities about contraceptives from the ages 15 years and above, while young girls that are 14 years and younger had not heard of family planning. The findings concur with the findings of the study conducted by Thobejane (2015), where almost 100% of the interviewed teenage mothers indicated that they had knowledge about contraceptives. A study conducted in Mpumalanga noted with great concern that contraception is not

consistently used by teenage girls during sexual activity, usually contraceptives are used after sexual activity or at the onset of pregnancy. The findings of this study further concur with findings of a study conducted by Mkhantshwa (2014) which revealed that 48% of the participants in her study used contraceptives inconsistently.

The findings of the study show that almost a quarter of the participants (24.07%) received information about family planning from health facilities, while 22.22% of the participants heard of family planning from their peers, and 16.67% from their parents. The findings show that parents contribute a smaller percentage when it comes to providing the participants with information about family planning.

#### *5.8.11 Knowledge about family planning methods*

The study shows that 77.59% of the participants knew about family planning methods. The vast majority (82.35% and 81.82%) were older (17 to 18 years or 19 years respectively), while the youngest participants (14 years and younger) did not receive any information about family planning methods. These findings reveal that young girls are receiving information about family planning methods late in their adolescence. The study findings concur with the findings of a cross-sectional study conducted by Boamah, Asante, Mahama, Manu, Ayipah, Adeniji and Owusu-Agyei (2013) about the use of contraceptives among adolescents in Kintampo, Ghana. This study revealed that knowledge of at least one contraceptive method was high, at 86.6%, among females. The findings of this study is consistent with the findings of a study conducted by Msuya, Mahand, and Manong, (2015) that the majority (93.8%) of the participants had knowledge of contraception, the study further indicated that most of the participants had knowledge of contraception. However, the rate of contraceptive use was found to be low. It is evident that, although a high number of adolescents knew about family planning methods, this knowledge did not influence them to consistently use contraceptives and prevent pregnancy.

#### *5.8.12 Access to family planning*

The findings of the study indicate that a greater proportion (76.92%) of the participants had easy access to family planning, compared to 23.08% who reported that they did not have easy access. This finding differs from the findings reported by Mkhantshwa (2014) where only 40% of the participants indicated that contraceptives were easily accessible, compared to 28% who indicated that contraceptives were not easily accessible. The current study findings concur with a study conducted by Kebede, Nahusenang, Birhane & Tesfaye (2015), which found that approximately 72% participants reported the use of family planning methods and that they access these methods from health facilities. Similarly; a systematic review study conducted by Brittain, Williams, Zapata, Pazol, Romero & Weik (2015), in which several electronic bibliographic databases were used, revealed that the majority of teenagers have access to family planning methods from health facilities.

### **5.9 Conclusions**

In view of the factors contributing to teenage pregnancy in Bushbuckridge, Mpumalanga that have been discussed in this study, it is evident that our young girls start engaging in sexual intercourse at the early age of 14 years and younger, since some of these girls were already pregnant during the study. The study found that, despite that high number of participants who knew about contraceptive methods, this knowledge did not influence them to consistently use contraceptive to prevent pregnancy. Some of their reasons given were to please their boyfriend or being forced to have sex by a boyfriend

### **5.10 Recommendations**

The researcher recommends the establishment of programs aimed at parents to equip them with the necessary competencies for positive parenting of, and constructive support to, adolescents. HIV prevalence is increasing among young girls and women. This increase calls for robust intervention to reduce the new HIV infections among young girls, and to educate young girls through dialogue from an early age. Further interventions and programs are needed to educate young girls about gender inequalities and equip them with negotiation skills to increase use of protection before engaging into sexual activities.

The researcher recommends that further studies be conducted on teenage boys and their behaviour.

### **5.11 Limitations**

The study was restricted to five clinics in Bushbuckridge Sub District therefore the findings cannot be generalised to the District and other District. The sample consisted of pregnant teenagers who were attending antenatal clinic. Teenage girls who did not attend ANC were excluded which could have given a wider perspective of the phenomenon.



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## Annexure 1: QUESTIONNAIRE

### 1. Section A: Personal Information

Choose the appropriate answer and write in the box provided

#### 1.1 Demographic/ Biographic profile

##### 1.1.1 How old are you?

1.1.1.1	15 years and below	
1.1.1.2	16-17 years	
1.1.1.3	18-19 years	

#### 1.2 Marital status

##### 1.2.1 What is your marital status?

1.2.1	Married	
1.2.2	Single	

#### 1.3 What is your religion?

1.3.1	Christian	
1.3.2	Non-Christian	
1.3.3	Other please state	

#### 1.4 Home language

1.4.1	Shangaan	
1.4.2	Sotho	
1.4.3	Other, please state	

#### 1.5 School information

##### 1.5.1 Are you currently attending school

1.5.1.1	Yes	
1.5.1.2	No	

##### 1.5.2 If yes what is the highest level

1.5.2.1	Below grade 9	
1.5.2.2	Grade 10	
1.5.2.3	Grade 11	
1.5.2.4	Grade 12	
1.5.2.5	Tertiary	

#### 1.6 Are you with both parents

1.6.1	Yes	
1.6.2	No	

#### 1.7 If no whom are you living with, you may choose more than one answer

1.7.1	Mother	
1.7.2	Father	
1.7.3	Partner	
1.7.4	Partner and parents	
1.7.5	Brother	
1.7.6	Sister	
1.7.7	Herself	



1.8 Under which conditions are you living with?

Choose the most appropriate answer

1.8.1	Friendly	
1.8.2	Abusive	
1.8.3	Unfriendly	
1.8.4	Poor	
1.8.5	Without finances	
1.8.6	Other, please state	

1.9 Socio economic status

What is the combined amount of main income of the people you are living with?

1.9.1	R1000	
1.9.2	R1500- R2000	
1.9.3	R2000- R2500	
1.9.4	R3000- R3500	
1.9.5	R3500 and above	
1.9.5	Don't know	

1.10 Do you contribute to the income

Yes	
No	

1.11 If yes what is the main source of your income

1.11.1	Working	
1.11.2	Social grant	
1.11.3	Boyfriend	
1.11.4	Husband	
1.11.5	Other, please state	

SECTION B: SEXUAL BEHAVIOUR

2.1 At what age did you start having sexual intercourse?

Choose the appropriate answer and write in the box provided

2.1.1	14 years and younger	
2.1.2	15 years	
2.1.3	16 years	
2.1.4	17 years	
2.1.5	18 years	

2.2 What were the reasons for having sexual intercourse for the first time?

You may choose more than one answer

2.2.1	Peer pressure	
2.2.2	Please boyfriend	
2.2.3	Forced by boyfriend	
2.2.4	Fear of rejection by boyfriend	
2.2.5	Family pressure	
2.2.6	To enjoy sexual intercourse	
2.2.7	Felt secure and loved	
2.2.8	Other please state	

2.3 Did you use protection and birth control or one or the other or none?

2.3.1	Yes	
2.3.2	No	

2.4 What could have made you to become involved in unprotected sex?

You may choose more than one answer

2.4.1	Peer pressure	
2.4.2	Forced by boyfriend	
2.4.3	I was under influence drugs or alcohol	
2.4.4	To please my boyfriend	
2.4.5	Other please state	

2.5 Who are the people you spend time with before being pregnant?

2.5.1	Boyfriends	
2.5.2	Girlfriends	
2.5.3	Family members	
2.5.4	Cousins	
2.5.5	Other, please state	

2.6 What do you usually talk about in the peer group?

You may choose more than one answer

2.6.1	Studying books	
2.6.2	Falling in love	
2.6.3	Sex	
2.6.4	Our boyfriends	
2.6.5	Other, please state	

2.7 Are there recreational facilities in your area/ community?

2.7.1	Yes	
2.7.2	No	

2.8 If yes which are those, you may choose more than one answer

2.8.1	Play area	
2.8.2	Netball ground	
2.8.3	Swimming pools	
2.8.4	Exercise machine	
2.8.5	Other, please state	

## SECTION C

### 3.1 FACTORS CONTRIBUTING TO TEENAGE PREGNANCY

3.1.1 Have you heard of the term family planning?

3.1.1	Yes	
3.1.2	No	

3.2.1 Where did you hear about family planning?

You may choose more than one answer

3.2.1	Health facilities	
3.2.2	Health staff	
3.2.3	Peers	
3.2.4	Parents	
3.2.5	Friends	
3.2.6	Others, please state	

3.2.2 Have you ever heard of family planning methods?

3.2.1	Yes	
3.2.2	No	

3.3.1 Do you know how to use them?

3.3.1	Yes	
3.3.2	No	

3.4.1 Which Family planning methods you mainly prefer

3.4.1	Pills	
3.4.2	Injectable	
3.4.3	Other, please state	

3.5.1 Do you get easy access to family planning methods?

3.5.1	Yes	
3.5.2	No	

3.6.1 If no to above question what might be the reason

Choose one or more answers

3.6.1	Staff attitude	
3.6.2	Clinic is far	
3.6.3	Clinic operating hours	
3.6.4	Shortage of contraceptives at times, out of stock etc.	

3.7 Does your parents communicate with you on issues related to sexuality, love and friendship openly?

3.6.7.1	Yes	
3.6.7.2	No	

3.6.8 Does your parents know about your love or sexual partner?

3.6.8.1	Yes	
3.6.8.2	No	

## Annexure 2: Consent form



Private Bag X1106, Sovenga, 0727, South Africa  
Tel: Cell No 079 559 6405, Email: [mnisiez@gmail.com](mailto:mnisiez@gmail.com)

### Consent Form

Study Title: Factors associated with teenage pregnancy with special focus to Dwarssloop Local Area Clinics, Mpumalanga Province

I have read the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I understand that participation in this study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for my condition neither will it influence the care that I receive from my regular doctor.

I know that this study has been approved by the University of Limpopo Ethics Committee and the Mpumalanga Provincial Department of Health Ethics Committee. I am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby given consent to participate in this study

\_\_\_\_\_  
Name of patient

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Place

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

### Statement by the Researcher

I provided verbal information regarding this study  
I agree to answer any future questions concerning the study as best as I am able  
I will adhere to the approved protocol

\_\_\_\_\_  
Name of Researcher

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Place

### Annexure 3: Ethical approval from University of Limpopo



University of Limpopo  
Department of Research Administration and Development  
Private Bag X1106, Sovenga, 0727, South Africa  
Tel: (015) 268 2212, Fax: (015) 268 2306, Email: noko.monyane@ul.ac.za

**TURFLOOP RESEARCH ETHICS  
COMMITTEE CLEARANCE CERTIFICATE**

**MEETING:** 25 January 2017  
**PROJECT NUMBER:** TREC/05/2017: PG  
**PROJECT:**  
**Title:** Factors associated with teenage pregnancy at Dwaarsloop Local Area Clinics, Bushbuckridge Sub-District, Mpumalanga Province  
**Researchers:** Ms EZ Mngisi  
**Supervisor:** Dr E Malmela  
**Co-Supervisor:** Prof L Skael  
**School:** Health Care Sciences  
**Degree:** Masters In Public Health

  
**PROF MASHEGO**  
**CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE**

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: REC-0910111-031

**Note:**

- i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
- ii) The budget for the research will be considered separately from the protocol.  
**PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.**

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## Annexure 4: Approval from Mpumalanga Department of Health



Indye Building, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200 Mpumalanga Province  
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Litsoelo Lelaphik

Department van Gesondheid

LimNyango wezaMaphilo

Eng: 013 788 3786/3511  
Ref: MP\_201907\_003

### Provincial Research Approval Letter

**MS EVDIA ZANDILE MNISI**  
P. O. BOX 1362  
HAZYVIEW, 1242

**TITLE: APPLICATION FOR RESEARCH AND ETHICS APPROVAL: FACTORS ASSOCIATED WITH TEENAGE PREGNANCY WITH SPECIAL FOCUS TO DWARSDOOP LOCAL AREA CLINICS IN BUSHBUCKRIDGE**


**Dear Ms EZ Mnisi**

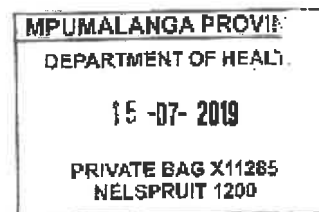
The Provincial Department of Health Research Committee has approved your research proposal in the latest format you sent.

- Approval Reference Number: MP\_201907\_003.
- Data Collection Period: 01/07/2019 to 30/12/2019.
- Approved Data Collection Facilities:
  1. Arthurstone Clinic
  2. Casteel Clinic
  3. Dwarsoop CHC
  4. Drinoco Clinic
  5. Shatata Clinic

Kindly ensure that the study is conducted with minimal disruption and impact on our staff, and also ensure that you provide us with a soft or hard copy of the report once your research project has been completed.

Kind regards

  
**MR J SIGUDLA**  
MPUMALANGA PHRC  
DATE: 15/07/2019



## Annexure 5: Affidavit from language editor



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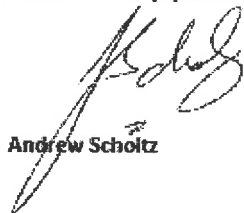
Date: 17 November 2019

#### **To Whom it May Concern**

I hereby confirm that I have proof-read the document entitled: "Factors Associated with Teenage Pregnancy with Special Focus on Dwarssloop Local Area Clinics, Mpumalanga Province" authored by Evodia Mnisi, and have suggested a number of changes which the author may or may not accept, at her discretion.

Each of us has our own unique voice as far as both spoken and written language is concerned. In my role as proof-reader I try not to let my own "written voice" overshadow the voice of the author, while at the same time attempting to ensure a readable document.

Please refer any queries to me.

A handwritten signature in black ink, appearing to read 'Andrew Scholtz'. The signature is fluid and cursive, with a long, sweeping underline that extends to the left and then loops back under the name.

Andrew Scholtz