Social Causes of Teenage Pregnancy: The case of an informal settlement, Polokwane, South Africa

By

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DISSERTATION

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DEDICATION

I dedicate this dissertation to three beloved people who mean so much to me and show me unconditional love and support. First and foremost, to my mother whose love knows no bounds and has taught me the importance of education, hard work and self-confidence, *Kea leboga go menagane Mologadi'a Hlabirwa'a Moloto, Moloto'a Phaahla* and I will always be grateful for your support and being the best mother, I could ever ask for.

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DECLARATION

I declare that “Social Causes of Teenage Pregnancy: The case of an informal settlement, Polokwane, South Africa” is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Declaration by: **Rasekele Bridgette Mphahlele** Signature

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ABSTRACT

The purpose of this study was to explore the social causes of teenage pregnancy in an informal settlement in Polokwane, South Africa. The study also examined factors that contribute to, and have an impact on, teenage pregnancy. An exploratory qualitative research method was employed to explore social causes of teenage pregnancy in an informal settlement at Polokwane, South Africa. The research participants of the study were purposively sampled 16 teenage mothers between the ages of 15-19 and residing in Extension 78, Polokwane. Data collection was done using semi-structured interviews. The collected data was analysed using a thematic analysis approach. The findings of the study reveal that teenage pregnancy can be attributed to multiple factors that include the failure of existing policies to mitigate or limit the prevalence of teenage pregnancy, transactional relationships between teenagers and elderly men, and a lack of accessible adequate healthcare services. This study recommends a holistic approach by the state departments concerned with teenage pregnancy, local communities, NGOs and scholars, who should collaborate in implementing suggested interventions to mitigate teenage pregnancy and its effects. To ensure effective implementation of legislative frameworks, it is essential to enhance progressive interventions and accountability measures in areas where they may be lacking and areas that have high numbers of teenage pregnancies.

Keywords:

Teenage pregnancy, Social Causes of teenage pregnancy, Extension 78, Polokwane, Limpopo Province, South Africa**.**

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CHAPTER ONE: INTRODUCTION AND BACKGROUND OF THE STUDY

This study seeks to explore the social causes of teenage pregnancy, which is a global concern. Teenage pregnancy is described as an unintended pregnancy during adolescence (Kirchengast, 2016). Pregnancy for a woman who is 19 years of age or younger can be referred to as teenage pregnancy. There is an increasing number of children born out of females under the age of 20 years, hypothesised to be a result of social problems such as environmental factors, gender-based violence, influence from peers, access to drugs and alcohol, unemployment, and educational opportunities (Barron, Subedar, Letsoko, Makua and Pillay, 2022).

Regardless of race, religion or culture, this social phenomenon can impact any community in society. Teenage pregnancy has an impact on the political, religious, cultural, educational, and economic domains of society (Wall-Wieler, Roos and Nickel, 2016). This chapter introduces the study and procedures. From the introduction, the research problem, literature review, the theory applied and the research methodology, to name a few. The outline of the study is also included to show the order in which this study is written.

1.1 Introduction

Teenage pregnancy affects young girls globally. The African continent is reported to have the highest number of teenage pregnancies across the globe (Kassa, Arowojolu, Odukogbe and Yalew, 2018). Similarly, South Africa is one of the African countries affected by the growing number of teenage pregnancies, which in turn affects the empowerment and development of young girls (Maharaj, 2022). During the Covid-19 outbreak, there was a great number of teenage pregnancies recorded in the country. Over 30,000 teenage mothers gave birth in 2020 (Stats SA, 2021). In recent years, there has been an increasing number of births attributed to teen moms (savethechildren.org, 2021).

Local and International organisations collaborating with governments and societies continue to try to find ways to reduce teenage pregnancies. Extension 78, Polokwane, South Africa is no exception. The researcher identified a gap in research on factors contributing to teenage pregnancy in Extension 78 because the area is a semi-urban area (a former informal settlement), and did not receive any municipal services until recently in 2019 when they built RDP houses. The study, therefore, aimed to explore

the causes of teenage pregnancy in Extension 78, Polokwane, South Africa and how it has affected their lives as teenage mothers. This was motivated by the growing number of teenage pregnancies in South Africa, where the law (South African Schools Act 1996) protects pregnant teenagers and teenage mothers from any discrimination and unfair treatment in schools that hinder their right to education (Naidoo, Muthukrishna and Nkabinde, 2021). Local and International organisations collaborating with governments and societies continue to try to find ways to reduce teenage pregnancies.

1.2 Research problem

Teenage pregnancy is a universal concern. According to the World Health Organization (WHO), an estimated number of over 10 million teenage girls give birth yearly. These young girls are reported to be diverting to unsafe abortions, putting their health at risk (WHO, 2020).

Contrary to developed nations, low- and middle-income countries have the largest prevalence of adolescent pregnancies, accounting for 90% of the global rate (Ayanaw, Yalew and Azale, 2018). In South Africa, this social phenomenon continues to affect teenagers and pupils. Over the years, there have been calls for stakeholders to assist in creating measures and solutions for teenage pregnancy (Du Preez, Manyathi, Botha and Rabie, 2019). Correspondingly, there have been calls to improve the quality of education and teaching on risky sexual behaviours amongst pupils, and that there be laws that discipline/ convict individuals who have sexual intercourse with minors.

In Limpopo Province, state hospitals reported that over 10 000 babies were born by teenagers between 2017 and 2018 (BBC NEWS, 2018). Mushwana, Monareng, Richter and Muller (2015) found that in Giyani, inaccessibility to health services, family guidance and risky sexual behaviours were among the contributing factors to teenage pregnancy. Ncube and Mudau (2018) discovered that in Kgapane Township, the majority of adolescent pregnancies were both unintended and unwanted. On 25 December 2023, the MEC of Health in Limpopo Province, Dr Phophi Ramathuba expressed concern in various media platforms as teenage mothers were among the 209 mothers that gave birth on the day (Maromo, 2023). 50 teenage girls contributed to the 209 newborn babies which were born in Limpopo Province public health facilities. The number has increased from 2022 with 33 teenage mothers. This

indicated an increase of 17 teenage mothers (Maromo, 2023). The MEC has added that teenage pregnancy continues to be a societal issue that requires intervention from various sectors of society to lessen the growing numbers.

Although the law (South African Schools Act 1996) allows young girls to return to school post giving birth, there are challenges faced by teenage mothers that can hinder their return to school, including financial means to provide for their children. Literature, academics, and leaders in South Africa tend to highlight teenage pregnancy as an issue that hinders teenage girls' educational achievements. Despite the progress that the South African government has made in curbing the social causes of teenage pregnancy (both in legislative frameworks and the socio-economic impact of teenage pregnancy), why is it that it continues to persist amongst South African teenagers?

1.3 Literature Review

In recent years, there have been progressive developments and improvements regarding access and the provision of family planning at no extra cost to citizens in South Africa (Bolarinwa, 2021). All citizens, including minors, are protected by laws that give them the right to choose their reproductive options and access to reproductive healthcare. Information and programmes have been introduced by various government departments to assist the society with basic health services and education. However, even with the existence of the programmes, projects and policies, it is not everyone, including teenagers, who has access to the resources and information available from the government (Paton, Bullivant and Soto, 2020). The government has introduced modern forms of contraception such as implants and the Intrauterine Device (IUD) in public hospitals and local healthcare clinics for citizens. This adds to other forms of contraceptives that have been available in healthcare services such as contraceptive pills and condoms. Access to contraceptives is available for children as young as 12 years old (Chersich, Wabiri, Risher, Shisana, Celentano, Rehle, Evans and Rees, 2017).

1.3.1 Accessibility to healthcare services

There are various challenges experienced by teenagers regarding the available access to healthcare services in South Africa such as poor access to contraceptives, challenges faced in the termination of pregnancy (TOP), issues regarding inconsistent

and incorrect use of contraceptives, negative attitude experienced by healthcare workers and lack of information regarding sexual and reproductive health (Nkosi and Pretorius, 2019). Since many young women who commit abortions continue to do so in dangerous or illegal ways that can be challenging to record in data, abortion figures continue to be difficult to quantify and compare across time (Mosley, King, Schulz, Harris, DeWet and Anderson, 2017). The negative attitude and treatment by healthcare workers who are not willing to perform TOP are among the challenges faced by patients (Stevens and Mudarikwa, 2018).

The termination of pregnancy (TOP), commonly referred to as abortion, is one potential option for dealing with teenage pregnancy, but it is important to understand that it is a complex and controversial issue with various ethical, legal and emotional considerations (Espinoza, Samandari and Andersen, 2020). Teenagers might not be emotionally or financially prepared to raise a child. Some may feel that terminating the pregnancy is a responsible decision, acknowledging their inability to provide a stable and nurturing environment for a child at that stage in their lives. Advocates for reproductive rights argue that individuals, including teenagers, should have the autonomy to make decisions about their own bodies and reproductive health (Espinoza, 2020). They believe that access to safe and legal abortion services should be available to those who choose it regardless of stigma and age. Judgements and stigma towards TOP leads young girls to receive services from illegal abortion clinics, known as “Back door abortions”. Despite knowledge that safe medical abortion services are provided for free in South African public health facilities, the prevalence of backdoor abortions, particularly on young people, is increasing as bogus doctors capitalise on young women's desperation (Harries, Daskilewicz,Bessenaar and Gerdts, 2021). Lack of nurses and skill shortages as well as a lack of awareness and stigma associated with abortion are some of the reasons why young people continue to terminate pregnancies through illegal abortions at backdoor clinics.

Netshikweta, Olaniyi and Tshitangano (2018) found that half of the participants in their study revealed that they were sexually active, and 86.7 per cent said they were unaware of contraception when they first started having sex. The tittle of the study is: “reproductive health choices among adolescents in secondary schools: a case study of selected schools in Limpopo, South Africa.” The study was conducted at a few chosen secondary schools in Limpopo Province. When male partners are reluctant to

use condoms, young girls are completely responsible for safeguarding themselves from pregnancy (Abdool Karim, Baxter, Frohlich and Abdool Karim, 2014).

A programme by the government's Integrated School Health Policy (ISHP) was introduced in 2012 to provide healthcare services in schools to accommodate learners by having nurses present in the school fields.

As a co-signatory to the ISHP policy, the Department of Education recommended that School Governing Bodies (SGB) support the authorisation of condom availability in schools as their attempts had been received with opposition and negative attitudes from the general population (Khoza, Zulu and Shung-King, 2019). Japan and the United States have demonstrated the effectiveness of having school-based healthcare (Keeton, Soleimanpour and Brindis, 2012).

In an article by Musetha (2013), nurses at Madimbo clinic, which caters for six villages, expressed their concerns about the youth in the area as teenage pregnancies and HIV/AIDS cases are growing steadily. Stats SA (2016) showed that only 64.2% of adolescent women use contraceptives. A longitudinal study by the South African Medical Research Council (SAMRC) conducted from 2017 to 2021 revealed how misinformation and barriers regarding the use of contraceptives play a role in teenage girls' decision-making. The participants also shared how confidentiality is not respected in local clinics, and the difficulty of getting to health facilities (SAMRC, 2021). Ajayi and Ezegbe (2020) explain that improper and irregular contraception use is cited as one of the leading factors of teenage pregnancy.

Musanshiko (2019) suggests that an individual's socio-economic and environmental factors can significantly impact their ability to access information regarding sexual health and contraception. This is particularly significant for teenagers from low-income families who may face additional barriers in obtaining the required knowledge and resources to make informed decisions related to their sexual health.

1.3.2 The social detriment of teenage pregnancy

Poverty can hinder teenagers from opportunities to seek empowerment to better their lives by finding success and bringing about change in their communities (Lambani, 2015). More than a few studies from developed, developing and underdeveloped countries have demonstrated that teens reared in underprivileged or impoverished

communities are more likely to become pregnant at a younger age than teenagers raised in regions with higher socioeconomic status (Mathewos and Mekuria, 2018; Abrams, 2021; McElroy and Moore, 2018). Intergenerational and transactional sex or relationships that benefit teenagers can result from poverty, which can have an impact on a girl's life in decision-making during relations with her male counterpart. Kriel, Milford, Cordero, Suleman, Beksinska, Steyn and Smit (2019) explain that there is unequal power amongst young girls and elder men in transactional relationships, which can result in the inability to negotiate condom use and safety in sexual relations. Young girls are involved in transactional relationships seeking financial support to assist in meeting their basic needs or other needs to help feed themselves or their families (Ursula and Valerie, 2019). The limited power that girls have in relationships can lead to unplanned pregnancies and exposure to sexually transmitted diseases as they are voiceless on how and when to have sex. The lack of financial means to pay for nursery schools and being able to provide for the baby's daily needs can also be a difficulty. The provision of the Child Support Grant (CSG) helps assist mothers financially in some ways to provide for their children up to the age of 18 (Granlund and Hochfeld, 2020). In 2021, the CSG amounted to R460.00. In an article by Ngubane and Maharaj (2018), it was found that due to financial constraints, the CSG is one of the reasons why teenage girls fall pregnant to alleviate financial stress at home or for themselves.

The Mail & Guardian interviewed two young girls from Tonga, a rural town in Mpumalanga where young girls drop off their resumes around town in local shops to find employment as a means to provide for their children (Skosana, 2013). Having no caregivers or financial means to afford daycare resulted in them being unable to return to school and complete their studies, and as a result, find alternative ways to survive. In a study with young girls from Capricorn District, social workers shared how economic reasons are some of the contributing causes of teenage pregnancy in Limpopo Province (Skobi and Makofane, 2017).

Raphael-Leff (2018) adds that there are unfavourable social issues that children living in poverty can be exposed to, namely, gender-based violence, risky sexual behaviours, unemployment, unfavourable living conditions and substance abuse.

1.4. Role of theory in the study

The chosen theory of this study is Albert Bandura's theory of social learning. The theory highlights how observing, modelling, imitating behaviours and attitudes, and other emotional reactions influence an individual's behaviour and upbringing (Bandura and Walters, 1977). It considers how environmental and cognitive factors interlink and influence human learning, the formation of oneself, and the power of society in socialising people. Bandura (1986) explains that the mediating process happens between the stimuli and responses. Behaviour is acquired and learned by observational learning from the environment. Through observational learning, Albert Bandura used the "Bobo doll experiment" where the contributors observed were called models (Bandura and Hall, 2018). In society, children have different influential models such as parents, family members, the media, peers, and educators at schools. The models provide examples of behaviour that can be imitated and observed (McLeod, 2011). Bandura further explains that children learn behaviour and pay attention to these models and encode their behaviour (Bandura, 2021). The child will reproduce the behaviour learned in society and believe it is appropriate. The response from the behaviour reproduced will be from the concepts of reinforcement and punishment.

The social learning theory helped explain how teenagers acquire life skills through learning and by imitating their environmental factors and social interactions (Tillman, 2016). Furthermore, the theory unpacked how the social causes of teenage pregnancy are a result of children's environmental and cognitive factors through models and how they encode them. This assisted in understanding early engagement in sexual relations, the use or non-use of contraceptives, the termination of pregnancy, living conditions and socioeconomic status.

1.5 Operational Definitions

Teenage pregnancy – Teenage pregnancy happens when a woman under the age of 20 becomes pregnant. It mainly refers to teenagers aged 15 to 19. However, it can involve girls as young as 10. It is also known as adolescent pregnancy or teenage pregnancy (Rohmah, Yusuf, Hargono and Laksono, 2020).

Social Causes of Teenage Pregnancy- Social causes are problems or conditions that have detrimental effects on members of society and hence necessitate a solution. That is, these causes affect not only the individuals but often enormous groups of citizens,

causing problems or poverty. In this study, the social causes of teenage pregnancy have been identified as poverty, family communication, the media and factors contributing to teenage pregnancy such as transactional relationships.

1.6 Purpose of the study

1.6.1 Research Aim

- The study aims to explore the social causes of teenage pregnancy at an informal settlement in Polokwane, South Africa.

1.6.1.1 Objectives of the study:

- To determine the social causes of teenage pregnancy among teenagers in a semi-urban area.
- Assess the broader societal impact of teenage pregnancy in society.

1.7 Research methodology

In this study, the qualitative research method was employed to help understand the social causes of teenage pregnancy and participants' circumstances through the meaning and relations of their social lives. An exploratory research design was chosen to gain a more thorough understanding of the current study problem. The population sample was teenage mothers residing in Extension 78, Polokwane, South Africa where the data was collected. Thematic analysis was used to analyse data. Ethical considerations and the quality criteria process applied are explained in the research methodology.

1.7.1 Research design

The study employed an exploratory research design, which was chosen on the basis that the topic under investigation is under-researched in townships in Capricorn district.

1.7.2 Sampling

Sixteen teenage mothers between the ages of 12 and 20 were chosen from a population of teenage girls in Extension 78, Polokwane, South Africa. The chosen number of teenagers to participate in this study was sufficient to reach saturation because the focus was on one area with only teenage mothers.

1.7.3 Data collection methods

The researcher used semi-structured interviews to obtain detailed data from the research participants who dropped out of school in Extension 78, Polokwane, South Africa and a high school mostly attended by pupils from Extension 78 in Polokwane. Purposive sampling was utilised as a sampling technique for the study. It is a non-probability sample chosen based on the characteristics of the intended population and the study's objectives. A voice recorder and notebooks were used to collect data from the participants. Besides collecting empirical data from the research participants, the researcher also made field notes.

1.7.4 Data analysis

The researcher analysed the qualitative data using thematic analysis, which is a collection of texts, such as interview transcripts. The researcher carefully examined the study findings to note recurring themes in the interviews (Deterding and Waters, 2021). Conducting thematic analysis involves several steps, including familiarisation, coding, generating themes, reviewing themes, defining, and naming themes and writing up. Thematic content analysis provided the interpretation of how the realities of teenage mothers interlink with clinical and social measures in addressing the problem of teenage pregnancy.

The themes that emerged from the study were crucial in terms of assessing the social realities that teenage mothers face. The themes that came out of the qualitative analysis were crucial so that the researcher could assess the effectiveness and accessibility of interventions that lessen the social causes of teenage pregnancy. Uncoded data was pooled together to determine whether it represented undiscovered or new themes.

1.7.5 Quality criteria

Trustworthiness and Credibility

In this study, the researcher guaranteed credibility by ensuring that the information and data extracted is a true reflection of the participants' voices and that the meaning of data is not lost in translation.

Dependability

To ensure trustworthiness and credibility, the researcher remained objective during the interviews and did not coerce participants into responding in ways that agreed with the researcher's standpoint or interests.

Conformability

The researcher allowed participants to respond according to their own free will and to the best of their knowledge on the social causes of teenage pregnancy. This was to ensure that the results remain consistent and accurate over time. The researcher, in no way, forced the participants to respond in a way that pleases the researcher to ensure accuracy or results.

1.8 Ethical considerations

This study followed the ethical standards needed for research to respect the participants' safety and privacy. A research proposal was submitted to the University of Limpopo's various committees, DREC, ScRec, FHDC and TREC. Turfloop's Research Ethics Committee (TREC) served for approval and permission to collect data for this research study.

Informed consent and Voluntary Participation

Research participants in this study are between the ages of 12 and 20. The researcher asked for the details of their parents or guardians for those who voluntarily agreed to participate in the study. Research participants under the age of 18 needed their parents or guardians to sign informed consent forms if they agreed that their child participates in the study. This was to cover aspects of consent before the interview from the guardians. The researcher proceeded with the interview if the teenage mother or parent or guardian granted permission. Only participants from the age of 18 and above signed informed consent forms on their own.

Permission

Permission to conduct the study with pupils from the local school was obtained from the principal. An application for ethical clearance was also made with the Turfloop Research Committee.

Confidentiality

To protect participants' privacy, the researcher ensured that their names are not shared or publicised, and confidentiality was crucial in preserving their participation.

Only the researcher knows their real names. Any personal information was kept private and confidential.

Anonymity

Participants' private information was safeguarded. Their real names remained private; only fictitious names are used. This ensured that they are protected from any harm and intimidation and that their dignity was preserved.

1.9 Significance of the study

By working together to develop answers as a society and using scientific research, communities, academia, the government, and non-governmental organisations may use this study to comprehend this phenomenon and find solutions. This study may also draw attention to the limitations of the current strategies in reducing teenage pregnancy in Limpopo Province and South Africa. Additionally, this study will offer crucial advice and recommendations on how to address the issue and causes of teenage pregnancy.

1.10. Outline of the study

This chapter (one) introduced the key concepts of this study, recent literature that relates to teenage pregnancy in SA and research methods that are used to collect, analyse, interpret and discuss the research findings. The key concepts that are introduced include teenage pregnancy, social causes of teenage pregnancy and other contributors to the pregnancy. The recent literature highlights that teenage pregnancy is a persisting problem in Limpopo and SA in general.

Chapter two provides a comprehensive review of existing literature related to teenage pregnancy. The chapter further identifies gaps, debates, and areas for further research.

Chapter three establishes the theoretical framework of the study and a summary of the theory, the fundamentals, and concepts.

Chapter four describes the research design, methods and procedures used to collect and analyse data. The chapter also justifies the chosen methodology, data analysis method and ethical considerations.

Chapter five discusses the data analysis and the findings of the study using thematic analysis. It addresses the research questions and highlights the linkage and limitations with the theory applied in the study.

Chapter six is the last chapter of this study. It discusses the limitations of the study and presents recommendations for future research.

The next chapter focuses on the literature reviewed to contextualise and identify gaps that exist concerning teenage pregnancy.

CHAPTER TWO: LITERATURE REVIEW

This chapter begins with an overview of teenage pregnancy from an African, sub-Saharan Africa and South African point of view. This is to highlight that social causes of teenage pregnancy are not uniquely a South African social ill but occurs throughout the continent.

The chapter outlines relevant recent research that relates to the social causes of teenage pregnancy. Further discussions are about other contributors (social and non-social) to the persisting problem of teenage pregnancy. The chapter also reviews existing laws, policies, and regulations on teenage pregnancy in South Africa, and a review of its impact on young mothers, their families and their immediate communities. The chapter concludes with a review of how organisations have attempted to alleviate the growing number of teenage pregnancies.

2. Teenage pregnancy in Africa

The issue of teenage pregnancy continues to have a significant impact on the African continent, particularly in poor and marginalised communities. Teenage girls are faced with the difficult challenge of becoming mothers while still being children themselves. According to Duby, McClinton Appollis, Jonas, Maruping, Dietrich, LoVette, Kuo, Vanleeuw and Mathews (2021), the lack of decision-making power regarding sexual and reproductive health is a major factor contributing to the continued rise in teenage pregnancy cases. Child marriage, early marriage and forced marriage are among the factors contributing to this social problem. The United Nations Population Fund (UNFPA) estimates that 49 million sexually active women in East and Southern Africa lack access to modern contraception or family planning services, with more than half of them being young women. As a result, the adolescent pregnancy rate in the region is twice the global average, at 92 births per 1,000 females (UNFPA, 2021).

The COVID-19 pandemic has also had an impact on young people's access to contraception and school attendance, which has contributed to an increase in teenage pregnancies (State of World Population 2022, UNFPA). Unfortunately, this cycle of poverty has had far-reaching effects on many girls. The aim of this desktop analysis

is to explore similarities and differences of the social causes of teenage pregnancy in Africa.

2.1. Teenage Pregnancy in Zimbabwe

Zimbabwe is one of the Sub-Saharan African countries facing the social challenge of teenage pregnancy. Female adolescents in the country demonstrate poor attitudes towards receiving and utilising sexual and reproductive health services. This results from myths about family planning and fears of proximity. One of the fears that females have towards utilising contraceptives is the fear of not being able to bear children in the future due to the effects of contraceptives. The other fear is their partners not supporting their decision to use contraceptives (Woollett, Bandeira, Marunda, Mudekunye and Ebersohn, 2021).

The country has faced a rising number of teenage pregnancies post the coronavirus pandemic years which affected the globe in 2020. Between January and February 2021, the country recorded almost 5000 teenage girls who had become pregnant. Additionally, 1800 teenage girls entered early marriages (Murewanhema, Moyo and Dzinamarira, 2023). The majority of teenage girls who fell pregnant or got married reside in poor areas. With stigma in some areas, young pregnant girls are discouraged from attending school. The result of teenage pregnancy and early childhood marriages makes young girls to drop out of school and exposes them to sexually transmitted diseases. Mutara (2015) explains that in rural areas or poor suburbs with low socio-economic status, young girls are exposed to financial constraints and social customs which may contribute to or hinder their development.

Young girls are likely to engage in early sexual relationships due to the challenges they are exposed to from their households and communities (Chingono, Kasese, Miles and Busza, 2022). Correspondingly, in a study titled “factors influencing access to and utilisation of youth-friendly sexual and reproductive health services in sub-Saharan Africa” teenagers argued that they are not able to access a comfortable and friendly healthcare facility that caters for sexual and reproductive health services (Ninsiima, Chiumia and Ndejjo, 2021). Some teenagers have engaged in sexual activities and yet do not have access to family planning options. A report conducted in Zimbabwe revealed that the prevalence of teenage pregnancy exists in both rural and urban areas and affect all existing provinces in the country. In a report by Gombe, Cakouros,

Ncube, Zwangobani, Mareke, Mkwamba, Prescott, Bhatasara, Murwira, Mangwiro and Prust (2020), the participants asserted that they did not know about condom use and other forms of family planning. Limited knowledge often increases the risk of pregnancy among teenagers.

There are contraceptives in clinics. However, due to traveling barriers and restrictions, young people have limited options to access these services. Although there have been attempts to have contraceptives accessible in schools, they have unfortunately been met with outrage because of conservativeness and religion in the country (Mavodza, Bernays, Mackworth-Young, Nyamwanza, Nzombe, Dauya, Dziva, Chikwari, Tembo, Apollo, Mugurungi and Madzima, 2022).

Young girls have trouble utilising contraceptives as parents have myths that until the teenagers reach a certain age or are married, they should not engage in sexual activities. However, in an article, a volunteer at a local clinic in Zimbabwe argued that regardless of the parents' restriction of the children, the teenagers are already having sex (Maibvisira, 2019). The age of consent to access contraceptives in Zimbabwe is 18 years old, without the consent of a parent. With the rising numbers of teenage pregnancy, a proposal by members of parliament and civil society groups that teenagers access contraceptives without the consent of parents was opposed and not approved by the Vice President and the health minister (Chingono, 2021).

Besides access and use of family planning in Zimbabwe, various social issues continue to affect young girls, namely, peer pressure, poverty, lack of sex education, traditional roles in communities, and low levels of education in their families (Mutara, 2015). Teenage mothers drop out of school for different reasons. In an article by Kurevakwesu, Mthethwa, Chirangwanda and Mabeza (2023), a 13-year-old girl has been affected by being a teenage mother. The teenage mother dropped out of school and now sells fruits to make a living for her child. Furthermore, she assists her siblings with homework after school. The teenage mother's life has changed after giving birth. The social causes of teenage pregnancy are not unique to Zimbabwe, the following country to be briefly discussed is Nigeria where the country also has a rising rate of teenage pregnancy cases.

2.2 Teenage Pregnancy in Nigeria

Nigeria had a rising rate of adolescent pregnancy in 2021. It was reported that 106 per 1000 teenage girls were falling pregnant. With 50 million adolescents, more than one in four youths, and half of Nigeria's current estimated population of 205 million, Nigeria has the greatest adolescent population in sub-Saharan Africa (SSA) (Cole, Coppola, Cutherell, Ede, Elabo, Hamza, Idris, Ogbondeminu, Ogungbenro, Oluwayinka and Phillips, 2020). Numerous factors have been identified as contributing to Nigeria's high rate of teenage pregnancies, including premature menstruation in females, early sexual activity, early marriage, low socioeconomic status, economic insecurity, inconsistent and ineffective contraception use, low educational and career aspirations, living in a single-parent household, dysfunctional family dynamics, and the decline of traditional African values (Somefun and Olamijuwon, 2022; Aderibigbe, Araoye, Akande, Musa, Monehin and Babatunde, 2011).

Akombi-Inyang, Woolley, Iheanacho, Bayaraa and Ghimire (2022) found that in Nigeria, adolescent pregnancy has been linked to single parenting, especially in families with a male head in the household. It has been discovered that teenage pregnancies are more common in families headed by men. This finding may be related to the fact that male heads may find it difficult to gain the trust of teenage girls, engage them in delicate conversations about their sexuality, and warn them of potential dangers. The following country to be briefly discussed is Eswatini, the country faces teenage mothers dropping out of school and a lack of sexual reproductive health education.

2.3 Teenage Pregnancy in Eswatini

Teenage pregnancy presents a significant challenge for young women in Eswatini, as it does for many other lower-middle-income countries and is one of the major causes of school dropouts in the nation, with the adolescent birth rate currently standing at 87 per 1,000 adolescents, as it does for many other lower-middle-income countries (Sonene, 2020). It is a significant barrier to the nation's social and economic advancement. Teenagers who participate in sexual activities typically have a variety of negative consequences, most notably for adolescent girls and young women, which can have long-lasting effects on their physical, mental, social, and economic well-being (Hultstrand, Tydén, Jonsson and Målqvist, 2019).

The main problem is that teenage pregnancies lead to Eswatini's loss of economically productive human capital. Children born to teenage girls' experience hardship and hopelessness because of teenage pregnancy, which accounts for about one-fifth of Eswatini's school dropouts (Tsabedze (2020). Tsabedze (2020) argues that they do not imply that being born to a teenage mother or being pregnant as a teenager equals failure or dire consequences. There are successful people born to teenage mothers. However, their chances of developing into fully functioning members of society and the economy are generally limited by the difficulties that they endure during their formative years. A study conducted at a local clinic in Swaziland, Nkalashane with teenage mothers and fathers found that teenage fathers as opposed to the girls returned to school while the teenage mothers dropped out (Kabwigu and Nsibirano, 2016). The study further found that teenagers engaged in sexual activities by the age of 16. The teenage mothers argued that they did not have any sexual education or knowledge of family planning before sexual intercourse. Although 60% of teenage mothers claimed that they and their partners shared responsibility of preventing conception, 71% claimed that their partners exercised greater influence over key choices that had an impact on their relationship (Kabwigu and Nsibirano, 2016).

In the same study, most teenage fathers (63% of them) did not have any outside financial support, and 64% of teenage mothers said they were dating someone five years older at the time of their first pregnancy and that they also relied on the baby's father (56%) or his family (16%) for financial support (Kabwigu and Nsibirano, 2016). Participants in a study by Mkhonta, Kaplan, Nxumalo-Magagula, Faye, Gary, Zanele, Mhlongo-Manana, Percis, Khumalo, Mkhonta and Mathunjwa-Dlamini (2019) indicated that ignorance was one of the major contributing reasons to teenage pregnancy. When they became mothers for the first time, teenage women lacked knowledge about safe sex and contraception. For example, while most teenage mothers were aware of condoms, very few had heard of injections, birth control tablets, IUDs or implants. Many young girls and women in their adolescence enter relationships without being aware of their rights as persons, what would be expected of them by their partners, or how to communicate and bargain for their safety and protection. Mozambique is the last African country to be highlighted on teenage pregnancy challenges faced in the country and one of the key challenges is child marriages affecting young girls before the age of 18.

2.4 Teenage Pregnancy in Mozambique

Thirty-eight percent (38%) of adolescent girls in Mozambique have given birth to a living child. This is the highest adolescent fertility rate among Southern African Development Community countries, with a growing trend between the years 1997 and 2015 (Chicanequisso, Sabonete, Sacarlal, Rossetto and Baltazar, 2023).

Jaén-Sánchez, González-Azpeitia, Saavedra-Santana, Saavedra-Sanjuán, Manguiza, Manwere, Carranza-Rodriguez, Pérez-Arellano and Serra-Majem (2020) assert that Mozambique is one of six countries in the world where at least one in every ten girls (14%) has had a kid before the age of 15, with 57% having had a child before the age of 18. According to the percentage of women aged 20 to 24 who were married when they were children under the age of 18, Mozambique has the tenth-highest rate of child marriage in the world.

The above countries have similar causes and impacts of teenage pregnancy to name a few, such as early marriages, lack of sexual reproductive health and dropping out of school. This shows that teenage pregnancy affects various countries in Africa with similar contributing social causes with governments and international organizations working collectively to alleviate this social phenomenon.

2.5 Teenage Pregnancy in South Africa

There are individual, family, and cultural causes of teenage pregnancy. These factors include, but are not limited to, culture, religion, moral principles, educational attainment, economic conditions, and the absence of social support. Girls who experience certain life conditions are more likely to become teenage mothers. These include a lack of resources, poor academic progress, and teenage pregnancy in their households. Along with that, young women frequently choose between their health and financial stability. Early sexual encounters, ignorance, curiosity, peer pressure, gender-based violence and power imbalances in sexual interactions are additional risk factors. In South Africa, there are numerous family planning clinics and reproductive health services throughout the country, but the youth are less likely to use them due to a variety of factors, such as societal morals and values, the judgmental and unfavourable attitudes of healthcare professionals (especially regarding access to contraception) and financial difficulties (Ajayi and Ezegbe, 2020).

NEWS24 reported that girl children as young as 9 years old were reported to be pregnant in 2020. An estimated number of 600 young girls between the ages of 9-10 gave birth in 2020 in South Africa. This is the number of reported and recorded births from official facilities. On the 21st of June 2023, SABC News reported that Kwa-Zulu Natal recorded 26,000 teenage pregnancies in a period of eight months. The three provinces in South Africa with the highest number of teenage pregnancies are Limpopo, KwaZulu-Natal, and the Eastern Cape (Barron et al., 2022).

Below are the social causes of teenage pregnancy in Limpopo Province, South Africa.

2.5.1 Family as a socialisation agency towards teenage pregnancy

Families play an important and influential role in the upbringing of children by sharing knowledge and how to navigate society as agents of socialisation. In the African culture, the role of the family is valued. Traditional families in the past were mostly polygamous, hierarchical, and patriarchal associated with having a perseverance lineage and forms of kinships (Mkwananzi, 2020). Families are the primary socialisation agents and can be trusted sources in sharing and teaching their children about sexuality and sexual education. However, during the adolescent phase, it can be challenging for parents and a missed opportunity to share or talk about sexual intercourse with the children (Chandra-Mouli, Plesons, Adebayo, Amin, Avni, Kraft, Lane, Brundage, Kreinin, Bosworth and Garcia-Moreno, 2017).

Teenagers with better involvement in parental guidance were found to be less likely to participate in sexual activities according to a quantitative study conducted in Washington on parental engagement in adolescents' first sexual experience. Conversely, teenagers who received the least amount of parental communication were more likely to have had sex before turning 16 years old (Evans, Widman, Kamke and Stewart, 2020). In some settings in South African households, it can be regarded as a cultural taboo and rare for elders to engage with children in sexual intercourse topics. According to Thobejane (2017), teenage pregnancies are exacerbated by parents and children not communicating with one another. According to Wanje, Masese, Avuvika, Baghazal, Omoni and McClelland (2017), parents believe speaking about sex with their children could be a sign of permitting them to have sex.

However, due to urbanisation and developments in South Africa, there are informative ways for parents to engage with their children about sexual education by having open,

honest, and reliable information conversations using forms of technological devices such as smartphones and allowing their children to watch educational safe sex shows in the mass media with parental supervision. Schools and mass media also contribute to the distribution of information to young people (Pieterse, 2019). An article by Nkosi and Pretorius (2019) found that some pregnant teenagers fear telling their parents and ask teachers to share their pregnancy with their parents. A study was carried out at various secondary schools in Limpopo Province regarding sexual education for both learners and parents. Parents argued that their culture prohibited them from talking about sex with their children (Munyai, Makhado, Ramathuba and Lebese, 2023). It is a cultural barrier for children and parents to talk or ask questions regarding sexual intercourse. Other parents argued that they do not know when the right age or time is to share information regarding sexual intercourse with their children. Feelings of embarrassment was also one of the reasons parents avoided having conversations with their children. Another study by Gunawardena et al. (2019) found that lack of communication, support and absence of parents lead to susceptible sexual involvement with men. Some children feel comfortable talking about sex with their peers as they do not feel judged or afraid to ask questions (Skobi and Makofane, 2017).

According to a study by Mmari, Kalamar, Brahmbhatt and Venables (2016), the family structure affects how adolescents behave when having sex. In line with one study, adolescents who grow up in families where the parent is actively involved in their lives are less likely to participate in sexual behaviour. Neville, Saran, and Crea (2022) explain how the likelihood of parental survival is a key factor in sexual debut. Whereas other studies have highlighted the importance of maternal orphanhood, this study adds that young men are especially likely to benefit from having both parents alive. Due to their living arrangements, which may include staying with relatives, a lack of supervision, and a lack of support, orphans are more vulnerable to making an early sexual debut.

When compared to young women who reported staying with their mothers, those who reported living with their fathers were more likely to engage in early sexual activities, which have been linked to poor parent-child communication (Neville et al., 2022). Although some young women were told that there was a connection between menstruation and pregnancy, the specifics of the association were never made clear.

Young women were frequently warned to keep themselves safe from and avoid boys, and many did not realise that sexual activity could result in pregnancy, therefore abstinence rather than contraception was promoted (Ndinda, Ndhlovu and Khalema, 2017).

2.5.2 Culture and gender roles

The causes of teenage pregnancies can be explained structurally or culturally. Structural factors include poor socio-economic status and limited access to healthcare and education (Mkwananzi, 2020). The cultural factors are the standards of the group the young mother is part of. In South Africa, both structural and cultural factors contribute to the growing number of teenage pregnancies. Understanding potential factors, such as gender norms and ideologies that may worsen these variances is important given the variations in sexual behaviours by race and ethnicity. Social messaging aimed at adolescents frequently contains gender ideologies, or socially formed notions of how men and women ought to behave (Jones, Whitfield, Seymour and Hayter, 2019). For instance, socially constructed notions of masculinity frequently value young men's sexual virility and promiscuity even though they prefer to be monogamous or refrain from sexual activity, in contrast to notions of femininity that frequently encourage virginity and discourage sexual activity for young women. In many communities, especially in patriarchal societies or underdeveloped regions, young girls are expected to become mothers at an early age. This is sometimes seen as a sign of womanhood or social acceptance (Mvune and Bhana,2023). Traditional masculinity may encourage risky sexual behaviour in boys, promoting early sexual activity as something that is encouraged or rewarded, which can contribute to teenage pregnancy.

Culture can have an impact on teenage pregnancy through the influence it has on controlled sexual behaviour and gender roles (Mkwananzi, 2017). Sexual taboos and submission for girls and sexual permissiveness for boys, poor involvement of females in the decision-making regarding their reproductive health, and the existence of female circumcision play a critical role in adolescent pregnancy in Africa (Lambani, 2015). Young girls are shamed for falling pregnant as teenagers, labelled sexually ignorant who fail to protect themselves from pregnancy, and are, on the other hand, encouraged to be sexually innocent. Although there are different religions, cultures

and races divided through their beliefs and customs; before marriage, sexual activity is often strictly forbidden, thus religious and cultural organisations uphold virginity and enforce it. In some African cultures such as AmaZulu, a girl's virginity is valued not just as a means of sexual restraint but also as a commercial commodity that can help her family make money through Lobola (Skosana, Peu and Mogale, 2020). Krobo in Ghana and Swaziland the Umhlanga Reed Dance are believed to encourage and keep young girls to keep their virginity to remain pure (Nyoni and Rapeta, 2022).

In patriarchal systems, losing one's virginity before marriage typically incurs the anger of the chief beneficiaries, with major consequences such as social rejection and exclusion of females from social institutions. Bhana (2016) explains that modern health-related issues have rekindled the emphasis on virginity, even though prior injunctions surrounding virginity were a result of a patriarchal society. African communities have reemphasised virginity in response to the devastation caused by HIV/ AIDS and teenage pregnancies, with many societal and cultural leaders stating that virginity before marriage is one of the methods to stop the spread of HIV/AIDS and teenage pregnancies (Bhana, 2016).

The information above paints a picture of how traditional societies view virginity, with Eswatini being one among them. As a female, being a virgin before marriage is highly valued in Eswatini society, as it is in other African communities, because it defines and develops an identity for the sake of young girls and their families. In South Africa, virginity testing is still prevalent in some areas and cultures. In Kwa Zulu-Natal and the Eastern Cape, virginity testing is still practiced yearly, and is called “ukuhlolwa”. There is also an event called “Umhlanga” where female virginity is celebrated in Eswatini.

Teenagers are socialised to believe in their family structure. Some cultures value early motherhood, particularly among communities where economic oppression limits alternative avenues for self-development. In some cultures, being pregnant and becoming a mother is viewed as positive, and one gains the status of becoming independent and responsible (Mkwananzi, 2020).

A study titled “Adolescent girls’ experiences regarding teenage pregnancy in the rural villages of Limpopo Province, South Africa” conducted at Greater Giyani Municipality villages in Limpopo Province highlighted how culture can be a cause of teenage pregnancy (Risenga and Mboweni, 2022). Participants in the study who are teenage

mothers shared how they were told they were women after their first menstruation and that they were ready to be married by their parents and caregivers (Risenga and Mboweni, 2022). Other participants shared how they had to get married at an early age to what they described as “rich men” to assist their families financially. Economic inequality and inflexible gender norms can lead to a higher likelihood of girls experiencing gender-based violence or sexual coercion, which can result in unintended pregnancies (Yah, Ndlovu, Kutywayo, Naidoo, Mahuma, and Mullick, 2020). Girls from lower-income families may have less ability to negotiate safe sexual practices or reject unwanted sexual advances, which further increases their vulnerability to early pregnancy (Adekola, and Mavhandu-Mudzusi,2021). In communities with established gender hierarchies, girls may lack the independence or means to obtain contraceptives or reproductive health services, even when they want to avoid pregnancy.

2.5.3 The social determinant of teenage pregnancy

Poverty can be defined as the absence of sufficient income to meet basic needs, such as clothes, food, and housing. Human poverty is characterised by the dearth of fundamental human abilities, including illiteracy, malnutrition, decreased life expectancy and poor health. Lack of access to infrastructure, energy, water and sanitation, telephone and education are indirect measures.

According to research by the Networking HIV & AIDS Community of Southern Africa (NACOSA), one of the contributing reasons to the high percentage of teenage pregnancies is poverty (NACOSA, 2018). According to the same Demographic and Health Survey, South African areas with the highest rates of teenage pregnancy are also the ones with the highest rates of poverty (NACOSA, 2018). Statistics South Africa divides poverty into three categories: food poverty, lower-bound poverty, and upper-bound poverty line (Mdluli and Dunga, 2022). Economic inequalities are the basis of South Africa's poverty. This is because of the country’s history, of which much of its money is concentrated in the hands of a few, notably those who controlled wealth during apartheid. South Africa's poverty rate has been decreasing since the mid-2000s. According to Mdluli and Dunga (2022), since 2006 almost 2 million South Africans have risen out of extreme poverty because of increased per capita health spending and the construction of RDP housing, among other government

programmes. Many South African families are still plagued by the effects of apartheid today. Watson (2021) elaborates how apartheid's effect jeopardises a family's fundamental functions, whether directly or indirectly; socialisation and family ties continue to be important elements that parents have to teach and instil in their children as tomorrow's leaders.

Many South Africans, however, struggle with poverty; as a result, parents are more concerned with finding work, ensuring their survival, and taking care of themselves than they are with teaching their kids how to be responsible citizens (Goudeau, Sanrey, Stanczak, Manstead and Darnon, 2021).

Poverty can lead to transactional relationships and age-difference partnerships (in which young women have sex with men 5-8 years older) both of which are known risk factors for HIV, early marriage, and multiple sexual partners (Gichane, Moracco, Pettifor, Zimmer, Maman, Phanga, Nthani and Rosenberg, 2020). In the same study by Gichane et al. (2020) conducted in Lilongwe Malawi, it was found that young women between the ages of 15-24 have transactional relationships due to their living experiences. Thus, having transactional sex assisted with covering their food security, paying for water and electricity and other necessities. The results of poverty places young girls at risk of becoming pregnant or HIV infection. For young women globally, poverty and economic inequality can have a variety of negative effects, including a higher chance of unavailability of contraception, unintended pregnancies, unsafe abortions, HIV/AIDS, and other STIs, as well as maternal mortality.

Poverty influences other factors such as multiple sexual partners and early marriage, which increase the risk of adolescent pregnancy (Cluver, Rudgard, Toska, Orkin, Ibrahim, Langwenya, Kuo, Xaba, Roehm, Smith and Bernardini, 2022). The detrimental effect of teenage pregnancy is more common among those living in poverty. Parents' poverty is regarded to be the underlying explanation for their decision their daughters married. However, this places teenage mothers in unpleasant and inconvenient conditions during motherhood.

A study conducted in Indonesia by Rohmah, Yusuf, Hargono and Laksono (2020) found that teenagers who were born in wealthy families were less likely to fall pregnant as opposed to those living in poor families. The majority of the teenage mothers in the study were from poor families. The study is in line with South Africa in a study in the

Northwest (Mkwananzi, 2015), showing that the highest rates of pregnancy were found among teenage girls from low-income families, households with mostly male heads but some female adults, and households with female heads who were unemployed. Finally, areas with high rates of poverty and no homeownership as well as rural locations had the highest rates of teenage pregnancies among adolescent females. The majority of the participants at almost 65% lived in households with poverty (Mkwananzi, 2015).

Poverty influences other factors such as transactional sex, multiple sexual partners, and early marriage, which increase the risk of adolescent pregnancy. The parents' poverty is regarded to be the underlying explanation for their decision to marry off their daughters. However, this places teenage mothers in unpleasant and inconvenient conditions during motherhood. A study conducted in Indonesia by Rohmah, Yusuf, Hargono and Laksono (2020) found that teenagers who were born in wealthy families were less likely to fall pregnant as opposed to those living in poor families. The majority of the teenage mothers in the study were from poor families. The study is in line with South Africa in a study in the Northwest Mkwananzi (2013) showing that the highest rates of pregnancy were found among teenage girls from low-income families, households with mostly male heads but some female adults, and households with female heads who were unemployed. Finally, areas with high rates of poverty and no homeownership as well as rural locations had the highest rates of teenage pregnancies among adolescent females. The majority of the participants at almost 65% lived in households with poverty. In a study by Risenga and Mboweni (2022), teenage mothers shared how they had sex with older men for a roof over their heads, and others shared how they had “blessers” to assist with their financial constraints. In another study, Mudau (2019), a teenage mother, shared how she sells steel wool and scrape pots to provide for her child; and another teenage mother shared how she uses her pocket money to pay for the child’s transport to nursery school.

The probability of girls to become pregnant while still in their teens increases with their level of poverty. Teenage mothers are less likely to finish school, are financially dependent on others, and have trouble finding jobs, all of which contribute to entrenching poverty. Due to limited access to other reproductive health care, teenage pregnancies may be more common among those who reside in low-income households. Contrarily, people who live in communities with low levels of poverty may

have a lower risk of becoming pregnant at a young age because these communities have more recreational facilities, parks, and other outdoor activities, which give teenagers less time to experiment with sex both within and between households (Jonas, Crutzen, van den Borne, Sewpaul and Reddy, 2016).

2.5.4 Transactional relationships

A transactional relationship is one in which there is an expectation of reciprocation or benefit. It is the practice of exchanging resources such as money, gifts and favours for sexual favours or interactions (Kilburn, Pettifor, Edwards, Selin, Twine, MacPhail, Wagner, Hughes, Wang, and Kahn, 2018). Different definitions have been applied by academics, such as the exchange of drugs and alcohol for sex (Kilburn et al., 2018; Krisch, Averdijk, Valdebenito and Eisner, 2019). Living in poverty exposes young girls to the risk of falling pregnant. Transactional sexual intercourse is occasionally utilised as a means of sustaining one's livelihood, according to research conducted in Mtwara (Tanzania) (TeLindert, Van der Deijl, Elirehema, van Elteren-Jansen, Chitanda and Van den Akker, 2021). The reasons people engage in transactional sex and relationships (TSR) are complicated and differ, ranging from hunger and poverty to social acceptance, status, glamour, and luxury aspirations.

Adolescent girls and young women (AGYW) in South Africa are subject to socio-cultural norms that normalise transactional sex, transactional relationships, and the use of sex as a medium of exchange. Transactional sex has grown to be a significant health concern. It is one of the risky sexual behaviour patterns that teenagers present. Youths frequently engage in it, and there is direct evidence that it contributes to gender-based violence, drug usage and HIV/AIDS (Duby, Jonas, McClinton Appollis, Maruping, Vanleeuw, Kuo and Mathews, 2021).

Older, wealthier men engage in sexual interactions with younger, less fortunate women, who may view this trade as a source of general material support rather than just extreme need. As a result of such relationships, young women have little or no negotiating power with their partners to insist on the use of condoms, putting them at a high risk of falling pregnant and contracting sexually transmitted diseases (STIs), including HIV/AIDS. In a study by Lince-Deroche, Shochet, Sibeko, Mdlopane, Pato, Makhubele and Bessenaar (2018), respondents argued that they preferred dating older men as they are easier to respect, are ready for marriage, and can take care of

their financial needs as women. Financial support was reported as a key factor when choosing a partner. The study focused on two provinces in South Africa, Gauteng, and Limpopo Province.

In 2022, the Citizen Newspaper reported that in Limpopo, over 11,000 students were pregnant in the province, and educators and blessers were responsible for the majority of these pregnancies (Matlala, 2022). Adult men who bless young girls with gifts frequently disappear after the girl becomes pregnant. The South African Council of Educators (SACE) stated last year that 11 instructors from all around the nation had been sacked after being convicted of various sexual offense-related crimes (Matlala, 2022). According to the organisation, the majority of them were fired for sexual misconduct against school learners. Currently, 11,287 pregnant students are enrolled in Limpopo's five district schools. According to reports, the majority of pregnant girls are between the ages of 10 and 19.

2.5.5 Inadequate access to healthcare services

According to the South African constitution, all citizens have access to both public and private health services. The nation is categorised into nine provinces, and each of the provinces has a local department of health in charge of health promotion and preventative services in addition to a national department of health that engages in the delivery of healthcare nationwide (Coovadia, Jewkes, Barron, Sanders, and McIntyre, 2009). With no official health insurance policies, all citizens have free access to public health care. Three levels of health services make up this public health system. Primary care centres are designed to be patients' first point of contact and to offer a preliminary evaluation of the patient. There are about 2,000 primary care clinics, the majority of which are staffed by nurses and offer community health services. The second tier includes district hospitals, where patients can receive basic treatments, minor surgeries, and tests (Christoffels and Mash, 2018). Tertiary hospitals have larger infrastructure and better technologies for major surgeries. These hospitals require specialists since they treat patients with serious illnesses. The National Revenue Fund, which gathers contributions made to local, provincial, and federal governments, funds most of the South African public health system. Funds are distributed and dispersed from the federal government to local municipalities, allowing local public

health organisations to allocate funds independently (Malakoane, Heunis, Chikobvu, Kigozi and Kruger, 2020).

The government intends to launch National Health Insurance in 2026 to address the lack of quality and access to care. It aims to ensure that all South African citizens and residents, regardless of socioeconomic level, have access to quality health services offered by both the public and private sectors (Christmals and Aidam, 2020). South Africa's health difficulties are exacerbated by the unequal distribution of health professionals across the private and public sectors, as well as an uneven distribution of public sector health professionals among provinces (Barron and Padarath, 2017). Tana (2013) carried out a study in which participants confirmed the inadequacy and insufficiency of health personnel, which they described as causing physical and emotional tiredness and, in some cases, additional deterioration of their medical state. Teenagers as citizens are eligible for the NHI however in bridging the gap challenges which could affect teenagers are infrastructure and resource constraints, governmental and administrative barriers, access to specialized teenage reproductive health services, limited healthcare workforce and skills gaps and geographical barriers.

Various barriers and accessibility to healthcare services contribute to teenage pregnancy in the country. During the adolescent stage, socioeconomic, age and gender-related risks in families, communities and societies interact with the individual’s physical, cognitive and emotional developmental processes to create conditions that put young people at risk of engaging in behaviours that could have long-term consequences for their health and ability to grow and develop to their full potential (Orben, Tomova and Blakemore, 2020). Govender, Naidoo and Taylor (2020) elaborate on substance abuse; exposure to sexual abuse as well as violence and injuries; early sexual debut and the associated exposure to sexually transmitted infections such as HIV, poor or lack of physical activity and increased risks of obesity; malnutrition; and high levels of early and unwanted pregnancies associated with unsafe abortions and pregnancies. Delany-Moretlwe, Cowan, Busza, Bolton-Moore, Kelley and Fairlie (2015) argue that despite implementation to address risks exposed to young people, the low use of health services by young people has been widely documented and has been attributed to a variety of factors, including access to healthcare services, a lack of information and awareness about service availability,

poor skills among service providers in dealing with young people, stigma associated with the use of sexual and reproductive health services by young people, and a lack of privacy and confidentiality in service provision.

Contraception is the intentional use of artificial means to prevent pregnancy caused by unprotected sex. The lack of advocacy and further sexual education for teenage mothers in using contraceptives and safe sex continues to affect teenage mothers in society (Jonas et al., 2016). The use of contraceptives can ensure the empowerment and growth of teenage mothers by returning to school, adequate birth spacing and gender equality. In a study conducted by Ahinkorah, Obisesan, Seidu and Ajayi (2021) in 17 Sub-Saharan African countries, it was found that contraceptive use was low in 14 countries. South Africa was among the countries in the study where only 5.10% of teenage mothers were using contraceptives. Chad was the country with the lowest use of contraceptives among teenagers and resulted in the highest teenage pregnancy birth rate ranging from 15- 19 years in age. Adolescent males and girls in South Africa have a reproductive health right to free contraception from their local health institutions. There are numerous contraceptive methods to select from. Since the Choice on Termination of Pregnancy Act was implemented in 1996, South African law has guaranteed access to services for sexual and reproductive health (SRH), and the number of deaths from unsafe abortions has decreased by more than 90% (Kaswa and Yogeswaran, 2020). However, there are still too many barriers for many women to have a safe, legal abortion, and the nation's maternal death rate is still too high. HIV and unwanted pregnancies are still prevalent in South Africa, and young women in particular struggle to protect their health and assert their rights (Govender et al., 2020). Before the age of 20, one in three women aged 15 to 24 became pregnant unintentionally, and the prevalence of HIV among females in this age range is more than four times higher than that among men (Nkosi and Pretorius, 2019).

There are various challenges experienced by teenagers regarding available access to healthcare services in South Africa such as poor access to contraceptives, challenges faced in termination of pregnancy (TOP), issues regarding inconsistent and incorrect use of contraceptives, negative attitude experienced from healthcare workers and lack of information regarding sexual health and reproductive health (Nkosi and Pretorius, 2019). Since many young women who obtain abortions continue to do so in dangerous or illegal ways that can be challenging to record in data, abortion figures continue to

be difficult to quantify and compare across time (Mosley, King, Schulz, Harris, DeWet and Anderson, 2017). The negative attitude and treatment from healthcare workers not willing to perform TOP are among the challenges faced by patients (Stevens and Mudarikwa, 2018). Netshikweta, Olaniyi and Tshitangano (2018) discovered that half of the participants in their study revealed that they were sexually active and said they were unaware of contraception when they first started having sex. The study was conducted at a few chosen secondary schools in Limpopo Province. When male partners are reluctant to use condoms, young girls are completely responsible for safeguarding themselves from pregnancy (Abdool Karim, Baxter, Frohlich and Abdool Karim, 2014). Operating clinic hours do not favour schooling girls, and negative attitudes and criticisms from staff members at clinics affect them not to go for assistance. In an article by Musetha (2013), nurses at Madimbo Clinic which caters for six villages expressed their concerns about the youth in the area as teenage pregnancies and HIV/AIDS cases are growing steadily. Stats SA (2016) showed that only 64.2% of adolescent women use contraceptives. A longitudinal study by the South African Medical Research Council (SAMRC) conducted from 2017 to 2021 revealed how misinformation and barriers regarding the use of contraceptives play a role in teenage girls' decision-making regarding contraceptives. The participants also shared how confidentiality is not adhered to in local clinics and the difficulty of accessing health facilities (SAMRC, 2021). Ajayi and Ezegbe (2020) explain that improper and irregular contraception use is cited as one of the leading factors of teenage pregnancy.

Gender inequality and patriarchy stimulate social-cultural beliefs that influence sexual relations decision-making. Boys in their adolescence are encouraged and, to some extent, have sexual relations to prove their manhood, whereas teenage girls are encouraged to refrain from sexual intercourse before marriage, and contraception use can lead to infertility and promiscuity (Savage-Oyekunle and Nienaber, 2015).

Healthcare workers are at the forefront of public health facilities to assist with sexual and reproductive services. When healthcare workers are available, teenagers often underutilise healthcare services for various reasons such as healthcare workers' negative attitudes and behaviours. Jonas, Crutzen, van den Borne and Reddy (2017) explain how negative behaviours and attitudes of healthcare workers can result in poor utilisation of sexual and reproductive services by teenagers and the care they receive. A study in Sub-Saharan Africa (SSA) showed that healthcare workers' attitudes and

behaviour can affect and discourage young people from seeking assistance in clinics or attending their follow-up visits (Geary, Gómez-Olivé, Kahn, Tollman and Norris, 2014). The prevalence of social stigma when seeking information and access to contraceptives due to their age, lack of privacy, or confidentiality tends to cause a rising number of teenage pregnancies and unsafe termination of pregnancies (Tolboom, 2015). A report by Janighorban, Boroumandfar, Pourkazemi and Mostafavi (2022) found that young people feel free to utilise sexual and reproductive health information and their services without stigma and public humiliation. With the lack of full information regarding sexual education by health workers and clear explanations of available choices for contraceptives as well as coping mechanisms for their use, teenage pregnancy will continue to rise. Access to information regarding what happens when one stops taking the contraceptives accordingly and the importance of constant use of contraceptives can help alleviate the discontinuation or fear of family planning (Reddy, 2018).

In a study by Jonas, Crutzen, Krumeich, Roman, van den Borne and Reddy (2018) in Cape Town, nurse participants expressed their beliefs and conflict against the termination of pregnancy. However, due to their professional code of conduct, they must assist patients who needed the service. Other nurses, however, argued that due to their religion, it is against their will to perform termination of pregnancy to patients. They further expressed how it felt inappropriate to provide condoms to teenagers as they would be encouraging the teenagers to have sexual intercourse. Regarding the role of nurses in addressing teenage pregnancy, various challenges are faced by healthcare workers in going to schools and sharing sexual education with learners. In a study by Ramalepa at Madibeng Municipality (2023), community health care workers argued that it is their role to provide health education to learners to prevent pregnancy and contraceptive use. However, the outreach to schools has declined. Other participants in the study shared that they encourage learners to come early to the clinic as opposed to the afternoon and to utilise youth-friendly clinics. There are nurses who argued that they are trained for youth-friendly services, and others indicated that they have attended training or workshop on youth-friendly services at clinics (Ramalepa, 2023). In a quantitative study by Mushwana, Monareng, Richter and Muller (2015) in Greater Giyani Municipality, Limpopo Province, 73% of participants expressed how

the relationship and attitude of healthcare workers at clinics are poor and negative and there is a lack of privacy and confidentiality.

In 2012, the National Department of Health unveiled several initiatives aimed at preventing teenage pregnancies. The Integrated School Health Policy (ISHP), the updated National Contraceptives Guideline Policy and a brochure titled "Preventing Teenage Pregnancy" are among the policies in question (Shaikh, Grimwood, Eley, Fatti, Mathews, Lombard and Galea, 2021). These were all jointly introduced by the Departments of Health and Basic Education. The National Department of Health launched the Adolescent Youth Health Policy in 2017 as an additional measure to reduce teenage pregnancy. As a co-signatory to the ISHP policy, the Department of Education recommended that School Governing Bodies (SGB) support the authorisation of condom availability in schools as their attempts had been received with opposition and negative attitudes from the general population (Khoza, Zulu and Shung-King, 2019). Japan and the United States have demonstrated the effectiveness of having school-based healthcare in school premises for the sake of pupils (Keeton, Soleimanpour and Brindis, 2012).

Although there is free healthcare, the cost of transportation and the distance to travel frequently prevent receiving effective healthcare services and prompt treatment. In a study conducted in the Eastern Cape, the participants shared how challenging it is to access healthcare facilities as they must use transport whereas the road infrastructure is underdeveloped and inadequate. There is no railway line, and the availability and cost of public and private transportation are highly reliant on the state of the roads and the surrounding weather, neither of which favour the usage of motorcycles or even bicycles. Due to the low number of drivers and the majority's inability to purchase a private four-wheel vehicle, the most popular modes of transportation are walking and donkey carts. One must go a considerable distance on foot to get to the fixed government health facilities in the Mbashe district, which was the area of focus in the study. The results of the study showed that it takes an average of 9 kilometres of walking to get to a healthcare facility in the district. To add, four communities in the Mbashe district had to cross the river to reach their closest local clinic. Khoza, Zulu and Shung-King (2019) describe the difficulties that exist in remote areas where citizens struggle to access services. In some areas, they must travel distances to access healthcare facilities.

2.5.6 The influence of media on teenage pregnancy

The media in modern society plays a significant role in displaying and mirroring society. It further plays a role in shaping lives. Globally and locally, the purpose of the media is to inform citizens regarding current news affairs. The behaviours, attitudes, and perspectives of adolescents can be significantly shaped by the media, particularly concerning sexuality and reproductive health. Social media, television, movies, advertisements, and digital initiatives exert influence on teen pregnancy by shaping behaviours that can be either beneficial or detrimental (Ngwenya and Moeketsi, 2022). Media platforms also share information on education, entertainment, advertising and geographical divisions (Loja, 2022). The influence of media has impacted society as it shares information with the masses, thus shaping their views, opinions and judgements on various issues. Information regarding the global world has become available in various forms of media (Ramathuba and Mashapha, 2019). People consume mass media, and the popular forms of mass media usually consumed are newspapers, magazines, radio, television, social media and the Internet.

In modern society with accessibility to technology and forms of mass media, citizens from teenagers to adults consume the media and new forms of mass media such as social media. Ngonso (2019) explains how social media plays a part in teenagers' lives, using platforms such as Facebook, Instagram, YouTube and WhatsApp. Social media serves as a platform that enables users to create online identities, communicate, and build social networks with other people. Social media can have positive and negative effects on the user's lives. Harmful ways in which social media can have negative effects are distracting their lives or academics and exposing them to bullying and peer pressure (Umar and Idris, 2018).

The media portrays various components and contents on their platforms, sexual activities being part of those contents. Sexual content in the media can be available and affect any age group; however, adolescents are likely to be vulnerable due to the exposure. Many advertisements, particularly in fashion, beauty, or lifestyle industries, contribute to the sexualization of teenagers. These advertisements often focus on attractiveness and desirability in ways that may encourage risky behaviour or reinforce unhealthy ideas about sexuality, without providing information on the consequences or prevention of pregnancy (Cook and Cameron,2020). The vulnerability is a result of the adolescent stage, which is a developmental period whereby gender roles, sexual

attitudes and sexual behaviours are shaped. A study by Usonwu, Ahmad and Curtis-Tyler (2021) found that on average, teenagers view sexual behaviour content on television. This adds to movies, music videos and series. Data has shown that adolescents use sources of media as a reliable form of information.

A study in Zambia found that adolescents are exposed to forms of mass media and consume it. The participants in the study were women from both rural and urban areas. 24.4% of the women who reside in urban areas had access to the internet and forms of traditional media. This was opposed to women from rural areas, which resulted in 46% of them not having access to the internet, radio, television and newspapers (Sserwanja, Sepenu, Mwamba and Mukunya, 2022).

Gray (2022) adds that the media can be utilised as a platform to create awareness for family planning, sexuality education, behavioural changes and addressing fallacies and myths about sexual desires. Data analysed from the Asian continent with focus on three countries reported that the use and access of mass media influences attitude and behaviour towards sexual intercourse-related knowledge of young people. Teenagers rely on the media for information. Information on sex education and various explicit content can be consumed in the media.

Vannucci, Simpson, Gagnon and Ohannessian (2020) explain how social media has shaped the thinking of teenagers. The influence of their thinking is directed at how they perceive and approach pregnancy and sexual intercourse. The misinformation and misleading knowledge or information can spread negatively to their sexual health, leading to unintended consequences and making misguided decisions (Vannucci et al., 2020).

Moreover, peer pressure from online platforms can influence impulsive decisions related to sexual activities; and the other risk is a lack of precise information on safe sex (Zuma, Seeley, Mdluli, Chimbindi, Mcgrath, Floyd, Birdthistle, Harling, Sherr and Shahmanesh, 2020).

2.5.7 Early Sexual Debut

Unintentional teenage pregnancy can be caused by early sexual debut, which is generally described as the first sexual encounter at or before the age of 14. An early sexual debut raises the risk of HIV, unsafe abortions, and other STIs in young people.

Early sexual debut can also be caused by sexual coercion or violence. In addition to being linked to early sexual debut and sexual risk-taking behaviour, sexual coercion, and sexual violence are drawing more attention as health issues on a global scale. Young women's capacity to manage their own reproductive decisions and health is put to the test by sexual coercion and sexual abuse (Mostert, Sethole, Khumisi, Peu, Thambura, Ngunyulu and Mulaudzi, 2020). Evidently, when forced sex leads to conception, there is a direct correlation between sexual violence and unwanted pregnancies. Sexual violence typically refers to forced sexual activity, such as rape or being restrained, struck, or threatened. Sexual coercion is the act of forcing (or attempting to force) another person to engage in sexual behaviour against his or her will by violence, threats, verbal insistence, deception, cultural expectations, or economic circumstances. According to a qualitative study carried out in Tunduru, Tanzania, many teenagers start having relationships when they are still quite young, which puts them at a risk of being pregnant (Malisa, 2015). Similar conclusions emerged from a quantitative study conducted in Nigeria, which showed that teenagers start having sex at a very young age (Adetutu, Asa, Solanke, Aroke and Okunlola, 2021). In Ghana, 2 out of 10 girls get pregnant or give birth to their first child before turning 18 (UNICEF, 2022). Early sexual debuts are not rare in South Africa. According to recent studies, an increasing number of teenagers are sexually active by the age of 14 and older (Bosire, Chiseri, Comeau, Richter, Stein and Norris, 2021) and (Mthembu, Maharaj and Rademeyer, 2019).

A study by Mostert, Sethole, Khumisi., Peu, Tambura, Ngunyulu and Mulaudzi (2020) at a South African rural school found that there are children who engage in various forms of sexual engagement at an early age. The study had 79 participants, and one of which argued how their first sexual debut was at age 11 and the oldest sexual debut was 17 years old. The age at which most participants shared to have had their first sexual debut was 15. Some of the male participants (44.9%) in the study agreed to have knowledge that sleeping with a young girl under the age of 16 in South Africa is against the law.

Additionally, a quantitative study by Mothiba and Maputle (2012) on the causes of adolescent pregnancies in Capricorn district of Limpopo Province found that 62% of the study's respondents said they first began having sexual relations between the ages of 13 and 15 years. 54 per cent of them claimed to have started having sex for the first

time between the ages of 16 and 19, while 4 per cent began when they were between 10 and 12 years old.

2.5.8 Peer influence on teenage pregnancy

Teenagers often comply with the sexual standards that are accepted by the social group to which they belong because of peer pressure, which can have a significant impact on how they perceive their sexuality. Finally, peer pressure has been shown to have a substantial influence on teenage pregnancy. There is pressure to believe that something is wrong with you if you are not having both oral and sexual relations and that the stigma of being a virgin is embarrassing and improper in some way. Unprotected sex (using a condom or abstaining from birth control) is another factor, among others. Such actions are careless and regarded as youthful lust or, in some situations, sexual deviance. The social vulnerability of adolescent girls in Vhembe District is further highlighted by peer pressure on the prevalence of teenage pregnancies. Adolescent girls' reliance on gangs and cliques in their socialisation has increased their vulnerability to the occurrence of pregnancy (Sepeng, Mulaudzi, Mathivha, Musie and Seretlo, 2023).

This is demonstrated by the study's findings, which show that adolescents who experienced peer pressure were 3.843 times more likely to become pregnant. Peer pressure was found to be a significant contributor to teenage pregnancy in a study conducted in Capricorn District of Limpopo Province (Mothiba and Maputle, 2012).

2.5.9 Risky sexual behaviour as a contributing factor toward teenage pregnancy

Risky sexual behaviour can be defined as sexual behaviour or acts that may have undesired consequences. Having sexual intercourse without a condom or other barrier device is one example. As a result, STIs and unexpected pregnancies can be increased by not using barrier contraceptive techniques such as condoms and dental dams. Premature sexual activities can lead to unwanted/unplanned pregnancy and sexually transmitted diseases. The use of substance abuse such as alcohol and drugs and multiple sexual partners is likely to contribute to risky sexual behaviours by having unprotected sex (Qolesa, 2017). One of the risky sexual behaviours engaged in is inconsistent condom use as the relationship continues over time, with protected sex associated with being unfaithful or untrusting. Learners who have access to good education and take precautions on the use of substance abuse are less likely to

practice risky sexual behaviour (Mthembu, Maharaj and Rademeyer, 2019). Lack of sexual education, gender inequalities, socioeconomic status and geographical location are believed to be associated with early sexual intercourse in teenagers. The lack of sufficient knowledge on HIV/AIDS prevention, transmission and treatment also places their lives at risk of acquiring the disease. There are also gender imbalances in some relationships where young girls engage in relationships with older males for financial resources. Furthermore, lack of parental support at home and peer pressure also increase the risk of teenage pregnancies (Edwards, Mkwanazi, Mitchell, Bland and Rochat, 2020). According to Govender et al. (2020), teenagers in South Africa frequently engage in unsafe sex, which is known to have several unfavourable health and social consequences. In South Africa, teenage pregnancy ranks first among the negative effects of unsupervised intercourse, ahead of STIs, HIV and AIDS.

In a study conducted by Mostert, Sethole, Khumisi, Peu, Thambura, Ngunyulu and Mulaudzi (2020), the youngest age sexually active teenagers were between the ages of 11- 17 years of age. In another quantitative study by Mothiba and Maputle (2012), 62% of the participants started engaging in sexual activities between the ages of 13 and 15 years. In both studies, similar responses showed how some teenagers have insufficient information on safe sexual intercourse, parental support on information regarding risky sexual behaviours, and imbalances of power in sexual relationships for girls. A study conducted in Limpopo Province by Mabunda, Lebese, Maputle and Chauke (2015) also found low condom use among the participants. The participants also shared to have more than one sexual partner, attending parties intoxicated with substances such as alcohol, which led to unprotected sex, and proving fertility to their sexual partners were among the risky sexual behaviours in which young people engaged in the study.

2.6 The impact of teenage pregnancy

The above literature has highlighted the causes of teenage pregnancy. This social ill affects teenage mothers' lives in different ways. Wuermli, Yoshikawa and Hastings (2021) argued that after the birth of their child, teenage mothers learnt that the postnatal period is considered stressful and overwhelming. School dropout is more common among adolescent mothers. Just over one-third of them complete high school.

Teenage females commonly drop out of school as they find it difficult to manage school, adolescence and parenthood on their own. Low birth weight is more prevalent in children whose mothers are teenagers. A higher rate of newborn mortality and several infant and developmental disorders are linked to low birth weight. They are less likely to obtain a diet that is nutritious and adequate. They face the risk of experiencing more difficult educational achievement as a result. Children born to teenage mothers are more likely to face social, emotional, cognitive and other issues, in addition to greater health concerns.

2.6.1 Dropping out of school an effect of teenage pregnancy.

Teenage pregnancy affects and compromises teenage girls' development opportunities, and dropping out of school can hinder their formal education, which can affect their skills while seeking better employment opportunities and productive disadvantages, which can make them vulnerable to poverty, violence, crime and social exclusion (Mchunu, Peltzer, Tutshana and Seutlwadi, 2012). Across Africa, teenage pregnancy seems to result in teenage mothers ending their schooling (Nkosi and Pretorius, 2019). Nearly 3% of 15-year-olds and nearly 9% of 17-year-olds dropped out of school in 2021 (Stats SA 2022). One of the causes of school dropout among children in the country has been identified as teenage pregnancy.

Pregnant teenagers and mothers are likely to face discrimination and lack of support in their communities, families and schools, which can lead to them dropping out of school. The burden of teenage pregnancy is likely to negatively affect financially disadvantaged teenage mothers who do not have financial support at home or from their partners to care for them or their child. However, mothers who have support at home and assistance with childcare are likely to return to school and complete their studies. Teenage mothers are motivated by their children to complete school to benefit themselves and their children. A study by Tebb and Brindis (2022) found that some teenage mothers view their child as a motivating factor to pursue education, challenging the traditional narrative that teen motherhood leads to school dropout. The study emphasizes the importance of supportive environments, such as family and school-based resources, in enabling these mothers to balance parenting and education. Shuger (2020) suggests that when teenage mothers are supported to finish high school or further their education, they are more likely to break the cycle of poverty

and offer a better future for their children. Their ability to earn a stable income improves, and their children often perform better academically as a result.

A population-based study carried out in Cameroon found that there are teenage mothers who are evicted at home, and this affects their schooling, resulting in them dropping out of school (Sobngwi-Tambekou, Tsague-Agnoux, Fezeu and Ndonko, 2022). 42.3% of the participants had dropped out of school from the 18,791 teenage mothers. In an article by Timaeus and Moultrie (2013), it was found that young girls who did not have children during their school year completed their studies in time as opposed to young girls who gave birth. In the Northern Cape, Joe Morolong Local Municipality also has concerns regarding the number of dropout cases rising post-birth from teenage mothers with pressure to earn income, lack of parental support, and association with criminal gangs and sugar daddies contributing to reasons why learners are unlikely to return to school (SABC NEWS, 2023).

In a study by Mushwana, Monareng, Richter and Muller (2015), it was found that high school teachers in Giyani District Limpopo supported the fact that teenage pregnancy affects the mother's class attendance or having to leave school earlier to provide care for their child. An article by Pretorius and Nkosi (2019) found that one of the reasons teenage mothers drop out of school is because they are left behind with their academic activities before giving and the first few weeks of giving birth. In an interview, the Minister of Education in SA announced that 120 000 learners fall pregnant ever year, and only a third of the number return to school.

2.3.2 Low labour force

Unwanted teenage pregnancies that result in either birth or abortion result in fewer years of education completed. Lower salaries and a proportional decline in labour supply in the market are affected as a result of poor education attainment (Gallen, Joensen, Johansen and Veramendi, 2023). According to research by Bergstrom and Özler (2023), teenagers who fall pregnant during their teen years are likely to experience poorer short-term labour market outcomes as opposed to their peers who do not fall pregnant. Additionally, if they grew up in areas with high rates of poverty and inequality, they are likely to have poor expectations for future labour-market success.

In South Africa, there is a high unemployment rate which was at 32.9% in the first quarter of 2023, according to STATS SA. Teenage pregnancy is reported to be among the contributing factors as teenage mothers drop out of school or have low educational skills. This results in them seeking job opportunities in the informal sector.

2.6.3 Sexually transmitted diseases/infections

Countries in the East and Southern Africa are exposed to teenage pregnancies, with dire consequences. The region's persistent high rates of new sexually transmitted diseases (STIs), particularly HIV, are cause for major concern. Each week, 4,200 young women aged 15 to 24 are infected with HIV, with girls accounting for six out of every seven new HIV infections among teenagers. While women and girls are biologically more vulnerable to HIV than men and boys, gender inequalities are also a major cause of the epidemic in their case. Furthermore, the prevalence of practically all STIs remains disturbingly high, with many morbidities affecting the health and well-being of girls now and in the future, including fertility. Another sexually transmitted virus, Human Papillomavirus (HPV) can be acquired during adolescence and have potentially fatal implications; cervical cancer mortality is highest in East and Southern Africa. Pregnancy rates and HIV infections among 9 to 19-year-olds in a Limpopo community are alarmingly high. According to 2018 disclosed data from rural clinics outside Thohoyandou, children as young as nine are becoming pregnant or contracting HIV (The Citizen, 2019).

2.6.4 Isolation and stigma

Stereotypes that portray teen mothers as lazy, careless and incompetent parents stigmatise them. Despite the prevalence of these misconceptions, stigma is rarely cited as a cause of the challenges faced by teen mothers, as well as the health and social inequities they experience (SmithBattle, 2013). Teenage mothers experience negative perceptions and discrimination, just like other stigmatised groups, which results in stress, humiliation, social isolation and health disparities.

Teenage pregnancies, particularly those of unmarried teenagers, are socially stigmatised in many societies because most of these births are unwanted and unexpected. It affects every level of society (Ventura, Hamilton and Matthews, 2014). Before the 1970s, pregnant and parenting teenagers were rarely stigmatised. From the 1940s to the 1970s, teenage birth rates were high but premarital sex was hidden

through marriages and adoptions (SmithBattle, 2013). Single mothers of any age faced severe scrutiny and stigma as marriages and adoptions decreased. In response to the perception that women have "ruined their lives," they view mothering as a motivator for returning to school, refraining from dangerous conduct and becoming decent parents. Teenage pregnancy and motherhood are stigmatised in both developing and developed countries, with stigma emanating from peers, institutions like schools and hospitals, as well as the general public (Tinago, Frongillo, Warren, Chitiyo, Cifarelli, Fyalkowski and Pauline, 2021). In a study by Thongmixay, Essink, Kahrs, Vongxay, Wright, Sychareun and Broerse (2023), the participants shared how they isolated themselves from their family and community due to stigma and negative comments they would receive in their community or at school. Other participants shared how their friends were isolated from them after finding out they were pregnant. It is difficult to make sure friends navigate their way into social settings.

Tinago et al. (2021) state that these circumstances, if not dealt with, may have detrimental effects on the adolescent mother's mental health as well as downstream consequences for her child.

2.6.5 Health and well-being

Teenage pregnancy and motherhood can affect the teenager's health and well-being in various ways, posing a risk to both the mother and child. Preeclampsia, a type of high blood pressure associated with pregnancy, and its complications are more common in teenagers than average-age mothers. Low birth weight and early birth are risky for the baby (Ochen, Chi. and Lawoko, 2019). Preeclampsia can potentially cause renal damage or could be deadly to the mother or the unborn child. Teenagers who are pregnant are also more likely to develop anaemia. Reduced levels of red blood cells (RBCs) are referred to as anaemia. This may make the teenage mother feel weak and exhausted and may have an impact on the development of the child (Abu-Ouf and Jan 2015).

As stated by WHO (2021)18, roughly 3.6% of adolescents aged 10 to 14 years and 4.6% of adolescents aged 15 to 19 years have an anxiety disorder, whereas approximately 1.1% of adolescents aged 10-14 years, and 2.8% of adolescents aged 15-19 years have depression. Another research found that teenage mothers experience high levels of stress, which may lead to mental health issues, and teenage

mothers experience increased depression rates in addition to higher postpartum depression rates (Dahmen, Konrad, Jahnen, Herpertz-Dahlmann and Firk, 2019; Roberts, Smith, Cluver, Toska and Sherr, 2021). Additionally, they have more suicidal thoughts than their peers who are not mothers. WHO (2021) estimates that the prevalence of depression in adolescent mothers range from 16% to 44%, whereas estimates for the prevalence of depression in adolescent and adult women who are not pregnant range from 5% to 20%.

Posttraumatic stress disorder (PTSD) is more common in young mothers than in other teenage girls. This might be the case because teen mothers are more likely to have experienced physical or emotional abuse (Govender et al., 2020). Teenage mothers are more likely to belong to demographic groups where mental health risk is higher. Having parents with poor levels of education, a history of abuse of children, having few social networks, living in unstable and unpredictable familial circumstances, and residing in low-income neighbourhoods are some of these risk factors (Govender et al.,2020. Poor maternal and child mental health during pregnancy and parenthood may have poor effects on maternal and child health, attachment and bonding, lastly the child's development outcomes (O'Connor, Monk and Burke, 2016). Adolescents in South Africa are also exposed to a variety of risk factors for poor mental health, such as poverty, violence and high levels of infectious diseases, such as HIV/AIDS. The risk of poor mental health may thus be exacerbated by the experience of adolescent pregnancy in these kinds of circumstances (Steventon Roberts, Smith, Toska, Cluver, Haag, Wittesaele, Langwenya, Jochim, Saal, Shenderovich and Sherr, 2022). A few factors can lessen the likelihood that a teenage mother would experience mental health problems. A teenage mother's risks are diminished if she has a positive relationship with her family and/or the baby's father.

2.7 Existing interventions on teenage pregnancy

South Africa has a somewhat progressive legislative response to teenage pregnancy and motherhood. There are laws in the country that protect all citizens, children included, to make decisions on their reproduction and access to reproductive health care. South Africa is a signatory to several international agreements, including conventions, protocols and declarations. These bind the nation to uphold standards set forth by those internationally agreed standards, including eliminating any form of

discrimination against women and girls in the sphere of education. This study focuses on selected legislative frameworks.

2.7.1 Government legislative frameworks

Some of the implemented laws are the Choice on Termination of Pregnancy (CToP) Act (No. 92 of 1996), the South African Children's Act (2005), the Criminal Law (Sexual Offences and Related Matters) Amendment Act (Sexual Offences Act) (2007), the Child Support Grant and measures for the Prevention and Management of Learner Pregnancy (MPMLP), to name a few. Although there are multiple programmes and policies available, there are teenagers who do not have sufficient information on the available assistance from the government (Paton, Bullivant and Soto, 2020). The Comprehensive Sexuality Education (CSE) program in South Africa is a crucial intervention aimed at preventing teenage pregnancy. CSE was introduced by the Department of Basic Education and is incorporated into the curriculum of schools to teach students about STIs, safe sexual behaviors, and contraception, as well as other aspects of sexual and reproductive health (SRH) (Adekola and Mavhandu-Mudzusi, 2021).

Policies implemented by the government are believed to influence combating teenage pregnancy and implementing programmes that can build and assist communities. These policies by the government have enabled family planning services, termination of pregnancies, the introduction of life skills and life orientation in schools, and the use of mass media programmes to reach young people (Erzse, Goldstein, Norris, Watson, Kehoe, Barker, Cohen and Hofman, 2021). One of the ways in which the government has assisted young mothers is by allowing them to stay in school during and post giving birth. The Department of Basic Education (DBE) introduced Comprehensive Sexuality Education (CSE) in schools to teach pupils to understand important concepts in life such as healthy lives, self-awareness, sexuality and sexual behaviours. In schools, subjects such as Life Orientation and Life Skills educate about sex education, diseases, and to an extent, family (Pieterse, 2019). It was deemed important for both male and female teenagers to be informed about safe sex and family planning.

In 2015, a programme was introduced that started in five provinces. The name of the programme was the Scripted Lesson Plans (SLPs) to help strengthen CSE in schools. Various programmes have been developed by the DBE to create awareness and

knowledge for pupils in schools, the Young Women and Girls (YW&G) Programme, Breaking the Silence, Determined Resilient Empowered AIDS-free Mentored Safe (DREAMS), and LET'S TALK Prevention of Early and Unintended Pregnancies (EUP) Campaign. The LET'S TALK Prevention of Early and Unintended Pregnancies (EUP) Campaign aimed to combat teenage pregnancy by 75% in 2020. The introduction of sex education has faced criticism from parents and some civil society organisations. Venketsamy and Kinear (2020) explain that teachers need support and effective training to teach learners about CSE. Love Life is one of the campaigns which is aimed at creating awareness for young people to practice safe sex and to prevent HIV/AIDS. The campaign has been effective in communities to engage young people with methods such as Born Free dialogues. The methods provide platforms for parents and their children to have conversations about sex. The National Adolescent-Friendly Clinic Initiative (NAFCI) works together with Lovelife and the Department of Health in advocating for public health institutions to become friendly for young people in their adolescent phase (Dickson-Tetteh, Pettifo and Moleko, 2001). One of the goals of this initiative is for young people to use services provided in clinics to learn about healthy lifestyles and sexuality. While the NAFCI was not available in various areas of the country, it has thrived in increasing male condom provision between the years 2001 to 2011 and reduced the number of teenage pregnancies (Branson and Byker, 2016). The programme only impacted young people who lived within 1km of an NAFCI clinic. In most available programmes, the focus is mostly on preventing HIV/AIDS and not pregnancy. NGOs nevertheless assist in providing awareness and support to teenage mothers and young people on sexual risk behaviours. According to Achen,Fernandes, Kemigisha, Rukundo, Nyakato, and Coene (2023) while CSE has increased awareness of SRH topics, it has not been as successful in reducing teenage pregnancy rates due to inconsistent implementation across schools, insufficient training of educators, and cultural resistance. The Department of Health, the Department of Social Development, and the Department of Basic Education work together to achieve the goal of assisting the challenges faced in society and schools. The analysis of teenage pregnancy interventions in South Africa reveals mixed effectiveness. While interventions such as Comprehensive Sexuality Education, contraceptive access, and community-based programs have shown some success, their impact is often limited by implementation challenges, lack of resources, and cultural barriers (Chavula, Zulu, and Hurtig, 2022). Interventions have been more

effective in urban areas with better infrastructure, while rural areas continue to struggle with high teenage pregnancy rates. Additionally, while legislative frameworks provide a strong foundation for addressing teenage pregnancy, poor implementation and lack of awareness reduce their overall effectiveness (Sepeng et al, 2023).

Financially, the South African Government introduced the Child Support Grant (CSG) through the Department of Social Development. The purpose of the CSG was/is to assist mothers to help care for their children financially up to the age of 17 (Granlund and Hochfeld, 2020). A community healthcare worker has argued that the Departments of Health, Education, and Social Development have a role to play in alleviating teenage pregnancy while working together rather than individually (Ramalepa, 2023).

2.7.2 Non-Governmental organisations (NGOs) and society interventions

Article 71 of the United Nations Charter, which was written in 1945, is where the phrase "non-governmental organization" (NGO) was first used. Although it has been adopted to refer to non-profit organisations or charities in several nations, it is recognised internationally as it refers to independent foreign help in contrast to government-sponsored international aid. Various organisations contribute to South Africa's civil society. These can include a wide range of organisations, from small community-based groups to large activist and advocacy organisations that conduct research, interact with the highest levels of government, and advocate for policy changes. Examples of these groups include early childhood education centres, humanitarian organisations, small community-based organisations, and environmental action groups. Several organisations in South Africa aid teenage mothers and their families. Yourlifeassit NGO (2023) has conducted and shared contributing factors of teenagers, and continues to encourage community involvement in lessening the growing number of teenage pregnancies in Limpopo Province. Sepeng et al (2023) agreed that parents, community leaders, healthcare providers and teenagers themselves are among the stakeholders accountable for preventing teenage pregnancy. Stakeholders need to be effective in addressing the causes of teenage pregnancy at all levels of society. Several activists as well as civilians have signed an online petition requesting that Health Minister Dr. Joe Phaahla implement a rule requiring doctors and nurses at public health facilities to disclose teenage pregnancies. Over 8000 people have

already signed the online petition, showing how many people support the drive to lower the country's high rate of teenage pregnancies and identify cases where statutory rape is to be blamed.

2.8 Summary of Findings

The above literature review has highlighted that teenage pregnancy is indeed a social challenge affecting societies in South Africa and Africa in general. The researcher also highlighted what other scholars, journalists and news organisations have found and researched regarding teenage pregnancy in Limpopo Province. Even with the implementation of existing laws relating to teenage pregnancy, it is evident that teenage pregnancy is a social problem affecting teenage girls in Limpopo Province and the surrounding communities. Additionally, research also reveals that teenage pregnancy affects the health and well-being of teenage mothers. The reasons and outcomes of teenage pregnancy have been the subject of extensive study, but there are still numerous areas that require further research. These include examining how sociocultural influences affect the use of contraception, evaluating the influence of media on behavioural patterns, and assessing the effectiveness of sustained support systems for young mothers. Exploring these areas in future research may lead to more holistic approaches to preventing adolescent pregnancy and aiding young mothers across different settings. There is also a gap in identifying some aspects of the literature that was reviewed focusing on informal settlements or areas that have been developed, such as recent literature on family as a socialisation agent, risky sexual behaviours and the role of culture.

CHAPTER THREE: THEORETICAL FRAMEWORK

In this chapter, the importance of theory in the current study is explained. The chosen theory to address and comprehend the increasing cases of teenage pregnancy is the social learning theory. According to this theory, individuals acquire social skills by observing and imitating the actions of others i.e., their family members. The theory was first introduced by Albert Bandura, a renowned psychologist.

Theories are developed to clarify, foresee and comprehend facts as well as, in many cases, question and extend known information within a framework of crucial limited assumptions or behavioural predictions (Van der Waldt, 2021). Van der Waldt (2021) emphasises that in social science, theories are crucial because they offer a framework for comprehending and describing social phenomena. Researchers can make predictions about future human behaviour and the causes of those behaviours using social science ideas. They are also helpful in organising and explaining study results. Bhattacherjee (2012) explained a few key points on how theory is crucial and effective in research, namely: the ability to organise data, offer techniques to arrange data and to interpret study results.

Researchers could find patterns and links in their data by utilising theoretical frameworks, which can result in innovative insights and ideas. Research guidance provides research direction by highlighting important factors and interactions that need to be investigated. This may help to narrow the focus of research efforts and raise the possibility of obtaining significant findings. Theories provide explanations thereby giving reasons as to why social phenomena take place. Theoretical frameworks can assist both scholars and practitioners in developing interventions and policies that are effective by understanding the fundamental causes of behaviour and social structures.

A theoretical framework serves as the study's "blueprint" in every aspect and specifies how the researcher will approach the study from a philosophical, epistemological, methodological and analytical standpoint. It also served as the foundation upon which to build and support the study (Grant and Osanloo, 2014).

3. The Social learning theory

The theory applied in this study is the social learning theory by Albert Bandura. The premise of the social learning theory is that people observe the behaviour, attitudes, and outcomes displayed by others and then use the information to develop their behaviours. Learning happens through observation. By simply imitating a model, learners might pick up new skills and knowledge. Both punishment and reinforcement have unforeseen repercussions for behaviour and learning. Based on how current responses are rewarded or punished, people develop expectations about the possible outcomes of future actions (Bandura and Hall, 2018). People's behaviour is influenced by mediational processes—cognitive factors which determine whether a behaviour is learned or not. Change is not always the result of learning, the simple fact that someone learns something does not guarantee that they will change their behaviour. Researchers have examined how individuals influence each other using the social learning theoretical perspective as a framework.

For the purpose of this study, the social learning theory was chosen as it can be applied to understand teenage pregnancy by examining how social factors, environmental influences, and learned behaviours contribute to teenage pregnancy. The social learning theory addresses teenage pregnancy through the interventions that can focus on the provision of comprehensive sex education, positive role modelling, and support systems that promote healthy decision-making (Abbott, 2021). Teaching teenagers about responsible sexual behaviour, contraception and the realities of parenting can help counteract potential influences that contribute to early pregnancy (Abbott, 2021).

The social learning theory is founded on three principles, individuals learn by example or what is observed; people have internal awareness, also known as intuition, as a means of understanding or learning knowledge; and one can observe and think without changing their behaviour. The learning theory is used to emulate real-world scenarios and to promote positive youth development, which can assist in

investigating how, if at all, motivational cues and social guidance influence teenagers' future life choices (Hall and Farkas, 2011; Sparks, 2015). Social learning theory has been utilised by researchers to investigate the cause of teenage pregnancy. A significant part of the theory has contributed to or studied pregnancy among teenagers exploring peer pressure, family dynamics, teenage sexual activity, and birth control methods. As a result, studies consistently demonstrate that social interactions and external factors have an impact on sexual behaviour (Mezmur, Assefa and Alemayehu, 2021; Ahinkorah, 2020; Strunk, 2008).

3.1 The four fundamental premises of the social learning theory:

Differential association

According to differential association, people are exposed to a range of behavioural models and acceptable and undesirable actions by those whom they come into contact with, both directly and indirectly. A person's immediate social circle produces behavioural models, which serve as a source of behaviour imitation. The people in a person's immediate social circle are their family, friends, neighbours, teachers and church organisations (Smith, 2021). These social organisations instil beliefs, values and attitudes that a person can absorb and internalise. Additionally, they establish proper social behaviour norms of conduct.

Role models play a significant role in shaping teenagers' attitudes and behaviours. If influential individuals in a teenager's life, such as family members or community figures, had pregnancies at a young age, it might impact the teenager's perception of pregnancy and parenthood. Peer groups and social circles can also influence attitudes towards sex, contraception and pregnancy.

Definitions

Smith (2021) explains that definitions are what an individual interprets and believes to be acceptable behaviour, moral principles and personal views. Differential association usually serves to create and strengthen definitions. Certain acts and behaviours would automatically be minimised if definitions adhered to customary and traditional values. For example, if definitions endorse aggressive and illegal behaviour, it will persuade someone to follow this course of behaviour. Adolescents tend to learn by observing

others, a process that is commonly known as vicarious learning. They are likely to imitate the behaviour of those they identify with and learn by engaging in similar behaviours. This means that individuals who are closer to them, such as peer groups and those in their immediate social environments, have a significant impact on their behaviour. This suggests that the application of the social learning theory in the study of how peers and family influence teenage pregnancy demonstrate that teenagers may learn from their exposure to and affiliation with peers or family members who participate in risky sexual behaviours and who hold permissive sexual attitudes that these behaviours are desirable. As a result, young people may be more likely to engage in risky sexual behaviours, which may raise the risk of early pregnancy.

Differential reinforcements

The process through which people feel and foresee the results of their actions is known as differential reinforcement. If the consequences are unpleasant, it may discourage the same action in the future. Positive or negative reinforcement can result from different associations and imitations of values, attitudes and beliefs. Through satisfying outcomes and rewards, positive reinforcement raises the likelihood that the same behaviour will occur (Smith, 2021). The goal of negative reinforcement is to punish or discourage behaviour with severe negative consequences or outcomes. Therefore, reinforcement helps to ensure that behaviour is repeated. Generally, people receive reinforcements from their interactions with family, peer groups and the external environment.

In relation to this study and teenage pregnancy, societal responses such as stigma, support, or lack thereof, can act as reinforcing or discouraging factors. For instance, if a community stigmatises pregnant teenagers or lacks support systems, it may discourage safe sexual practices or seek assistance for contraception.

Imitation

Imitation is the last element. People participate in actions that they have previously seen their models perform; and individuals imitate the models after observing their traits, actions and the results of their actions (Bandura and Hall, 2018). People with whom one is in close proximity will, for the most part, become sources of imitation.

The four fundamental learning criteria are the primary ideas underpinning this approach. According to social learning theory, these four actual stages in social learning include attention, retention, memory, initiation, motor behaviour and motivation. Instances of social learning theory are frequently seen in daily life (Bandura and Walters, 1977). One of the most striking instances is how young people behave when they imitate their peers, family members, celebrities, and even fictional characters on television. Children will eventually engage in such conduct if they believe they will eventually receive a worthwhile reward. People emulate others on social media in a variety of ways, including acting out movie scenes, mimicking dancing motions in music videos, and participating in a variety of social media challenges. Usually, the need to be accepted or liked by others drives this irrational behaviour. Additionally, in the context of teenage pregnancy, adolescents might mimic the behaviours related to unprotected sex, lack of contraceptive use, or early parenting if they witness or perceive such behaviours as normative or acceptable within their social circles.

Approaches of teenage pregnancy prevention intervention have shifted slightly from sex education to positive youth development. To promote developmental skills, such programmes have blended integrated personal perception and social competence. Teenage pregnancy prevention training has yet to embrace relationship building as a model for prevention, from risk reduction for unplanned pregnancies and sexually transmitted diseases to comprehensive developmental and cognitive skills building. To influence how individuals relate to one other, the social learning theory proposes a regimen of activities similar to real-life social situations and human encounters. The key element of this theory is that it can be effective in understanding why teenage pregnancy occurs and why it may happen repeatedly. It will also analyse different aspects of a young mother's life, as well as what has led to early pregnancy using concepts such as differential association, definitions, imitation and differential reinforcement (Rotter, 2021). Hancock (2012) explains that when teenagers associate with peers who engage in risky behaviours, there is a probability that they will also engage in risky behaviours, such as risky sexual behaviours. People are more likely to embrace definitions that are supportive of risky sexual behaviours and to conform to these risky behaviours when they associate with peers who engage in risky sexual behaviours. The application of the social learning theory to the study of peer influence

on teenage pregnancy shows that teenagers may learn from their exposure to and affiliation with peers who engage in risky sexual behaviours and who hold permissive sexual attitudes that these behaviours are desirable (Hancock, 2012). Consequently, teenagers may be more inclined to engage in risky sexual behaviours, which may raise the risk of becoming pregnant at an early age.

In this study, the researcher concentrated on teenage mothers from an informal settlement, Extension 78, Polokwane as a sample population. The researcher applied the social learning theory model to deconstruct the behaviour, perceptions, actions and attitudes of teenage mothers by gaining insight from participants. The theory has helped in understanding the social phenomenon of teenage pregnancy and will further provide possible interventions in minimising the growing number of teenage pregnancies.

The theory has guided the researcher to develop a better understanding of the causes of teenage pregnancy, such as the influence of peer pressure, the media, early sexual debut and risky sexual behaviours. Bucknall and Bick (2019) discussed how the effects of teenage exposure to sexual content on their behaviour are another factor that contributes to teen pregnancy. The dominance of media concerning its influence on societal behaviours is taken into consideration by the social learning theory.

The environmental influence that television pictures have on viewers' mental and behavioural processes is emphasised by the social learning theory. Teenagers gravitate to media content, and in contemporary society, it is uncommon for a show to be explicit of sexual content. Teenagers' reactions and responses to situations presented in social environments are influenced by the relationships in which they are involved. According to the social learning theory, teenage pregnancy is a learned behaviour. From their family, peers and the media, teenagers learn about sex and relationships. They are more likely to engage in risky sexual activity themselves if they observe someone they admire doing so. Through positive reinforcement and encouragement fostered through the social learning theory, the health status and general lifestyle of teenagers and teenage mothers can improve (Tillman, 2016).

3.2 Limitations and criticism of the social learning theory:

When discussing teenage pregnancy, this theory offers insights into how adolescents may learn and adopt behaviours related to pregnancy and parenthood. However, it also has limitations when applied to understanding the complex issue of teenage pregnancy, as it:

Underestimates individual agency

It may not fully account for individual differences and the ability of individuals to act autonomously. It somewhat diminishes the role of personal choice and self-determination in learning.

Limited scope of observational learning

Not all learning occurs through observation. Some learning experiences may involve trial-and-error, direct experiences, or implicit learning, which the social learning theory does not entirely encompass.

Overlooks cultural differences

The theory does not adequately address the influence of cultural variations and how different cultural contexts might impact observational learning processes.

In the context of this study, the limitations of the social learning theory include:

Oversimplification of factors

The social learning theory primarily focuses on how individuals learn through observation and modelling. It may oversimplify the multitude of complex factors contributing to teenage pregnancy, such as socioeconomic status, cultural norms, access to education and healthcare, family dynamics, peer influences, and individual psychological factors. Ignoring these broader contextual elements can limit the theory's explanatory power.

Neglect of structural influences

The theory often overlooks structural influences and systemic factors that contribute to teenage pregnancy rates, such as lack of comprehensive sex education, limited access to contraception, poverty, inadequate healthcare, and societal attitudes

towards adolescent sexuality. These factors significantly impact teenagers' choices and behaviours beyond mere observational learning.

Individual agency versus societal factors

While the theory acknowledges the influence of social environments, it may downplay the agency and personal choices of individuals. Teenage pregnancy is a result of a complex interplay between personal decisions and external influences. The social learning theory might not fully account for how individuals navigate these competing influences.

Limited focus on cognitive processes

The theory highlights observational learning but does not deeply explore cognitive processes, such as decision-making, risk assessment and goal setting, which play a crucial role in adolescent behaviours, including sexual activity and contraceptive use.

Cultural variations and norms

The social learning theory's applicability might vary across different cultures and societies due to variations in norms, values and attitudes regarding sex, relationships and parenthood. It may not adequately address how cultural contexts shape behaviours related to teenage pregnancy.

Failure to account for unintended pregnancies

The theory might struggle to explain unintended pregnancies, where individuals may not intentionally model behaviours related to pregnancy but still find themselves in such situations due to various factors, including lack of knowledge about contraception or peer pressure.

In conclusion, from the standpoint of the Social Learning Theory, teenage pregnancy can be understood as a phenomenon influenced by observations, modelling and the internalisation of behaviours and attitudes learned from the social environment (Hancock, 2012). Adolescents may adopt behaviours related to sexuality and pregnancy based on what they observe and learn from those around them, impacting their decisions and actions regarding sexual activity and pregnancy prevention. Limitations arise when attempting to comprehensively explain the multifaceted nature

of teenage pregnancy, often failing to account for broader societal, structural, cultural, and individual factors that contribute to this complex issue (Van der Waldt, 2021).

CHAPTER FOUR: RESEARCH METHODOLOGY

An overview of the research methods used in the study is provided in this chapter, which also gives details about the study's participants, including what was required for participation in the study, the profile of the participants, and the methods used to sample them. The researcher explains the selection of the research design and its rationale in the research study, a description of how data was collected and the type of research design. The methods that were utilised to analyse the data are also covered. Finally, the ethical considerations and quality criteria steps are presented.

4. Research methodology

The research methodology outlines the steps taken to investigate the research problem and the justification for the use of procedures or techniques used to locate, pick, process and analyse data relevant to understanding the problem (Gupta and Gupta, 2022). This information enables the reader to critically assess the overall validity and reliability of a study.

This chapter describes the qualitative research methodology used in the study to investigate the lived experiences of teenage mothers residing in Extension 78, Polokwane,South Africa. The chapter aims to explain the research method used in the study and to reflect on some of the experiences of the researcher while collecting data that either made the process possible or difficult. This includes the kind of tools and procedures used, as well as the reasons given for selecting the methods. The research question provided the context within which the lived experiences of teenage mothers were investigated. The sampling method, data collection method, measures to ensure trustworthiness and ethical issues are discussed.

The research methodology enabled this research study to obtain and gain insight into the lived experiences of teenage mothers and to understand their society better through qualitative research. Qualitative research is the research method applied in this study, a form of social science research that aims to interpret meanings from non-numerical data to better understand social life by focusing on specific groups or locations (Kostere and Kostere, 2021). This is opposed to quantitative research, which applies statistical procedures to ascertain causal and correlative links between variables, and analyses numerical data to discover broad trends (Mehrad and Zangeneh, 2019). Kostere and Kostere (2021) describe the methods of qualitative

research, namely, observation, interviews, open-ended surveys, focus groups, content analysis of visual and textual materials, and lastly, oral history.

Study Area:

Extension 78, Polokwane- An informal settlement in Polokwane Municipality, South Africa.

South Africa- officially the Republic of South Africa, is a country in Southern Africa that encompasses the Cape of Good Hope, where the Atlantic and Indian Oceans meet. It is bordered to the north by Namibia, Botswana and Zimbabwe, and to the northeast by Mozambique (Butts and Thomas, 2019).

Data for this study was collected at an informal settlement Extension 78, Polokwane, South Africa.It is an informal settlement in Polokwane alongside Nelson Mandela Drive, located between Seshego Township and Polokwane CBD in Limpopo Province. The majority of residents in Extention 78, Polokwane are Blacks of various South African ethnic groups (Sepedi, isiZulu, isiXhosa, Xitsonga and Tshivenda). These ethnic groups originate from various regions of the province of Limpopo and other provinces of South Africa, while others come from close by nations like Zimbabwe, Mozambique, Swaziland and other parts of Southern Africa (Chidi, 2011). The above-mentioned ethnic groups moved from their various home countries to the Extention 78 area. The residents moved to Extention 78 as a form of rural-to-urban migration for better economic opportunities as it is closer to town. The Department of Human Settlement in 2019 allocated 200 RDP houses to Extention 78 which was an example of a typical informal settlement with limited access to essential services (Jacobsen and Nichols, 2011). The community was exposed to environmental dangers, the citizens did not have a sewage system, and waste was deposited nearby, leading to hygiene issues in their houses made of corrugated iron shacks (Jacobsen and Nichols, 2011). The area had limited infrastructure, and the population density made it challenging for emergency services to reach the area. Because there was no electricity available, residents utilised candles and paraffin lamps. The Municipality provides water through a few shared taps to the community.

4.1 Research Design

The research design refers to the strategy and analytical technique selected to integrate, coherently and logically, the many study components, thus guaranteeing a full investigation of the research problem. The design serves as a guide for gathering, measuring and interpreting information and data (Sileyew, 2019). The type of design selected is determined by the research problem. This study employed the exploratory design. When there are few or no prior studies to refer to or rely upon to anticipate an outcome, an exploratory design is used to investigate the research problem. Gaining knowledge and understanding for future research is the main goal, or it may be done when research problems are still being investigated (Bless, Higson- Smith and Sithole, 2013). Exploratory designs are frequently used to determine the best course of action to investigate a problem or the most efficient information-gathering method. The exploratory research design allowed the researcher to thoroughly explore the background and contributing factors of the social causes of teenage pregnancy and challenges endured by teenage mothers at “Extention 78”. This design will also assist in bridging the gap for studies relating to teenage pregnancy in semi-urban areas and to answer the ‘what’, ‘why’ and ‘how’. The explanatory design has also given a realistic portrayal of how teenage pregnancy has affected the participants and their families. In some settings, the social causes of teenage pregnancy are under-researched, particularly in informal settlements or informal settlements which have upgraded to formal settlements or marginalized communities. Exploratory design is ideal for investigating such topics, as it allows the researcher to map out previously unexplored social phenomena. The results of the study are described and explained through the data collected.

4.2 Profile of Participants

The sample of the study comprised 16 teenage mothers residing in at an informal settlement Extension 78, Polokwane, South Africa. See the table below for information.

Participant	Race	Age	How old were you when you got pregnant	Father of the child's age	Currently enrolled or dropped out.	Highest grade.	Was pregnancy planned or unplanned?
#1	Black	16	15	19	Enrolled	Grade 10	Unplanned
#2	Black	19	18	20	Enrolled	Grade 10	Unplanned
#3	Black	19	15	22	Enrolled	Grade 11	Unplanned
#4	Black	18	16	24	Enrolled	Grade 11	Planned
#5	Black	18	16	25	Enrolled	Grade 11	Unplanned
#6	Black	16	13 and 16	17 and 32	Enrolled	Grade 10	Unplanned
#7	Black	18	17	22	Enrolled	Grade 11	Unplanned
#8	Black	18	16	Not known	Enrolled	Grade 9	Unplanned
#9	Black	18	17	20	Enrolled	Grade 12	Unplanned

#10	Black	17	17	20	Enrolled	Grade 11	Unplanned
#11	Black	18	15	21	Enrolled	Grade 12	Unplanned
#12	Black	19	15	23	Enrolled	Grade 12	Unplanned
#13	Black	17	15 and 16	20	Enrolled	Grade 10	Unplanned
#14	Black	18	17	18	Enrolled	Grade 11	Unplanned
#15	Black	18	15 and 17	32	Dropped out	Grade 9	Unplanned
#16	Black	19	17	28	Dropped out	Grade 10	Unplanned

The study interviewed 16 research participants; the research participants were profiled according to the age when they fell pregnant additionally there are research participants who gave birth at different ages too. One teenage mother fell pregnant at the age of 13. Six fell pregnant at the age of 15, five fell pregnant at the age of 16, six fell pregnant at the age of 17 and one at the age of 18. Out of the 16 research participants, three fell pregnant again in their teenage years being participants 6,13 and 15.

The participants were chosen as they met the requirements for the objectives of the study considering their ages being teenage mothers and the area in which they reside, a former informal settlement. The various ages, races, and whether in school or dropped out assisted the study in having more insightful lived experiences of the participants and the findings shaped the themes that emerged. The researcher did not meet any potential participants from another race thus the research participants are

black as the area “Disteneng” Extension 78 is predominantly black citzens residing in the area.

4.3 Population sampling

This study employed non-probability sampling techniques and also applied two sampling methods; purposive and snowballing sampling. With non-probability sampling methods, not all members of the community or population have an equal chance of participating in the study as opposed to probability sampling (Bless et al., 2013). The potential limitations to non-probability sampling is that research participants are not randomly selected, and the findings cannot be generalised to the entire population. This may result in selection bias, as certain groups within the population might be overrepresented or underrepresented. Purposive sampling can be described as the type of sampling selection method where the sample is selected based on the in-depth knowledge and/or experience of the phenomenon being studied (Khoa, Hung, and Hejsalem-Brahmi, 2023). Snowball sampling, frequently utilized in qualitative research, is a non-probability sampling method. It is particularly valuable for reaching inaccessible, hard-to-find, or specialized populations that are challenging to locate using traditional approaches (Gierczyk, Gromkowska-Melosik, Scott, and Parker 2023). When using purposive sampling, the researcher had the opportunity to actively choose participants from diverse backgrounds to ensure the representation of various experiences. For instance, as the study focused on teenage pregnancy, the researcher chooses to involve participants from different ages, educational backgrounds (in school and dropped out), and socioeconomic statuses to encompass a wider range of experiences. Purposive sampling was selected as the intended participants of the study were teenage mothers, who had lived experiences of teenage pregnancy and were within the age range which helped the researcher reach the study’s aim and objectives. This does not disregard the other teenage girls in the community. Snowballing sampling was employed as other research participants referred the researcher to teenage mothers who had dropped out of school in the community. Combining purposive and snowball sampling can provide researchers with access to hidden or hard-to-reach communities, offering valuable insights that would otherwise be challenging to obtain.

However, in this study, the researcher focused only on teenage mothers. The sample of the study was drawn from teenage mothers at a secondary school in Polokwane near “Extension 78” with participants who had dropped out of school. The sample was drawn from their community. All participants had to be between the ages of 12-19, in or out of school.

4.3.1 Sampling procedure

The selection of teenage mother participants was steered by their ages. The participants had to be residents of Extension 78, Polokwane, South Africa and be teenage mothers. After showing interest in the study, the potential research participants shared their contact details and when they would be available for further information on the study. The study excluded teenagers who were currently pregnant and those who were minors and showed interest in participating in the study, but their guardians or caregivers refused to sign the consent form.

The participants were aware and knew learners who lived in their community who dropped out of school post-birth and referred them to the researcher. Thirteen (13) learners from the secondary school met the criteria of the study and three (3) participants who also met the criteria had dropped out of school, but resided in Extension 78, Polokwane. The total number of girls at the school was 317. The potential research participants who showed interest in the study reached the intended number of research participants for this study. As a result, the researcher did not have to visit another local secondary/primary school to invite other potential research participants.

4.4 Data collection

To meet the requirements of a qualitative research study, data was collected through semi-structured interviews with teenage mothers in their natural context (Babbie & Mouton, 2002). The participants were approached from their school and community, Extension 78, Polokwane. The principal at one of the schools that accommodates learners from the informal settlement, Extension 78 pupils was approached, informed about the study thereafter, and asked for permission to ask learners to participate in the study through a permission letter. The principal agreed and signed the permission letter to conduct the study with learners from the school, and offered a mobile office to conduct the research interviews at the school. The potential participants were

approached in their classrooms and informed about the study and its purpose. Only teenage mothers were invited to participate in the study and were informed about the ethical considerations to be adhered to. Interested participants approached the researcher to enquire further about the study. The researcher's details were also pasted on the school notice board for any potential participants who did not want to approach the researcher in the presence of other learners or educators to engage with their parents/guardians for permission. Regarding the participants who were referred by other learners, the researcher made means to find them and shared information regarding the study as they had dropped out of school and were not available within the school premises. The purpose of the study, the informed sheet, and the consent form were read to them. Only when the potential participants agreed to participate in the study and signed the consent forms where they declared participants. For participants who were under the age of 18 years, the researcher approached their parents/guardians and read the informed sheet of the study (see Appendix A and Appendix B, for consent forms). The participants only participated in the study with the approval and signature of their guardians or parents. Only participants over the age of 18 read the informed sheet and signed the consent form on their own (see Appendix C).

Interview schedules were planned and designed for the study; and questions were constructed in an open-ended format. Semi-structured interviews have the potential to unleash and extract data on perspectives that are more relevant to the research participants and allow participants to dictate the direction of the interview as opposed to the researcher dictating the interview or setting (Barbour, 2014). A tape recorder was used as a data collection tool. This enabled me to capture both facial and nonverbal cues from participants. The questions were asked in English and Northern Sesotho (Sepedi) for further clarity and understanding of the questions by the participants. The recordings from the tape were used to transcribe data analysis. Motes, a notebook and pens were also used during the interviews. The participants were approached from their schools and community, Extension 78, Polokwane.

With consideration of most of the participants being learners, the participants chose the day, time and venue suitable for the interviews. One of the challenges experienced during the data collection was finding a suitable time and setting for participants who had dropped out of school. A date and time would be set for interviews. On the day of

the interviews, participants were either not available or it was not easy to reach them as they did not have cell phones. Only one participant had a cell phone thus communication was effective in terms of interview appointments. As the school offered a mobile office for interviews, the participants had the option to choose their preferred venue for the interview sessions either at school or at home. Some participants chose the school's mobile office as their preferred venue for the interview, and others were comfortable with the interviews being conducted at their homes. Before the commencement of the interviews, the researcher shared with the participants how the questions could trigger their emotions. Therefore, considering that participants may need psychosocial support, the details of the school's care and support assistant and the area social worker were shared with the participants for professional assistance/counselling. The two agreed to offer their services to the participants. During the interview session, only the participant and the researcher were present. Despite the challenges of reaching some of the participants who dropped out of school, with patience and resilience, all 16 participants were interviewed.

The information sheet, parent/guardian consent form, informed consent form and interview schedule were translated into Sepedi to ensure that they were able to read and comprehend the information in a language suitable for them i.e either in Sepedi or English.

4.5 Data Management

Salmona, Lieber and Kaczynski (2019) make it clear that managing qualitative data entails categorising all of the data collected in a qualitative study so that organisation and qualitative analysis are feasible although not simple. The purpose of effective qualitative data management is to make relevant data segments easily understandable and searchable for data analysis and presentation to the intended audience (Salmona et al., 2019). Researchers can gain several advantages from creating a thorough management plan for each and every one of their data files before they begin with data gathering. The methods for gathering data, maintaining its confidentiality, organising it during the research (for instance, by data type or method), storing and backing it up to prevent loss, and its disposal after the project, if needed, should all be covered in this plan. This plan serves as a roadmap for the research while guaranteeing that researchers manage their data consistently and effectively.

In this study, the researcher ensured effective data management and analysis by following the necessary research management plan to ensure credibility and that the data collected is maintained and kept safe for the dignity and respect of the research participants and the study. The data was extracted from audio and transcribed into textual data. It was important to maintain confidentiality throughout the process of audio recordings of textual data, and a password was created to avoid authorised access to the data. The data was backed up by a tape recorder to a password-protected computer. All data was backed up using digital storage files. The following storage files were used as a form of backup and safety: Google Drive, iCloud, Share Drive and Dropbox. The textual data was organised using highlighters, colour pens and pencils to keep track of new emergent themes. While organising the data, the researcher kept track of dates, times and tittles of every detail of the data in the notebook used to assist with the organising of the data. The creation of a codebook/notebook was to ensure a record of all the codes, themes and any resourceful information regarding the research study that may prove helpful to the researcher during the coding process. The researcher may have had only one opportunity to engage with the participants. As a result, the researcher had to prepare ahead carefully for the interviews and gather as much data during both the preparation stage and semi-structured interviews.

4.6 Data Analysis

The researcher analysed the qualitative data using thematic analysis, which is a collection of texts, such as interview transcripts. The researcher carefully examined the study findings to note recurring themes during the interviews (Deterding and Waters, 2021). Conducting thematic analysis involves several steps that include familiarisation, coding, generating themes, reviewing themes, defining and naming them and writing up. The thematic content analysis provided the interpretation of the social causes of teenage pregnancy and the challenges faced by the phenomenon in Extension 78, Polokwane. Steps to be used in thematic analysis were followed in the study. For an adequate understanding, the researcher familiarised herself with the data by frequently listening to the interview recordings and reading the transcribed data in terms of how the participants verbalised it. The field notes also assisted in complementing the transcripts. Once the transcript of the data was complete, the researcher began to code the transcripts; and with the assistance of the supervisor,

the codes were discussed and the most relevant codes applied. In terms of post-coding, the researcher categorised all the identified codes with familiar and similar meanings which characterised the codes accordingly. Thereafter, the themes were reviewed to verify relevance and suitability to the study. Only the relevant themes were kept and those not relevant were left out. To identify and name the themes, the researcher was guided by the objectives and the theory of the study.

4.7 Ethical Considerations

A set of rules and principles that guide your study designs and procedures are known as ethical considerations in research. Voluntary engagement, informed permission, anonymity, secrecy, the possibility of harm, and respect are some of these principles (Burkholder and Thompson, 2020). The ethical considerations safeguard study participants' rights, improve research validity and preserve scientific integrity.

Ethical considerations are very important when conducting a study; moreover, when working with human participants. This study consisted of participants who were minors. As a result, it was important to take into consideration and pay attention to any ethical issues that may have arisen. Ethical considerations in research help ensure the safety and protection of the research participants, and ensure and maintain scientific integrity to improve the validity of the study. The dignity and human rights of the research participants matter as well as ensure a relationship between science and society. The study abided by the University of Limpopo's Research Ethics Committee (REC) rules and ethical procedures. The study was approved and permitted by REC. Following the approval of the university's committees, the relevant schools with learners from Extension 78, Polokwane. The information sheet and the purpose of the study were presented to the school principal, who signed the permission letter and agreed that the study be presented to the learners. Potential participants who showed interest in the study were then addressed on the ethical considerations the researcher was going to ensure in the study. The participants were assured that the data collected was for research purposes only. Only my supervisors could have access to the voice records/interviews. Informed consent and voluntary participation for participants who were minors was only allowed on condition that the parents read the information sheets and signed the consent forms.

Voluntary participation and informed consent

It was also explained that participation in the study was voluntary, and no form of compensation would be given. Participants were informed that their participation in the study was entirely voluntary, and that they were able to discontinue with the study at any time without facing any negative repercussions, and that their choice to participate or not to participate would not cause them any harm. The researcher also agreed with the participants that there would be no financial gain or any form of compensation from participating in the study. Informed consent specifies that researchers give precise information about what participation entails. Participants should understand from the information provided why they are being asked to participate, what kind of data is being gathered, how it will be used, who will use it, and for what goals. Potential participants from 18 years and above were read an informed sheet and signed the consent form if they were willing and interested in participating in the study. Participants under the age of 18 and interested in participating in the study were assured that their parents/guardians would have to sign the consent form for them if they agreed that their children/dependants participate in the study. If the parent/guardian did give not consent, the teenage mother could not take part in the study. The information sheet and consent form were read to both parents and teenage mothers to explain the purpose of the study clearly. All minors who showed interest in the study were given permission by their parent/guardians. Thus the researcher met with the caregivers of the research to ensure that all the requirements and ethical requirements are adhered to fairly and permission is granted.

Anonymity and confidentiality

Anonymity signifies that the answers provided by respondents cannot be used by the researcher or readers of the final research report or paper for identification purposes (McLeod and O'Connor, 2020). Ensuring confidentiality requires protecting the data that a participant has shared with the researcher in a trustworthy relationship and with the understanding that it will not be shared with anyone else without consent unless it is in a manner that aligns with the initial disclosure. In the context of human research, confidentiality also refers to the researcher's agreement with participants, when appropriate, for example (through informed consent), about the handling, management, and dissemination of their personally identifiable information. Only when informed that their information would be kept private and not disclosed to other parties will individuals be willing to provide it for research purposes. The parents, guardians,

principal and participants were assured of confidentiality and anonymity. The school's name and details of the principal will not be shared or revealed. Additionally, participants' private details will not be shared or publicised to ensure their safety and privacy. Only pseudo names were used in this study, and information from participants was recorded. The participants will always remain anonymous. Participation is voluntary. However, the dissertation will be shared with the school's principal and community leaders in their area. It will also be published on the University's library website. To further respect their privacy and confidentiality, both the social worker and care and support assistant agreed that they would not share any personal information about the participants should they come for consultations or share the contents of the session. The audio recordings of the interviews were also safeguarded by using passwords to avoid unauthorised access.

Respect and Dignity

Human dignity is the central value in research studies, and is safeguarded by various principles: equality, freedom, autonomy, beneficence, respect and protection from significant harm and unreasonable burdens, and justice in procedures and the distribution of benefits and burdens (Khoa, Hung and Hejsalem-Brahmi, 2023). These guidelines ensure appropriate research. The rights, freedom and human dignity of participants must be protected by researchers. The researcher had an obligation to all research participants who were involved in or impacted by the study. The researcher ensured respect for the human dignity of participants and considered their personal integrity, safety and well-being. In general, participation was based on understanding and consent. The participants were also assured that their time and comfort is important, and will not be coerced by the researcher to oblige to any form of setting that makes them uncomfortable. They were respected at all times during the data collection process of the study.

Standard of care

The researcher was aware of the potential emotional impact of broaching the topic of teenage pregnancy. To ensure the well-being of the participants, the area social worker and care and support assistant from the school were enlisted to provide psychosocial support. At the outset of the interview schedule, the participants were provided with the contact information of the aforementioned individuals. Moreover,

they were given the autonomy to select a location and time that suited their comfort level.

4.8 Quality Criteria

In order to assess the reliability of the findings of the study, several factors were considered, including credibility, dependability, confirmability and transferability (Bless et al., 2013).

Credibility

Credibility assures the reader that the findings accurately reflect the real-world context under investigation, which was achieved through a rigorous evaluation of the study's outcomes by the research supervisors. Their input helped ensure the accuracy and trustworthiness of information. Additionally, the participant's profile helps ensure that the findings are accurate and drawn from teenage mothers who had lived experiences of the social causes of teenage pregnancy. The researcher also did research regarding the research topic by using books, journals and credible internet sources from established organisations and used credible information to guide the research study.

Dependability

Dependability involves the researcher's commitment to a systematic and well-documented research process (Bless et al., 2013). It required a clear explanation of the research strategy and a demonstration that each step was carried out meticulously. By providing comprehensive insights into the research process, the study established its dependability.

Confirmability

A measure of the extent to which the findings of the study are a result of the research focus rather than the researcher's biases, was upheld (Babbie and Mouton, 2002). It is crucial for research to have findings that other researchers or observers can replicate by following a similar research procedure in a similar setting (Bless et al., 2013). All the research findings in this study are from what the research participants without being coerced by the researcher. The researcher was not biased and only presented the research participants' responses from interviews.

Transferability

The aim was to make the results applicable to similar challenges and to find new information regarding the social causes of teenage pregnancy. To achieve this, every aspect of the context in which the data were collected and the dynamics between the researcher and the participants was thoroughly documented. This effort aimed to facilitate the application of the study's results in comparable settings.

4.9 Conclusion

An overview of the research methods used was discussed in this chapter. Data collection methods which ensured rigour-preserving techniques, and a brief overview of pertinent ethical considerations were all covered. The data analysis and its outcomes are discussed in the next chapter.

CHAPTER FIVE: DISCUSSION AND INTERPRETATION OF FINDINGS

This chapter discusses the data findings of this study and analysis of the collected data. The previous chapter briefly discussed how the data was collected and the methods applied. This presents the data findings of the social causes of teenage pregnancy at an informal settlement in Polokwane, South Africa. The findings and discussion sections have been merged to provide a rich summary of the qualitative data collected. In this manner, the data is presented alongside current studies on teenage pregnancy. This literature provides the reader with more insights into the findings. It should be emphasised that the discussion is shaped by the research study aim, objectives and theoretical framework.

The results are presented in themes and sub-themes resulting from the verbatim codes which were shared by the participants with the researcher. The aim of this study was to explore the social causes of teenage pregnancy in an informal settlement, Polokwane, South Africa. The objectives of the study guided the research questions and data analysis. The following are the objectives of the study, which determine the social causes of early childbirth among teenagers in a semi-urban area and examine factors contributing to teenage pregnancy in semi-urban areas. The social learning theory was applied.

Themes and sub-themes emerged from the aim and objectives of the study.

These are the main themes and sub-themes in this study and are analysed in terms of the sequential order below:

5.1 Social causes of teenage pregnancy in an informal settlement in Polokwane, South Africa.	5.1.1 Socio-economic determinants of teenage pregnancy 5.1.2 Poverty 5.1.3 Transactional relationships 5.1.4 Family communication on teenage pregnancy 5.1.5 The media as a social cause of teenage pregnancy
5.2 Factors contributing to teenage pregnancy at an informal settlement Polokwane, South Africa.	5.2.1 Lack of adequate healthcare services 5.2.2 Low use of contraceptives 5.2.3 The attitude of healthcare workers 5.2.4 Peer Pressure 5.2.5 Risky sexual behaviour 5.2.6. HIV/AIDS Infection
5.3 The effects of teenage pregnancy on teenage mothers	5.3.1 Academic progress and school attendance 5.3.2 Dropping out of school. 5.3.3 The social experiences and stigma of teenage pregnancy
5.4 Support and available interventions towards teenage pregnancy	5.4.1 School curriculum and government interventions 5.4.2 Stakeholder's Intervention

5.1 Social causes of teenage pregnancy in an informal settlement in Polokwane, South Africa

This theme focuses on the social causes of teenage pregnancy in Extentionn78, Polokwane. The social causes are acts or circumstances that have a negative influence on teenagers in society. and in this study focusing on the impact of the social causes of teenage pregnancy in Extension 78, Polokwane. This shows that these societal problems affect not only individuals but often huge groups of people, causing disruption or awful conditions in their communities.

5.1.1 Socio-economic determinants of teenage pregnancy

Socioeconomic status pertains to where an individual or group stands on the socioeconomic scale. This is determined by a combination of social and economic factors like income, educational attainment, occupation standing and type, place of residence, and sometimes, ethnic, or religious background in certain societies or parts thereof.

The modelling behaviour on socio-economic determinants concerning teenage pregnancy and communities entails that teenagers often learn by observing the behaviours of individuals in their socio-economic environment. If they witness peers or community members facing economic hardships, limited educational opportunities, or unstable employment, it may influence their attitudes and behaviours. This can result in limited role models.

Teenagers in socio-economically challenged environments may have limited access to positive role models who demonstrate responsible sexual behaviours and the importance of education and career aspirations. The absence of such role models can impact their behavioural choices. Teenagers often learn by observing the behaviours through observational learning and the role modelling of individuals in their socio-economic environment. If they witness their peers or community members facing economic challenges, limited educational opportunities or unstable employment, it may influence their attitudes and behaviours.

This theme will explore three sub-themes, which incorporate the challenges of the socio-economic status and geographical location of the teenage mothers and what has led to them to fall pregnant.

5.1.2 Poverty

In the context of teenage pregnancy and poverty, the theory can help explain how socioeconomic conditions and social environments contribute to the likelihood of early childbirth. Poverty seemed to affect some of the participants in the study as there are those whose parents/caregivers are not employed, which causes financial strains in meeting their basic needs. The financial burden continues to be more difficult as the teenagers fall pregnant and give birth despite receiving the child social grant. Participant 6 shared the following in relation to the aforementioned,

"I had to enter into a relationship with an elderly man because he would give me money for the stuff I need and could not get from my family, and this led to me falling pregnant…" P#6.

The above-mentioned participant engaged in sexual intercourse with the father of the baby because he gave her lunch money for school as her parents were unable to provide this for her. This is in line with what was discussed in chapter 2 by scholars on poverty and economic constraints, leading young girls into transactional relationships due to the economic conditions. On transactional relationships and the social detriments of teenage pregnancy:

P#6, P#8, P#9, and P#16 argued that the socio-economic challenges that have led them to fall pregnant unintentionally as discussed below.

For P#6, she is raised by her grandparents and lives with her cousins as their parents relocated to seek employment elsewhere. It was challenging at home, and this resulted in her finding a partner who is employed to provide for her, as stated below:

"*At home, I live with my grandparents and my cousins, there are 8 of us at home and only my grandfather is employed. There are days when not all your needs are catered for. I needed someone to look after me and my firstborn baby as her father is still young and in school. I met the father of my second child, and he is working and taking care of us without asking anything from my grandparents." P#6.*

For P#8, she engaged in early sexual intercourse as her family struggled to give her money for lunch until she met the child's father, who provided her financial needs:

“My mom is unemployed, and my father does not support us, so I wanted to eat nice food from the tuck shop during school break so the person I was dating I had to constantly ask him for money because I saw that he had money then he asked me out and I agreed, we had been together since 2019 because I enjoyed the money. Money got me into the relationship”. P#8

P#9 argued how they only make ends meet at home through social grants. From her observation, she assumed that her mother was struggling to provide for her and her siblings. As a result, she engaged in casual relationships to seek financial assistance and help her mother:

“I don’t have a father, and my mother is unemployed, so we survive through social grants, and I felt to make a plan to help my mom with my siblings even though she did not say anything, I could tell she was struggling so I started sleeping with men and they gave me money, sometimes I would buy bread and snacks for my siblings”.

P#16 also engaged in early sexual debut because of the conditions she faced at home. Her mother worked casual jobs which did not cater for all their basic needs at the time:

“*My mom worked piece jobs to provide for me and my siblings and had to pay rent where we stayed. It was tough until I met my boyfriend, and he helped me where possible.” P#16*

From the above extracts, it is evident that poverty can lead teenage girls into transactional relationships. It seems like an alternative to reduce the financial difficulties faced in their families. The challenge faced in their household was unemployment for their elders. However, this places young girls at risk of STI/STD infections, and are entrapped in the cycle of poverty and teenage pregnancy. The above participants have shared the difficulties faced in their households such as their parents/caregivers who are unemployed. This was a challenge in their lives and their basic needs being catered for. The cycle of poverty, however, is perpetuated by their current phase in their lives as teenage mothers. NACOSA (2018) has argued that teenage pregnancy is high in areas with high rates of poverty and unemployment. A study by Mkwananzi (2015) as discussed in chapter 2 also found that in the Northwest province, South African households living in areas experiencing poverty have higher rates of teenage pregnancy. This was opposed by a study by Rohmah et al. (2020),

which argued that children born in wealthy families are less likely to fall pregnant during their adolescent phase.

The Social Learning Theory also addresses the transmission of behaviours across generations. Teenage parenthood and poverty can become cyclical patterns within families. If a teenager grows up in a household where early parenthood is common and poverty is prevalent, they may be more likely to follow a similar path unless alternative models and opportunities are presented. The Social Learning Theory emphasises the importance of positive role models. In poverty-stricken areas, limited access to positive role models who have pursued education or career goals before starting a family may contribute to the normalisation of early parenthood. This is what the teenage mothers have been exposed to, a lack of positive role models in their households and community.

Understanding the interplay between poverty and teenage pregnancy through the lens of the Social Learning Theory highlights the importance of addressing environmental factors, promoting positive role models, and providing resources and education to break the cycle and empower adolescents to make informed choices. Interventions that target both individual behaviour and broader social influences can be more effective in mitigating the impact of poverty on teenage pregnancy.

5.1.3 Transactional relationships

A transactional relationship involves a business-like approach where each person has a specific role and benefits. These obligations outline what each person is expected to contribute and the rewards they will receive in return. Convenience and pre-determined benefits are common in transactional relationships, meaning that a trade-off is agreed upon before a formal relationship is established. In addition, individuals in transactional relationships are typically aware of the benefits they will gain from the relationship and what is expected of them.

In this sub-theme, participants expressed the reasons why they dated men who were able to provide financially.

P#15 dated an older person as he was able to financially provide for her as opposed to boys her age. This led to her being in a transactional relationship:

P#15:

“My partner is older than me but not too much, he is able to assist me with certain things if I need help with something he is able to provide because he is employed. The boys our age tease us or say they want us but cannot buy anything I want.”

P#15 and P#6 have similar reasons for being in transactional relationships which is the provision of financial assistance by these men. P#6 had a child and as she faced challenges to provide for the child and her grandparents struggling to meet some basic needs, she started dating her partner as he promised to take care of her and her child. She had this to say:

P#6: “With my first child, I did not date the father for money. He is just a year older than me and still in school however things got hard financially as I mentioned before, living with my grandparents, sometimes they did not buy us sanitary pads or school shoes, what matters to my grandparents was that we eat before bed other things were not that serious for them, so I had to think for my baby? I met and dated the father of my second child because he promised he would take care of me as long as I slept with him, cooked, and cleaned his room. He gave me money and I was able to provide for my child and myself unfortunately I fell pregnant again, but I believe after I give birth he will take care of his child too”.

P#16 enjoyed the money she was given and enabled her to eat the same food and have clothes as her peers and thus shows the fundamental key of the social learning theory, which is that imitations play a role to influence and shape an individual’s behaviour without considering the consequences. She envied her peers and that resulted in her having a transactional relationship:

P#16:

“He gave me money when I was coming back from school, and I was eating the same lunch as my peers, and he bought me clothes I loved that and in fashion, so I dated him because of those things. I fit in. “

It is evident from the extracts above that transactional relationships contribute to teenage pregnancy in Extension 78, Polokwane. The above teenage mothers got into relationships with their partners for money as they could cater for their needs and wants. This was due to financial constraints faced at home or because they could buy them lunch during school breaks. What matters to the teenagers in this theme is

money. They do not consider the risky sexual behaviours which they could be exposed to.

From the biographic data looking at the age of the fathers and the shared statements, it shows that these partners are older than the teenage mothers, which shows that negotiating power in the sexual relationships can be a challenge for them. Risenga and Mboweni (2022) found that young girls engage in sexual relations with older men who are able to provide financially and have “blessers” to assist. Matlala (2022) also found that majority of the teenage pregnancy were due to “blessers” and older men who lure young girls will gifts and money. The sexual relationship with the older men limits the control of power in regard to safe sex and protective measures to avoid risky sexual behaviours or falling pregnant.

Transactional relationships also highlight the limitation of the social learning theory on the oversimplification of factors that teenage pregnancy does happen only through observational learning. But there are reasons such as socio-economic factors which may lead young girls to fall pregnant.

Socioeconomic challenges such as limited access to quality education can impact an individual's understanding of sexual health and family planning. Lack of education about contraception and reproductive health may contribute to a higher risk of unintended pregnancies. The Social learning theory emphasises the importance of information dissemination. In socio-economically challenged environments, if there is a lack of comprehensive sexual education and limited access to information about contraception, teenagers may be less equipped to make informed decisions.

5.1.4 Family communication on teenage pregnancy

This theme describes the relationship between teenage mothers and their families, particularly on sexual education or topics regarding sex in their households with members of their families. The family is regarded as the first agent of socialisation; thus, an important system to shape one’s personal development, growth and ability to integrate into society. The Social Learning Theory provides insights into how family dynamics, interactions and relationships influence the socialisation process. Participants (P#16, P#14, P#10 and P#7) argued that it is not easy to engage the topic with elders. However, others indicated that they try to talk to their sisters about sex-

related issues. In this theme, there are mixed reactions and responses from the participants.

When asked if a member of their family has communicated to them about sex, Participants argued as follows:

P#16:

"No, they never did but before I got my period, they just told me to stay away from boys. They did not explain why I had to stay away from boys."

The above participant's experiences show the lack of effective communication by parents as sources of reliable information to their children regarding sex. P#16 did not receive adequate teaching on the reason for staying away from boys because of being on her first menstrual cycle. Neville (2022) also found that teenage girls are not given clear information on the relationship between a menstrual cycle and sex from their families. This is also supported by Thobejane (2017) and Chandra et al. (2017), who argued that during the adolescent phase, parents miss an opportunity to talk to their children about sex. This can result in the children finding other sources of information from external factors.

Similarly, P#14 had the same experiences as stated below where her mother has never spoken to her about sex, thus her source of information was her aunt, who was able to engage her about sex:

P#14:

> *"My mother has not spoken to me about sex, but my aunt does because I am close with her, I take her as my sister. She does not judge me even when I have questions about boys and sex. I had all the information, but still feel pregnant".*

P#14 had a source of information from her family although not her mother or father within a nuclear family structure, but her aunt played a role in educating her about sex, and had an open line of communication. However, this contradicts the findings that when teenagers are spoken to about sex by their family, they are less likely to fall pregnant.

P#10's mother has spoken to her about sex and opened a line of communication. However, she fell pregnant as a result of her not listening to her mother's informative talk. She had this to say:

P#10:

> *"My mother did talk to me about sex when I started menstruation and told me to ask her questions if I start dating or having sex, but I didn't listen, and I fell pregnant."*

P#7 was told about sex and forms of preventing pregnancy when sexually active. Although she followed her mother's teachings and took the injection as a form of contraceptive, she stopped taking it because of the side effects.

P#7:

> *"Yes, when I started my periods, my mother told me don't do this, do this. When I entered the stage, she was like okay, there are things of prevention (family planning) so how about you prevent so I started preventing with the 3-month injection and that's when I left it because I was not getting my periods."*

The above extracts show that there are parents who communicate with their children about sex to the extent that they find ways of preventing pregnancy. This is evident from P#7 as her mother argued that there are alternatives to prevent pregnancy, such as the use of injection when she became sexually active. However, the reason she stopped using the injection was due to the side effects she experienced. Participants who did not receive adequate information regarding sex at home impacted on their decisions to engage in sexual intercourse without knowing the risks they could be exposed to.

P#16's statement indicates that one factor influencing teenage pregnancy is poor parent-child communication, particularly when it comes to sexuality issues. Talking about sexuality seems to be taboo in households. Effective communication and being open to children could have enlightened teenagers on the risks and consequences of unsafe sex.

Irrespective of information and knowledge from their mothers, the above participants (P#16, P#14, P#10 and P#7) fell pregnant. Various scholars in such as Chandra et al.

(2017), Nkosi and Pretorius (2019), Munyai (2019) and Gunawardena et al. (2019) argue that if parents were involved and communicated with their children regarding sex, it would reduce their chances of falling pregnant. In this regard, the participants were spoken to and yet still fell pregnant. Thus, it is important to look into other key factors behind the rising number of teenage pregnancy and what solutions are needed as mothers or families are playing a role. Other external factors could be the cause of this social phenomenon. Parents play a central role in the socialisation process, according to the Social Learning Theory. They are important socialising agents who model behaviours, set expectations and provide feedback.

These findings highlight the limitations of the social learning theory, which limits the scope of observational learning and underestimates individual agency. Thus, the above participants could have acted on their own accord, role of personal choice, trial/error, or direct experiences and without any role model influence. Regardless of how the role models have enforced teachings.

The participants argued that they had not asked about sex at home and were afraid to do so.

P#1:

> *"No, my family isn't the kind I can talk to about such things besides they are always busy."*

P#5 indicated how she feels it would be awkward asking about sex at home. She has this to say:

P#5:

> *"No, it is awkward, and they could shout at you for asking because it is like you doing old people things."*

Although P#9 has a sister who is willing to talk to her about sex, she feels it is uncomfortable and she is also scared to ask at home:

P#9:

> *"No, because I am scared to ask about it, my sister says I can speak to her, but it is uncomfortable."*

The above extracts show that teenage mothers were scared or uncomfortable to engage or ask questions about sex at home because they presume may be their families would be unwilling to talk about it. This is line with Munyai et al. (2023) and Skobi and Makofane (2017) regarding sex related topics in African households as a cultural barrier and a taboo. Being afraid to ask about sex at home could have led to the teenager's seeking information from their peers, the media or members of the community. This cultural barrier limits them from asking their family unit. The limitations of the social learning theory highlight this important factor of overlooking cultural differences within the fundamentals of the theory.

In accordance with the social learning theory, the way parents communicate about sex, contraception, and family planning can impact a teenager's understanding and behaviour. Open and honest communication within the family can contribute to a more informed and responsible approach to relationships and sexuality through verbal reinforcement. Parents are the first role models to children and the family as a unit key for observational learning. The Social Learning Theory suggests that societal norms and values influence individual behaviour. In other words, in communities where early pregnancy is prevalent or accepted, teenagers may be more likely to model their behaviour accordingly.

5.1.5 The media as a social cause of teenage pregnancy

The media plays a role in modern society as a source of information, knowledge and entertainment. The media is also an agent of socialisation. According to the social learning theory, the media can play a role in shaping attitudes, beliefs and behaviours by providing models for individuals to emulate. While the media itself may not directly cause teenage pregnancy, it can influence adolescents' perceptions and attitudes towards sex and relationships, potentially contributing to the prevalence of teenage pregnancy. The participants from Extension 78, Polokwane have argued how the media has affected their decision-making. The extracts below are in line with what was discussed in chapter 2 on the media's influence on sex towards teenagers.

The forms that teenage mothers are exposed to have influenced their thoughts on sex and curiosity to start having sex:

P#3:

"I felt influenced by social media because a lot of times social media will deem you as stupid if you don't do certain stuff people do, before falling pregnant you would find people that have posted videos of sex, and I would find them confusing and wish to do it."

Social media also influenced P#5 to have sex as she was exposed to sexual content:

P#5:

"Nowadays on social media if you go through people's posts, they are all about sex and so you also want to experience the things they talk about. I take what they say on social about sex as true because at home they are not honest regarding the topic".

P#9 shared similar experiences with P#3 and P#5 that what is posted on social media posts has influenced their thoughts on sex and wanted to have sex from the videos that are posted on social media:

"People are constantly sharing different stuff on social media such as videos on sex and on WhatsApp people are posting porn and I thought about doing stuff like that". P#9

The media has played a role in teenage mother's lives regarding their perceptions of sex and for accurate information that has influenced them to engage in sexual intercourse through what they are exposed to. In terms of sexual intercourse, the research and statement show that teenagers who watch sexual content in the media are more likely to become pregnant as teenagers. This was also found by Usonwu et al. (2020) and Vannucci et al. (2020).

Media may not always depict the realistic consequences of early parenthood and sexual relations, such as financial challenges, limited educational opportunities and the emotional toll it can take on individuals. This lack of portrayal may contribute to a distorted perception of the real-life implications of teenage pregnancy. If the content in the forms of traditional media and regulatory bodies does not emphasise the importance of safe sex practices, contraception and responsible decision-making, it may contribute to a lack of awareness and understanding among teenagers, potentially leading to unintended pregnancies. It is important to note that while the

media can influence behaviour, teenage pregnancy is a complex issue with multiple contributing factors, including socioeconomic status, education, family structure and access to healthcare. The media is just one of the many factors that can play a role in shaping adolescents' attitudes and behaviours. Additionally, individual agency, family dynamics and community influences also contribute significantly to the choices made by teenagers regarding sexual activities and relationships.

5.2 Factors contributing to teenage pregnancy at an informal settlement, Polokwane, South Africa

This theme describes factors that have made teenagers fall pregnant. The theme emerged through participants sharing their lived experiences in their personal and community lives.

5.2.1 Lack of Adequate Healthcare Services and low use of contraceptives

In communities where there is a lack of access to healthcare services, teenagers may lack proper guidance and information about reproductive health. Observing the experiences of others in similar situations, such as peers or community members may influence their attitudes and behaviours related to sexual activity and contraception. The lack of adequate healthcare can significantly impact teenage pregnancy in several ways. Access to comprehensive healthcare services is crucial for the well-being of adolescents and can influence their decisions relating to sexual health, family planning and pregnancy.

Participants shared the challenges they faced in receiving adequate healthcare services in their area, the knowledge or lack of knowledge on contraceptives, and the attitude of healthcare workers in health facilities where they receive services. Participants do not have a clinic within 5km from their area and the mobile clinic which offered services to the community on Thursdays was closed by parents/caregivers in the community as they believed it promoted their children to have sex.

P#10:

“We had a mobile clinic that would come on Thursdays from 10:00 am but it was closed by the community because learners would go to the clinic for family planning during school hours.”

The closure of the mobile clinic by the community shows the need for sexual education, social ills awareness and advocacy campaigns to educate members of the community about the social risks and challenges that are faced by teenagers and youth in South African communities. However, the lack of this knowledge led to the removal of the mobile clinic as indicated below:

P#4:

> *"There was a mobile clinic I knew nearby but the community removed it because they felt that it was promoting sexual activities for young people. Now it is not there anymore, and I have to take a taxi to the clinic."*

The results of the closure illustrate lack of knowledge on the rising numbers of teenage pregnancy and other health services young people may need. The community needed to be knowledgeable about the importance of having health care services nearby such as mobile clinics to the citizens as opposed to struggling to access these services as there are challenges such as transportation fare, school hours or reluctance.

The mobile clinic assists learners in gaining access to sources (healthcare workers) of knowledge and forms of contraceptives by walking to the mobile clinic and resuming their studies after receiving the services without worrying about transportation fares. Inadequate healthcare services may contribute to a lack of comprehensive sexual education for teenagers. Without proper information about reproductive health, contraception, and sexually transmitted infections (STIs), adolescents may be more likely to engage in risky sexual behaviour and unintended pregnancies.

5.2.2 Low use of contraceptives

Regarding knowledge and use of contraceptives, P#2, P#14 and P#1 argued that they were aware of family planning but feared using them because of the side effects and how they could affect their bodies. Subsequently, P#7 used contraceptives but stopped using them after she experienced bad effects on her body. She had this to say:

P#2:

> *"I knew about contraceptives and prevention, but I was lazy to go get them."*

P#14 heard about the misconceptions of contraceptives and the side effects, so she was scared to use them:

P#14:

"I was scared to get family planning because I heard people around the area saying injection negatively changes your body."

The above participant highlights that imitation, role modelling and observational learning are key in an individual's perception to take family planning. Teenagers learn by observing the behaviours of those around them, including family members, friends, and peers. If individuals within their social circle do not prioritise or model responsible contraceptive use or are misinformed, teenagers may be less likely to adopt these behaviours themselves. The perceived approval or disapproval of contraceptive use by peers and influential figures can shape individual choices. If there is a lack of social approval for responsible contraceptive practices, teenagers may be less motivated to adopt these behaviours. Jonas et al. (2016) added the importance of the lack of advocacy and sexual education in contraceptive use needed for teenagers and teenage mothers.

P#1 wanted to use family planning but had to wait for her sister to help with transportation fare to the clinic:

P#1:

> *"I had initially asked my sister that I wanted to get the contraceptive injection however she gave me the run-around and I couldn't go myself because I had no money for transport."*

Despite being aware of the various forms of accessible contraceptives, the participants' decision not to use these methods was affected by some misconceptions and lived experiences from the effects on their bodies, placing them at risk for teenage pregnancy.

Subsequently, P#7 used contraceptives but stopped using them after she experienced bad effects on her bodies. She had this to say:

"Firstly, I was using family planning (the 3-month injection), but the problem was I was not getting my period for a whole year, and that made me sick so I decided to take a break from them so I could get my period." P#7

P#7 shares important information on having taken precautions. But after experiencing side effects and getting sick, she stopped taking them.

For P#4, the pregnancy was planned and intentional. She got her implant removed to conceive a baby with her partner:

"I was intentional on falling pregnant as I wanted a child and so did my boyfriend because he already had a child, but his ex-girlfriend refused to let him see the child. So, I removed the implant that I had for family planning to have a baby with him. I do not regret the decision because I love him." P#4

Conversely, for P#10, she experienced an unfortunate fate. She indicated that she was on the implant and surprisingly fell pregnant:

"*I fell pregnant while I was on the implant, I do not know how that happened to be honest even my family did not believe I was preventing when they found out I was pregnant because it was supposed to prevent me from all this, but here I am today, a mother to a baby girl." P#10*

The experience by P#10 unfortunately could influence her peers or family not to have any belief in contraceptives as she also used them believing that she could be protected from falling pregnant at an early age. P#7 and P#10 highlight an important point that although the teenagers use contraceptives, the side effects could affect their perceptions of these methods. Limited access to accurate information about contraceptives and reproductive health may hinder adolescents from understanding the benefits and risks associated with contraceptive use. The social learning theory emphasises the role of information dissemination in shaping behaviour.

5.2.3 The attitude from healthcare workers

In the extracts below, the participants highlighted the services and attitude of healthcare workers at the clinics where they had gone for services, their experiences during pregnancy and before pregnancy. Negative attitudes of healthcare workers can indirectly contribute to certain challenges associated with teenage pregnancy.

The respondents described the attitude of healthcare workers at the clinic:

P#16:

> "*The nurses are sometimes rude because they judge us based on our age, they insult us, and I am quite impatient. So, I leave."*

P#7 encountered negative attitude from health care workers before and during pregnancy. She was not given preventative pregnancy measures as she was a school learner:

P#7:

"Eh! We are treated very badly at the clinics, because when you are there, they say "hey! Why are you getting pregnant, you are still young, hey why did you not prevent" but when you go there to prevent, they will say they don't give prevention to school learners."

P#9 experienced unfair treatment/ services at the clinic during her pregnancy and at times when she was not pregnant and needed healthcare services. She had to wait long hours to be assisted and that was a problem as she had to consider going to school:

P#9:

> *"If you are pregnant while you are still young, they insult you, they become impatient with you. They don't treat you the same as a pregnant adult. They help you after a long time. Sometimes even when you are not pregnant, you wait long hours to be helped and you have to go to school."*

P#11 points out that nurses are rude sometimes, which shows the negative attitudes. This has been supported by other participants above. However, she adds that not all the nurses are rude:

P#11:

"*The nurses are rude sometimes, but it also depends on what kind of nurse helps you that day. Not all of them are rude."*

Regardless of the attitude encountered by the participants at the health facilities, they argued that privacy and confidentiality is valued by healthcare workers who assisted them.

P#8:

"The nurses are rude, but I never heard them discussing patient's privacy."

The negative attitudes by the nurses at the clinics can be a barrier for teenagers to access information from reliable sources and knowledge regarding sexual reproductive health. Clinics can be a safe environment where teenagers can feel free to ask for information. However, with the continued negative attitudes, teenagers will believe information and misconceptions they receive from peers, family members and the community about contraceptives and risky sexual behaviours. If healthcare workers show negative attitudes or judgmental behaviour, teenagers may be discouraged from seeking reproductive health services, including access to contraception and family planning. This lack of access to services contributes to a higher risk of unintended pregnancies. Negative attitudes from healthcare providers create a hostile or unwelcoming environment for pregnant teenagers seeking prenatal care. This could lead to a decreased likelihood of regular prenatal check-ups and medical guidance, impacting both the health of the teenager and the unborn child. This negative attitude perpetuates negative reinforcements of societal stigma surrounding teenage pregnancy. This stigma may contribute to a cycle of discrimination and exclusion, making it difficult for pregnant teenagers to access the resources and support they need. The negative attitudes of healthcare workers were also found to be a challenge for teenagers to receive sexual education and contraceptives (Nkosi and Pretorious, 2019; Stevens, 2018).

The lack of healthcare often intersects with socioeconomic factors. Teenagers from economically disadvantaged backgrounds may face additional challenges in accessing healthcare services, exacerbating the impact of social determinants on teenage pregnancy rates. The availability or lack of healthcare services can act as a form of reinforcement or punishment. If there are consequences for seeking reproductive healthcare, such as stigma, judgment, or limited access, teenagers may be less inclined to engage with these services. On the other hand, if there are positive

outcomes associated with responsible behaviour such as access to contraceptives and education, it could encourage safer choices.

5.2.4 Peer Pressure

Peer pressure has been identified as one of the contributing factors in this study. Peer pressure refers to the influence applied by a peer group, encouraging individuals to conform to the group's norms, behaviours and attitudes. Participants shared how their peers have influenced them to have sex and not to feel excluded during sexual intercourse conversations. That is why they decided to start having sex and then fell pregnant.

P#3's influence was not from her peers but her family. She shares what has made her to fall pregnant:

> *"My family would compare me to some of my peers, and I felt pressured to be like the individuals that they were comparing me to so I started doing things that those individuals were doing for example dating, and I thought if I did those things then my parents would be happy and stop comparing me to them." P#3*

The above participant shows the role that the family plays in line with the social learning theory and modelling. The participant observed her peers with the influence of her family and being compared to children who seemed being accordingly well thus she imitated what those peers were doing and she unfortunately fell pregnant. Parents are significant role models, and their behaviours and attitudes can be observed and learned by their children. Teenagers learn about sexual behaviours and attitudes from their peers, family members and the media. If they observe peers engaging in risky sexual behaviours without facing negative consequences, they may be more likely to engage in similar behaviours.

P#11 felt pressured by her friends as she felt left out during conversations and she was the only virgin in the group. This made her to have sex:

P#11:

"My friends pressured me, in grade 10 it was like some fashion, and I was the only one in the group who was still a virgin when they had sex talk, I felt left behind, I ended up doing it just to know what they felt."

Similarly, P#11 and P#10 were also pressured by friends to start having sex. During conversations, she had no form of contribution without being sexually active:

P#10:

> *"Yes, I can say I felt pressured by my friends because the majority of them were already sexually active way before me and when they spoke about it, I thought it was something I should also try."*

Teenage pregnancy is clearly influenced by what teenagers hear and see from their friends. According to the social learning theory, individuals learn by observing the behaviours of others and modelling their own actions based on these observations. Teenagers are at risk of teenage pregnancy due to their curiosity about what their peers say and do about sexual activity and the temptation of fitting in. In the adolescent stage and while trying to find themselves, teenagers could find their source of trusted information being their friends as they relate to them with similar experiences and easier to talk to than their family members. It is evident from the research findings that peer pressure contributes to sexual debut and pregnancy.

The teenagers observed their peers engaging in sexual activities. This behaviour was portrayed as positive or acceptable within the peer group. The observing teenagers were more inclined to adopt similar behaviour. In Vhembe District, Limpopo Province, scholars also found that peer groups are a contributing factor to early sexual debut and teenagers feel pressured to have sex because of their peers (Sepeng et al., 2023).

5.2.5 Risky sexual behaviour

This sub-theme emerged as there were participants who shared the risky sexual behaviours exposed to in their community and their lives. Although not all of them were aware of contracting STD/STIs, teenage mothers also did not think that they would fall pregnant while having unprotected sex with their partners. Teenagers may observe peers or media portrayals engaging in risky sexual behaviours, such as unprotected sex or having multiple partners. If these behaviours are seen as acceptable, they are more likely to replicate them.

The risky sexual behaviour that the participants indicate are likely to be experienced in Extension 78, Polokwane:

P#3:

"Rape happens in our area; a lot of times you see a lot of unwanted/nonconsensual sexual behaviours to drunk girls by men especially on weekends after people go home from taverns and you feel like helping but you can't because you're a girl and your first instinct is to run because you're afraid they might attack you too."

Teenagers witness peers facing few negative consequences or gaining perceived benefits from risky sexual behaviours. They may be more likely to engage in similar activities, underestimating the potential risks involved. However, in this instance in Extension 78, Polokwane, the teenagers are exposed to rape which could be seen as a negative reinforcement as it limits them from going to taverns and being exposed to the sexual violence experienced by other ladies.

P#14 argued that one of the risky sexual behaviours she is exposed to is having sexual intercourse with men at taverns without condoms as this places them at the risk of contracting STI/STDs:

P#14:

"We go to taverns and meet men who buy us alcohol and end up sleeping with them without condoms or testing for HIV besides its at night where is the time to test? People here don't like testing."

If within a society, risky sexual behaviours are normalised or even valued, teenagers may feel pressure to conform to these norms in order to be accepted. The desire for social acceptance can lead to engagement in behaviours such as unprotected sex and risky sexual behaviours such as engaging in sexual relations with men while drunk, contributing to the risk of teenage pregnancy.

P#16 also shares similar sentiments with P#15, which is that they hardly use condoms when out at taverns and have unprotected sex. The lack of safe sex can pose danger to their health and well-being.

P#16:

"I think people who go to Taverns like I used to say you can easily be exposed to unprotected sex because most of the time these older men that we find there refuse to use protection and we are scared to even tell them that we want to

use condom because they buy us alcohol, so we just end saying yes so we can drink alcohol and enjoy."

The above extracts show that alcohol contributes to risky sexual behaviours among teenagers and the exposure can cause STI/STDs and pregnancy. Risky sexual behaviours can make these teenagers to be vulnerable to men who can buy them alcohol, and the intoxication from alcohol places them at risk of being raped and unable to consent to sex. Substance abuse, including alcohol and drug use, can impair judgment and decision-making, leading to increased risk of engaging in unprotected sex and unintended pregnancies. This is also supported by literature in Chapter 2 that substance abuse contributes to risky sexual behaviours amongst young people.

Furthermore, there are participants who took safety precautions regarding their HIV/AIDS status with their partners. This is evident from the following participants:

P#1:

"Yes, I thought about STDs, I was scared and unsure because I thought a lot about HIV, and I asked him if we could go to the clinic to test, and the tests were negative for both of us".

P#7:

"My partner suggested that we get tested for HIV, I was scared as it was my first time testing, but our tests came back negative, and we were happy. I just did not think I would fall pregnant from unprotected sex."

P#5:

"Pregnancy was not on my mind because we were not always together, but we went to the clinic to test because for me when someone works far away when they come back, I request we go test."

P#8 thought she and her partner were careful and use condoms. However, she fell pregnant using a safety precaution:

P#8:

"We used condoms every- time we had sex because I told him I didn't want to fall pregnant so maybe he popped the condom."

Edward et al. (2020) and Govender et al. (2020) have discussed the exposure of the risky sexual behaviour of teenagers in South Africa.

5.2.6. HIV/AIDS Infection

Teenage pregnancy places young girls at the risk of contracting HIV/AIDS. This is evident from the transactional relationships and risky sexual behaviours in which they are exposed to or engage in. Having sex without testing for any STI/STDs with your partner or negotiating condom use is a risk for infection.

P#6 shared her experience of contracting HIV from the father of her second child. She did not have multiple partners whom she can suspect could have transmitted the disease to her:

"When I suspected I was pregnant I went to the clinic and the nurses check everything when you want to test for pregnancy. They checked everything about my health. One of them was my HIV status so I could get counselling, I agreed because I wanted to know if I was pregnant. I remember she gave me counselling about HIV and I got tested after counselling. Yoh! She told me it was 2 lines and that meant I was HIV positive; I was scared, and I cried because where did I get it? I only had sex with my boyfriend. I was surprised cause with my first child I tested, and the results were HIV negative. I suspected that maybe it was the father (my boyfriend) who gave me the sickness and I was scared to tell him I was pregnant imagine now having to ask if he is HIV positive and maybe did not tell me? Why have sex without using a condom if he knew? I am still hurt and in disbelief, but I have to be strong and take medication from the clinic for the sake of my children". P#6

The above teenage mother is now HIV positive and contracted HIV from her boyfriend who is now the father of her second child. The biographical data in Chapter 4 (profile of participants) clearly indicates the age difference between P#6 and the father of the second child. Her boyfriend is 32 years of age whereas she is only 16 years. The age difference states that this can be regarded as statutory rape and the participants by law cannot consent to the sexual relationship. The results of the relationship have now placed the learner to be a mother of 2 children, currently on chronic medication and her mental health can also be affected. The participant also faces the risk of stigma in her society and acceptance to live with the illness while growing up and in school. Her community, school and family failed P#6 by not reporting the case to the relevant

stakeholders i.e., South African Police Services (SAPS) and area social workers to let the law take its course, thereby safeguarding the teenage mother.

5.3 The effects of teenage pregnancy on teenage mothers

This theme focuses on how teenage pregnancy has affected the participants and the effects of teenage pregnancy in their lives as teenage mothers in Extension 78 Polokwane.

5.3.1 Academic progress and school attendance

In this sub-theme, the participants shared how their academic studies have been affected or improved during pregnancy and after giving birth to their child. Finding a balance between the child and school can be a struggle to teenage mothers, especially when there is a lack of support from family or educators.

P#3:

> *"My attendance during pregnancy was consistent I attended every class except the last month because I started to have pains. I gave birth in December, and I was able to take care of the child for a longer due to COVID-19 happening and there was a lockdown. My performance in school started dropping in grade 10 when I had issues with the baby's father, he started having doubts about the child not being his and I was considered leaving school and that's when my grades started dropping."*

P#12:

> *"I would always attend school. Sometimes I would pass and sometimes I would fail because I was constantly tired, the child made me tired, and my performance was just poor."*

P#11:

> *"During pregnancy, I wasn't able to cope. I'm this girl that teachers knew behaved well and my grades were good but once you fall pregnant things change, I was able to bounce back after birth because I had less stress and performed better. "*

P#10:

"I was passing well before falling pregnant, but when I fell pregnant because of stress and worrying I didn't perform that well in my grades and my attendance was affected some days when I had to go to the clinic or not feeling ok. I did however take a gap year in 2021 because I had to stay and take care of the child because there was no money to take the child to crèche. When my sister got a job, she told me to come back to school and she will pay for the child's crèche."

It is evident that pregnancy and motherhood affects the teenage mother's academic progress while having to deal with this new experience in their lives. Trying to find a balance between being a mother and schoolwork seemed challenging for the participants in the above extracts as they shared how their grades have dropped.

5.3.2 Dropping out of school

Teenage pregnancy affects young girls' educational achievement as it may result in drop out. P#16 and P#15 have dropped out of school due to falling pregnant and having no support from their families to assist in caring for the child while they go to school. Dropping out of school as a result of teenage pregnancy is in line with the literature reviewed in Chapter 2 on the impact of teenage pregnancy.

P#16: "*I have to stay home with the children, my partner goes to work so I am on my own to take care of them during the day. My mother chased me out at home, she wanted nothing to do with the children because I decided to be a grown-up as she says. So, who will stay with them if I go to school?"*

P#16 dropped out of school as a result of being pregnant. Being chased out of home by her mother places her at the risk of various social challenges considering that she has to stay with her partner for housing, financial and food security. The teenage mother could have to endure exposure to gender-based violence and homelessness. For the sake of her children, she may endure any hardships and challenges to avoid being homeless, to add if she never returns to school. She will never compete in the labour force market but may only seek employment in the informal sector. Being chased away from home by her mother can be perceived as a negative reinforcement that the mother does not condone or support the participant from falling pregnant.

P#15: "I dropped out of school because we cannot afford to take the child to crèche at home, the social grant money helps to buy some things the baby needs as the father does not give me anything. Being at home is boring, my friends are progressing and me? Nothing. I have to wait for the child to grow up so I can go back to school".

P#15 is also impacted by teenage pregnancy, forcing her to drop out of school. This has a bad impact on her future as she stays home without receiving an education to better her life. The lack of financial means to take her child to day care has resulted in her staying home but is hopeful that she can return to school when the child grows up.

Dropping out of school is evidently caused by a lack of finances for day care or support at home. When these two are available, teenage mothers would be able to resume their studies. Scholars have also found that dropping out of school affects the development and economic growth of women.

5.3.3 The social experiences and stigma of teenage pregnancy

The social experiences surrounding teenage pregnancy often involves stigmatisation, which can have significant implications for the well-being of young mothers. Stigma refers to the negative attitudes, beliefs and stereotypes associated with a particular attribute or condition. Teenage pregnancy is often stigmatised due to societal norms and expectations around the appropriate age of parenthood. This social stigma can contribute to feelings of shame, guilt and isolation, affecting the mental health and self-esteem of teenage mothers.

Below the participants share their experiences during and after pregnancy:

For P#2, she was smoking during her pregnancy and was exposed to violence by the child's father: "*Yho it was tough, I came across so many things that you didn't expect to face, what if maybe something goes wrong because I was smoking while pregnant or if something upset the baby daddy, he would hit me for no reason. So, I was scared that my baby would be hurt."*

P#2's experience during pregnancy highlights that she was exposed to gender-based violence by her child's father, which placed her at the risk of losing her child and being mentally and physically hurt. Her journey of transitioning into motherhood was, as she described it, tough, clearly showing that being pregnant as a teenager, one is likely to

face new life challenges they did not expect or anticipate. The participant was also smoking while pregnant, and this could affect her child's well-being in future as smoking during pregnancy might lead to major complications. The baby may suffer from a birth defect, be delivered prematurely, or succumb to sudden infant death syndrome (SIDS). Smoking can harm the development of the brain and lungs of the child. The negative effects may persist throughout childhood and adolescence. Compared with non-smoking mothers, children whose moms smoke during pregnancy or who are exposed to second-hand smoke after birth have weaker lungs, which increases their risk for several health issues.

P#4 shared how she endured bullying while at school during her pregnancy:

> *"At school, it was unpleasant cause of the learners and the way they would behave around me, I even lost some of my friends but at home it was fine, however when going to give birth yoh! It was tough, I will never again in my life have another baby" P#4*

P#9 shared similar experiences of bullying in the family, school and community members. The shared experiences are stated below by P#*9:*

> *"I didn't think people would judge me, I know teenage pregnancy is wrong, but I was not expecting the treatment, people in class would laugh at me and make jokes about me like saying I am making them sleep. At home, people would say I did not know who the father of my baby was, and I spent a lot of time at home, yet they made it seem like I dated a lot of people. Some people would even post about me on social media, including my friend also posted about me but I didn't take it seriously and had to be strong so I could have my child. I did not want to spend too much time stressing because I'm constantly sick." P#9*

Victims of bullying are more vulnerable to engage in risky behaviours, and experience mental health problems such as depression, anxiety and low self-esteem. The bullying experienced by the participants shows that there is a stigma regarding teenage pregnancy in Extention 78, Polokwane.

P#16 had to move out of home as a result of her pregnancy, and her mother told her to leave their homestead:

"The journey was difficult, even my self-esteem was affected and some of my friends started distancing themselves from me, I didn't have my family's support as my mother told me to leave her house because I decided to be a grown-up. Imagine taking care of two children and you are still young? I regret my decision, but life goes on. I am now living with the children's father, so I have to take care of him and the children to avoid staying in the streets" P#16

P#16 has lost her sense of belonging and being part of a family unit as her mother chased her out. P#16 argued that she got into a transactional relationship to assist her mother. But this resulted in her falling pregnant and being chased out of her home. She now has to depend on the father of her children for security and solely depend on him. She may have to endure ill-treatment in the relationship to avoid homelessness. She is now at a stage where she is faced with conditions of despair and helplessness.

Although they receive the child social grant, the teenage mothers face financial constraints to make ends meet. However, there are participants who share their families assist financially with their children The child support grant assists teenage mothers financially with some of the necessities that a child needs. However, it does not cover all the necessities.

P#8 earns the CSG for her child, but she struggles to cover other basic needs such as food and clothes:

P#8: "My child earns the SASSA grant; it helps buy his nappies and toiletries, but food and clothes are part of the problem I have to provide for my child."

P#10 also receives the CSG for her child, and her family assists her financially with her child as the father of the child chooses when to assist financially:

P#10: "The father's child only chooses when to help financially so my family helps me with the child's expenses where necessary adding on to the SASSA grant".

Unfortunately, P#4 has had to sacrifice from being bought clothes at home for her child. She believes this is better as she does not have the means to support her child financially:

P#4: "Providing for a child is hard, worse at home they make me choose when they must buy clothes, choose between me and my child obviously I will choose the child

because where will I get money to buy clothes and food for her? The Child's grant does not buy everything they need".

The above extract shows that the CSG assists to an extent in providing for the child. But as they are still in school and unemployed, the teenage mothers receive financial assistance from their parents or the child's father. Beyond those forms of support, they will be exposed to more financial burdens. That could cause distress and worry to the teenage mothers to find ways to care for themselves and the children.

5.4 Support and available interventions towards teenage pregnancy

This theme emerged as participants shared what they have been taught regarding safe sex and available interventions from stakeholders such as the Department of Health, and nurses visiting their schools to address teenage pregnancy.

5.4.1 School curriculum inclusion in comprehensive sexual education

Sexual education is part of the ways DBE seeks to mitigate teenage pregnancy and teach school learners comprehensive sexual education.

P#1 has been taught about safe sex in primary and high schools, adding that the teachers were open. She was also taught about the dangers of not practicing safe sex:

> *P#1:*
>
> *"I was taught about sex from primary to high school, the teachers they are open because they do inform us that when you are having sex there are possibilities of you getting pregnant and contracting diseases especially if you don't use condoms."*

P#9's experience in her LO class was different. She believes that her teacher, being a man, may have contributed to her not being taught much about sex:

> *P#9:*
>
> *"I was not taught much about sex in Life Orientation because our teacher was a man, so he was not going into too much detail and did not let us ask questions."*

P#11 was effectively taught about sex in LO, and similar to P#1, the teachers were also open:

> *P#11:*

"We were taught about sex in Life Orientation, and they also called people to come to the school to teach us. I would say on a scale of 1-10 they were open about 8, and they gave us the platform to ask questions, it's just that we didn't listen."

P#4 received adequate sexual education when she moved to her current school. In the school in rural areas where she attended, she was not taught about sex:

P#4:

"Only in grade 9 when I moved here that's when I was taught about it at my new school because my old school was in a very rural area and so they don't inform us about a lot of things assuming they at home we are told about these things".

It is evident and worth to acknowledge that by focusing on Life Orientation, the school curriculum addresses sexual education in their content to teach learners about safe sex and the risks to which they can be exposed. This is also supported in Chapter 2 by literature on how the Department of Education is implementing ways to teach sexual education in classrooms. The participants also shared important information that their teachers are open to communication regarding safe sex and the consequences which could be faced for failure to take safe precautions during sexual intercourse. However, P#9 did not have enough learning about sex because her teacher who was a male did not have an open line of communication in the classroom during LO class.

5.4.2 Stakeholder's Intervention

Some participants (P#8 and P#11) argued that nurses and social workers went to their schools to address or create awareness of teenage pregnancy.

P#8:

"*Nurses and social workers have come during assembly to talk to us about teenage pregnancy and rape. They also told us where to go when we need help, especially with abortion, to not do it on the streets."*

Nurses went to school to address and educate learners about abstaining from sex:

P#11:

"Nurses come once a year and they tell us about teenage pregnancy and not to have sex as school learners and wait for when we finish school."

The above participants argue that nurses and social workers went to the school to raise awareness on teenage pregnancy. This clearly shows that stakeholders are playing a role in schools. However, it does not seem effective as the number of teenage pregnancies is still rising in Extension 78, Polokwane. Stakeholders and schools are at the forefront of assessing the risks of teenage pregnancy and other social ills to which learners are exposed. For schools to allow stakeholders to enter their premises and address the learners is a step in the right direction. However, it is evident that more needs to be done by stakeholders to minimise teenage pregnancy. It is essential to recognise that any intervention should be culturally sensitive, age-appropriate, and adapted to the specific needs of the South African context. In addition to the school curriculum, a multi-sectoral approach involving families, social partners (NGOs), government departments, communities, and healthcare providers is crucial for a comprehensive response to the issue of teenage pregnancy in Limpopo Province and South Africa as a whole.

5.5 Summary of research findings

The teenage mothers in this study were knowledgeable about where to obtain contraceptives but were hesitant to use them due to concerns about potential side effects. Additionally, some reported negative attitudes from healthcare workers at the clinic as a barrier to accessing contraception. These young women primarily received information about contraceptives from trusted sources within their communities, such as family, friends and the media. Despite efforts from healthcare workers, social workers, and educators to educate them about the causes and effects of teenage pregnancy, some mothers still felt that more could be done to prevent it, including more comprehensive awareness campaigns in schools.

Despite being informed about the benefits of contraceptives in preventing pregnancy, teenage mothers in Extension 78 Polokwane, often choose not to use them. Unfortunately, many of these young women express concerns about the potential side effects of contraceptives instead of exploring safe and effective ways to prevent unintended pregnancies. The misconceptions about contraceptives, coupled with

negative attitudes from healthcare workers, is contributing to the alarming rates of teenage pregnancy in the area.

The negative attitude of nurses has serious implications for teenagers seeking quality information about sexual and reproductive health. Teenagers often turn to alternative sources of information, as they find the healthcare system unpleasant due to the attitudes of some nurses. This can lead to a lack of trust in the healthcare system and potentially harmful decision-making. Additionally, school hours often clash with clinic operating times, making it challenging for teenagers to access nearby clinics. Although a mobile clinic was previously available, its closure has made it difficult for teenage mothers to receive necessary services, particularly if they face transportation challenges.

The sexual debut of teenage mothers can often be attributed to peer influence, leading to unintended pregnancies. Study participants revealed that their friends' opinions regarding sexual activity had a significant impact on their decision-making. Despite receiving information from other sources, many teenagers found the negative influence of their peers to be compelling. However, the study also showed that most teenage mothers were not motivated by transactional sex, but rather a desire to fit in and avoid social stigma. This desire to conform is common during adolescence and can be disempowering to young people. Peer pressure can have harmful effects on teenagers and limit their choices.

Teenage pregnancy continues to have drastic effects on teenage mothers who do not have support at home after giving birth as they have to make means to enrol their children at nursery schools or drop out of school to care for their children. Teenage mothers with support at home can continue with their studies after birth and during school assessments. Their families cater for their children while they study. For those with lack of support, this can be challenging and affect their academic progress. Teenage mothers who drop out of school have to find alternative ways to feed their children such as seeking casual jobs and relying on their partners for a source of income.

Transactional relationships in this study have also been found to be contributing to teenage pregnancy as teenagers who are vulnerable date men with means to provide for them financially, and unfortunately, they do not have the means to negotiate safe

sex. The participants argued that the reasons behind this is to help with food or enjoy the gifts or money given by these men to survive. Teenagers engage in transactional sex for benefits. However, they do not have any means of power in negotiating condom use, which can result in pregnancy or STI/STDs. A participant in the study contracted HIV from an older man who got her pregnant. Teenagers engage in early sexual debut, although factors such as transactional sex contribute. The participants of this study engaged in sexual activities because they wanted to and not forced. Some participants asserted that they took precautionary measures such as testing for HIV/AIDS with their partners. Unfortunately, they did not predict that they would fall pregnant.

It is clear that teenager's frequent media platforms as a means of accessing information and entertainment. This notion is further corroborated by experts in Chapter 2, who discuss the impact of media on adolescent attitudes and actions on sexual activity, as portrayed and shared on conventional media outlets like television and social media.

Although the law protects pregnant learners, the teenagers were exposed to bullying and exclusion from their peers and friends. Statutory rape is a prevalent factor contributing to teenage pregnancy. This is evident from the profile of participants, focusing on the age of the fathers and the age of the teenage mothers. P#16 and P#6 shared their lived experiences as to why they dated these older men. However, they are bearing the consequences of this decision to date.

According to this study, teenagers reported spending their weekends at taverns consuming alcohol. They acknowledged that this made them more susceptible to risky sexual behaviours due to impaired judgment. Peer pressure also played a significant role in their decision-making when it came to engaging in risky sexual behaviour, as did misinformation and negative perceptions about contraception. Unfortunately, alcohol consumption among young people only exacerbates these risks. It is important to note that unprotected sexual encounters can result in unplanned teenage pregnancies, and alcohol usage increases the likelihood of engaging in such behaviours.

Despite efforts of the school curriculum and stakeholders to teach sexual education in schools, the number of teenage pregnancies continue to rise. Unfortunately, teenage mothers face bullying in schools and their communities as well.

The overall findings of the study show that teenage pregnancy is contributed by various factors from the themes, and that each teenage mother in the study has a reason that led to her pregnancy. It is evident that in Extension 78, Polokwane, teenagers are at a risk of falling pregnant due to stigma and false information about family planning, transactional relationships, statutory rape and peer pressure. Although the school has a relationship with stakeholders such as nurses and social workers who come to address and create awareness of teenage pregnancy, learners still get pregnant.

CHAPTER SIX: RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

This chapter outlines the overall results of the study and recommendations while considering measures that ought to be taken at a community, healthcare, educational and governmental levels, including stakeholders to address factors and social causes of teenage pregnancy. Lastly, the limitations and conclusions sum up the study.

6.1 Recommendations

The recommendations are based on the research participants' assertions.

6.1.1 Social causes of teenage pregnancy

Economic support and opportunities

To address socio-economic factors by providing support for young parents, such as access to education, job training, childcare services and financial assistance. Empowering young parents to continue their education or to pursue career opportunities can positively impact their future and that of their children. The creation of job opportunities in vulnerable communities for parents/caregivers to assist in providing for young girls and children.

Supportive Family and Community Engagement

To encourage open communication between parents and teenagers about sexual health and relationships. Creating a supportive and non-judgmental environment at home and in the community can help teenagers feel more comfortable discussing these sensitive topics and seeking guidance when needed. Parent and teenager workshops with stakeholders at schools and community levels will help parents to understand the risks and exposures that children are faced with in their communities as they grow into the adolescent stage.

Communities and local governments can find ways to ensure a good working relationship with the local South African Police Services (SAPS), schools, healthcare services, social development and religious organisations to address and prevent teenage pregnancy through awareness and advocacy campaigns. They are available to assist the teenagers within their professional capacity. Mentorship and role models by engaging mentors and positive role models within communities to support and

guide teenagers, especially those at risk of early pregnancy by providing guidance and encouragement.

Media intervention

Media platforms need to be utilised and communication strategies devised to disseminate accurate information about relationships, sexual health, and the risks associated with transactional relationships leading to early pregnancies. Media and technology literacy, promotion and implementation of media literacy and critical thinking skills to help teenagers navigate the influence of media and social media on their perceptions of relationships, sex and body image. Parents also need to ensure and monitor teenagers' access to social media and traditional media such as television shows on age/ parental guidance.

6.1.2 Factors contributing to teenage pregnancy.

Accessible healthcare

Access to contraception and reproductive health services and ensuring easy access to contraception methods and reproductive health services for teenagers. This includes providing information about different contraceptive options and making them affordable and accessible. It is also important for healthcare workers to teach and share accurate information about contraceptives with communities and teenagers to avoid misconceptions and low use of birth control methods.

Youth-friendly healthcare services need to be established nationally, especially in areas where there are higher rates of teenage pregnancy. Youth-friendly healthcare services are specifically designed for young people, ensuring confidentiality, respect and non-discriminatory care. This will encourage teenagers to seek reproductive health services and advice without fear of stigma or judgment.

Educational initiatives need to concentrate on both males and females to mitigate teenage pregnancy. Informative teachings need to be rolled out to teenage boys regarding the facts about risky sexual behaviours, STDs and sexual health. Urge young men to use condoms to prevent unwanted pregnancies and diseases. Additionally, they can be informed about postcoital and alternative forms of contraception. Assist teenage males in realising their responsibilities as partners.

Empower teenage girls by provide them support and a sense of security. Development of efficient strategies that enhance social networks, educate life skills and build self-esteem for girls. Moreover, a concerted effort to change societal standards and perceptions about forced sex and sexual violence is needed.

The establishment of support networks, counselling services and helplines that offer guidance and support to adolescents navigating relationships, peer pressure and sexual health concerns. This can be established by stakeholders who help to alleviate teenage pregnancy in society, both private and public organisations with funding and guidelines. These networks and counselling services will help create a safe space for teenagers.

Empowerment and life skills training programmes can be implemented to build life skills, self-esteem, decision-making and goal-setting to empower teenagers to make informed life choices about their sexual health and overall well-being.

6.1.3 The effects of teenage pregnancy on teenage mothers

Educational and state intervention

Empowerment and life skills training programmes can be implemented to build life skills, self-esteem, decision-making and goal setting to empower teenagers to make informed life choices about their sexual health and overall well-being. This can also be achieved by strengthening existing DBE programmes such as the Young Women and Girls (YW&G) Programme, Breaking the Silence, Determined Resilient Empowered AIDS-free Mentored Safe (DREAMS), and LET'S TALK Prevention of Early and Unintended Pregnancies (EUP) Campaign. There should be accountability for officials and stakeholders who have pledged with DBE and the government as a whole who fail to implement and ensure that the measures and programmes introduced to address teenage pregnancy are working for communities.

To address the issue of bullying of pregnant learners and teenage mothers in schools, SAPS, Social Development, and school policies need to educate students about the laws and effects of bullying. Additionally, social development professionals can establish a referral system with schools to ensure that urgent cases related to statutory rape, risk and bullying receive appropriate assistance.

6.1.4 Support and available interventions towards teenage pregnancy

Comprehensive sex education

Implementing comprehensive and age-appropriate sex education in schools and communities is crucial. This comprehensive sex education should cover topics such as, to name a few, healthy relationships, consent, contraception and the consequences of early pregnancy in Life Orientation and other subjects such as Life Sciences. Although this is covered in the school curriculum currently, there needs to be implementation of peer educators in classrooms and schools who are well informed by their educators and attend training to build a peer-learning environment which can assist learners in having an open line of communication with their educators as mentors. The school curriculum subjects such as Life orientation need to include and highlight transactional relationships, whose consequences need to be shared with teenagers.

Enforcement of laws

There needs to be enforcement of the legal protection of male adults against young girls. Enforce existing laws that protect minors from exploitation and abuse, including laws against child marriage, statutory rape, and exploitation of minors for financial or material gain. More research needs to be done on the culture and family setting's contribution to teenage pregnancy.

It is recommended that a culture that encourages open communication between parents and children, educators and healthcare providers regarding sexuality and relationships be created. This facilitates a safe space for discussions and guidance.

Government departments in collaboration with the Department of Basic Education and non-governmental organisations can organise mobile clinics to visit schools to offer sexual reproductive health services to learners with correct planning measures with schools and school governing bodies.

Advocate for policies that support progressive comprehensive sex education in schools and communities; improve access to reproductive health services; and address systemic issues contributing to teenage pregnancy. Policy changes can play a significant role in creating a supportive environment for teenagers.

There needs to be enforcement of the legal protection of male adults against young girls. Enforce existing laws that protect minors from exploitation and abuse, including laws against child marriage, statutory rape and exploitation of minors for financial or material gain. More research needs to be done on the culture and family setting's contribution to teenage pregnancy.

Addressing teenage pregnancy requires a holistic approach that considers various factors influencing young people's lives. Collaboration among stakeholders and focus on education, access to resources, empowerment and support can contribute to reducing teenage pregnancy rates and promoting the well-being of adolescents.

6.1.5 Experiences of teenage mothers during and after birth

It is important to recognise that teenage mothers may face unique challenges during and after pregnancy. To help them navigate these challenges, it is recommended that they and their families receive psychosocial support. Unfortunately, social stigma, discrimination and negative stereotypes can make things even more challenging for these young women. It is of utmost importance that school management teams, organisations and the wider community come together to establish secure and conducive environments such as support groups with mentors and other teenage mothers that enable teenage mothers to express themselves and receive the necessary support to overcome their challenges and reach their aspirations. By collaborating effectively, we can empower these young women to achieve their full potential.

Advocacy and awareness campaigns need to be implemented in Extension 78 Polokwane, South Africa by community leaders and the municipality to educate the residents on the importance of family planning, laws on statutory rape and the importance of mobile clinics in communities. This will help eradicate the misinformation on forms of contraceptives in the area.

Schools, social partners and government departments working closely with DBE can improve existing advocacy programmes that address learners in preventing teenage pregnancy in schools.

Future research on teenage pregnancy can focus on how the medical field can address the side effects of contraceptives, use other theories to explore and apply on

the social causes of teenage pregnancy and how communities can navigate this social phenomenon with available social spheres of society.

6.2 Limitations of the study

It is important to recognise that teenage mothers may face unique challenges during and after pregnancy. To help them navigate these challenges, it is recommended that they and their families receive psychosocial support. Unfortunately, social stigma, discrimination and negative stereotypes can make things even more challenging for these young women. That is why schools, organisations and the community at large must create safe spaces where teenage mothers can express themselves and receive effective support. By working together, we can help these young women overcome their challenges and achieve their goals.

The study did not include input from nurses, educators and area social workers, which could have broadened understanding of the causes of teenage pregnancy. This is a limitation that newer studies may take up and research further on social causes of teenage pregnancy. This could be done by including the aforementioned important sample group of nurses, educators and area social workers when conducting interviews and collecting data.

The social learning theory was also a limitation in the study as it did not cover a clear explanation to all the themes and sub-themes relating them to the social causes and factors contributing to teenage pregnancy. Thus, researchers can opt for other social science theories to best understand the phenomenon of teenage pregnancy from a scientific view.

6.3 Conclusion

This study has delved into the intricate and multifaceted issue of teenage pregnancy, exploring its various dimensions, and shedding light on the interconnected factors that influence its occurrence. The study has sought to deepen our understanding of the challenges faced by teenage mothers with particular emphasis on the impact of socioeconomic factors, peer pressure, the role of social learning theory, healthcare services and interventions from government and NGOs.

Through this study, it was discovered that teenage pregnancy remains a persistent social issue that impacts both local communities and the country at large. The

experiences of young mothers who have left school underscore the importance of intervention programmes and policies that can help these teenage mothers return to school and build better lives for themselves and their children. To address this problem, legislative frameworks should be present throughout South African communities, and online petitions should be given serious consideration by the government as a means of identifying effective solutions to the increasing number of teenage pregnancies.

Lastly, this study contributes to the existing body of knowledge on teenage pregnancy, offering insights that can inform evidence-based interventions and policies aimed at improving the lives of pregnant teenagers and fostering a more supportive and understanding society. The journey towards addressing teenage pregnancy is ongoing, and it is our collective responsibility to work towards creating a future where every young person has the opportunity to thrive, irrespective of their reproductive choices.

LIST OF REFERENCES

Abbott, T., 2021. *Social and personality development*. Routledge.

Abdool Karim, S., Baxter, C., Frohlich, J. and Abdool Karim, Q., 2014. The need for multipurpose prevention technologies in Sub-Saharan Africa. *BJOG: An International Journal of Obstetrics & Gynaecology,* 121, pp.27-34.

Abrams, B., 2021. *Maternal undernutrition and reproductive performance*. In Infant and Child Nutrition Worldwide*:* (pp. 31-60). CRC Press.

Abu-Ouf, N.M. and Jan, M.M., 2015. The impact of maternal iron deficiency and iron deficiency anemia on child's health. *Saudi medical journal*, *36*(2), pp.146.

Aderibigbe, S.A., Araoye, M.O., Akande, T.M., Musa, O.I., Monehin, J.O. and Babatunde, O.A., 2011. Teenage pregnancy and prevalence of abortion among in-school adolescents in North Central, Nigeria. *Asian social science*, *7*(1), pp.122.

Adetutu, O., Asa, S., Solanke, B., Aroke, A.A. and Okunlola, D., 2021*. Socio-cultural and gender-based issues that shape sexuality of emerging adults in Nigeria: A qualitative approach.*

Ahinkorah, B.O., Obisesan, M.T., Seidu, A.A. and Ajayi, A.I., 2021. Unequal access and use of contraceptives among parenting adolescent girls in sub-Saharan Africa: a cross-sectional analysis of demographic and health surveys. *BMJ open*, *11*(9), pp.e051583.

Ahinkorah, B.O., 2020. *Individual and contextual factors associated with mistimed and unwanted pregnancies among adolescent girls and young women in selected high fertility countries in sub-Saharan Africa: a multilevel mixed effects analysis. Plos one*, *15*(10), pp.e0241050.

Ajayi, A.I. and Ezegbe, H.C., 2020. Association between sexual violence and unintended pregnancy among adolescent girls and young women in South Africa. *BMC Public Health*, 20(1), pp.1-10.

Akombi-Inyang, B.J., Woolley, E., Iheanacho, C.O., Bayaraa, K. and Ghimire, P.R., 2022. Regional trends and socioeconomic predictors of adolescent pregnancy

in Nigeria: a nationwide study. *International journal of environmental research and public health*, *19*(13), pp.8222.

Ayanaw, Y., Yalew, A. and Azale Bisetegn, T., 2018. Prevalence and factors associated with teenage pregnancy, northeast Ethiopia, 2017: A cross-sectional study. *Journal of Pregnancy,* 2018.

Achen, D., Fernandes, D., Kemigisha, E., Rukundo, G.Z., Nyakato, V.N. and Coene, G., 2023. Trends and challenges in Comprehensive Sex Education (CSE) research in Sub-Saharan Africa: A narrative review. *Current Sexual Health Reports*, pp.1-9.

Adekola, A.P. and Mavhandu-Mudzusi, A.H., 2021. Addressing learner-centred barriers to sexuality education in rural areas of South Africa: Learners' perspectives on promoting

Babbie, E. and Mouton, J., 2002. *Social research.* Belmont, CA: Wadsworth Group.

Bandura, A., 1986. The explanatory and predictive scope of self-efficacy theory. *Journal of Social and Clinical Psychology*, *4*(3), pp.359-373.

Bandura, A., 2021. Analysis of modelling processes. In *Psychological Modelling* (p. 1-62). Routledge.

Bandura, A. and Hall, P., 2018. *Albert bandura and social learning theory*. *Learning theories for early years practice*, pp.63-65.

Bandura, A. and Walters, R.H. 1977. *Social learning theory (Vol. 1).* Prentice Hall: Englewood Cliffs.

Barron, P. and Padarath, A., 2017. Twenty years of the South African health review. *South African Health Review*, *2017*(1), p.1-10.

Barron, P., Subedar, H., Letsoko, M., Makua, M. and Pillay, Y., 2022. Teenage births and pregnancies in South Africa, 2017-2021–a reflection of a troubled country: Analysis of public sector data. *South African Medical Journal*, *112*(4), pp.252-258.

BBC News., 2018. *South Africa teen pregnancy: Juggling school exams and baby twins.* Available at: https://www.bbc.com/news/world-africa-45889366. [Accessed 7 February 2022].

Bergstrom, K. and Özler, B., 2023. Improving the well-being of adolescent girls in developing countries. *The World Bank Research Observer*, *38*(2), pp.179-212

Bhattacherjee, A., 2012. *Social science research: Principles, methods, and practices*. USA.

Bolarinwa, O.A., 2021. Factors associated with limited access to condoms and sources of condoms during the COVID-19 pandemic in South Africa. *MedRxiv*, pp.2020-09.

Barbour, R.S., 2014. Quality of data analysis. *The SAGE handbook of qualitative data analysis*, pp.496-510.

Bhana, D., 2016. Virginity and virtue: African masculinities and femininities in the making of teenage sexual cultures. *Sexualities*, *19*(4), pp.465-481.

Bosire, E.N., Chiseri, K., Comeau, D.L., Richter, L., Stein, A.D. and Norris, S.A., 2021. A qualitative study of risks and protective factors against pregnancy among sexually active adolescents in Soweto, South Africa. *PLOS Global Public Health*, *1*(11), pp.e0000044

Branson, N. and Byker, T., 2016. *Youth friendly clinics make inroads in reducing unintended teen births in South Africa*.

Burkholder, C. and Thompson, J. eds., 2020. *Fieldnotes in qualitative education and social science research: approaches, practices, and ethical considerations*. Routledge.

Butts, K.H. and Thomas, P.R., 2019. *The geopolitics of Southern Africa: South Africa as regional superpower*. Routledge.

Cole, C., Coppola, A., Cutherell, M., Ede, J.O., Elabo, A., Hamza, I., Idris, R., Ogbondeminu, F.O., Ogungbenro, T., Oluwayinka, A.G. and Phillips, M., *Connecting contraception to girls' lives and aspirations in southern Nigeria: the case of 9ja girls.* 2020.

Chavula, M.P., Zulu, J.M. and Hurtig, A.K., 2022. Factors influencing the integration of comprehensive sexuality education into educational systems in low-and middle-income countries: a systematic review. *Reproductive health*, *19*(1), p.196.

Cook, S.M. and Cameron, S.T., 2020. Social issues of teenage pregnancy. *Obstetrics, Gynaecology & Reproductive Medicine*, *30*(10), pp.309-314.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D. and McIntyre, D., 2009. The health and health system of South Africa: historical roots of current public health challenges. *The lancet*, *374*(9692), pp.817-834.

Chandra-Mouli, V., Plesons, M., Adebayo, E., Amin, A., Avni, M., Kraft, J.M., Lane, C., Brundage, C.L., Kreinin, T., Bosworth, E. and Garcia-Moreno, C., 2017. Implications of the global early adolescent study's formative research findings for action and for research. *Journal of Adolescent Health*, *61*(4), pp.S5-S9.

Chersich, M.F., Wabiri, N., Risher, K., Shisana, O., Celentano, D., Rehle, T., Evans, M. and Rees, H., 2017. Contraception coverage and methods used among women in South Africa: A national household survey. *South African Medical Journal,* 107(4), pp.307-314.

Chicanequisso, E.M., Sabonete, A., Sacarlal, J., Rossetto, E.V. and Baltazar, C.S., 2023. *Factors associated with high HIV infection among adolescents and young adults in Mozambique: Sub-Analysis of Immunization, Malaria and HIV/AIDS Indicators Survey in Mozambique-IMASIDA 2015.*

Chidi, S.C., 2011. *An evaluation of rural-urban migration and its link to informal settlement pattern: a case study of Disteneng in Polokwane Municipality in Limpopo Province* (Doctoral dissertation, University of Limpopo (Turfloop Campus).

Chingono, N., 2021. https://www.theguardian.com/global-development/2021/jul/20/contraception-divides-opinion-tackling-taboos-in-zimbabwe-as-teen-pregnancies-soar.

https://letabaherald.co.za/115673/more-than-11-000-limpopo-learners-impregnated/.

Chingono, R., Kasese, C., Miles, S. and Busza, J., 2022. 'I was in need of somewhere to release my hurt:' Addressing the mental health of vulnerable adolescent mothers in Harare, Zimbabwe, through self-help groups. *Global health action*, *15*(1), pp.2040151.

Christmals, C.D. and Aidam, K., 2020. Implementation of the National Health Insurance Scheme (NHIS) in Ghana: lessons for South Africa and low-and middle-income countries. *Risk Management and Healthcare Policy*, pp.1879-1904.

Christoffels, R. and Mash, B., 2018. How well do public sector primary care providers function as medical generalists in Cape Town: a descriptive survey? *BMC Family Practice*, *19*, pp.1-9.

Cluver, L., Rudgard, W.E., Toska, E., Orkin, M., Ibrahim, M., Langwenya, N., Kuo, C., Xaba, N., Roehm, K., Smith, M. and Bernardini, S., 2022. Food security reduces multiple HIV infection risks for high-vulnerability adolescent mothers and non-mothers in South Africa: a cross-sectional study. *Journal of the International AIDS Society*, *25*(8), pp.e25928.

Dahmen, B., Konrad, K., Jahnen, L., Herpertz-Dahlmann, B. and Firk, C., 2019. Mental health of teenage mothers: impact on the next generation. *Der Nervenarzt*, *90*, pp.243-250.

Delany-Moretlwe, S., Cowan, F.M., Busza, J., Bolton-Moore, C., Kelley, K. and Fairlie, L., 2015. Providing comprehensive health services for young key populations: needs, barriers and gaps. *Journal of the International AIDS Society*, *18*, pp.19833.

Department of Basic Education., 2015. *Draft Department of Basic Education national policy on HIV, STIs and TB* (pp. Government Gazette 395).

Deterding, N.M. and Waters, M.C., 2021. Flexible coding of in-depth interviews: A twenty-first-century approach. *Sociological Methods & Research, 50*(2), pp.708-739.

Dickson-Tetteh, K., Pettifor, A. and Moleko, W., 2001. Working with public sector clinics to provide adolescent-friendly services in South Africa. *Reproductive Health Matters*, *9*(17), pp.160-169.

Duby, Z., McClinton Appollis, T., Jonas, K., Maruping, K., Dietrich, J., Lovette, A., Kuo, C., Vanleeuw, L. and Mathews, C., 2021. "As a young pregnant girl… the challenges you face": exploring the intersection between mental health and sexual and reproductive health amongst adolescent girls and young women in South Africa. *AIDS and Behavior*, *25*, pp.344-353.

Du Preez, A., Manyathi, D.G., Botha, A.J. and Rabie, T., 2019. Secondary school teachers' experiences related to learner teenage pregnancies and unexpected deliveries at school. *Health SA Gesondheid*, 24(1), pp.1-7.

Edwards, T., Mkwanazi, N., Mitchell, J., Bland, R.M. and Rochat, T.J., 2020. Empowering parents for human immunodeficiency virus prevention: Health and sex education at home. *Southern African Journal of HIV Medicine*, *21*(1).

Erzse, A., Goldstein, S., Norris, S.A., Watson, D., Kehoe, S.H., Barker, M., Cohen, E. and Hofman, K.J., 2021. Double-duty solutions for optimising maternal and child nutrition in urban South Africa: a qualitative study. *Public Health Nutrition*, *24*(12), pp.3674-3684.

Espinoza, C., Samandari, G. and Andersen, K., 2020. Abortion knowledge, attitudes and experiences among adolescent girls: a review of the literature. *Sexual and reproductive health matters*, *28*(1), pp.1744225.

Evans, R., Widman, L., Kamke, K. and Stewart, J.L., 2020. Gender differences in parents' communication with their adolescent children about sexual risk and sex-positive topics. *The Journal of Sex Research*, *57*(2), pp.177-188

Gallen, Y., Joensen, J.S., Johansen, E.R. and Veramendi, G.F., 2023. The labor market returns to delaying pregnancy. *Available at SSRN 4554407*.

Geary, R.S., Gómez-Olivé, F.X., Kahn, K., Tollman, S. and Norris, S.A., 2014. Barriers to and facilitators of the provision of a youth-friendly health services programme in rural South Africa. *BMC Health Services Research*, *14*(1), pp.1-8.

Gichane, M.W., Moracco, K.E., Pettifor, A.E., Zimmer, C., Maman, S., Phanga, T., Nthani, T. and Rosenberg, N.E., 2020. Socioeconomic predictors of transactional sex in a cohort of adolescent girls and young women in Malawi: a longitudinal analysis. *AIDS and Behavior*, *24*, pp.3376-3384.

Gombe, M.M., Cakouros, B.E., Ncube, G., Zwangobani, N., Mareke, P., Mkwamba, A., Prescott, M.R., Bhatasara, T., Murwira, M., Mangwiro, A.Z. and Prust, M.L., 2020. Key barriers and enablers associated with uptake and continuation of oral pre-exposure prophylaxis (PrEP) in the public sector in Zimbabwe: qualitative perspectives of general population clients at high risk for HIV. *PLoS One*, *15*(1), pp. e0227632.

Goudeau, S., Sanrey, C., Stanczak, A., Manstead, A. and Darnon, C., 2021. Why lockdown and distance learning during the COVID-19 pandemic are likely to increase the social class achievement gap. *Nature Human Behaviour*, *5*(10), pp.1273-1281.

Govender, D., Naidoo, S. and Taylor, M., 2020. “My partner was not fond of using condoms and I was not on contraception”: understanding adolescent mothers’ perspectives of sexual risk behaviour in KwaZulu-Natal, South Africa. *BMC Public Health*, *20*, pp.1-17.

Govender, D., Naidoo, S. and Taylor, M., 2020. Antenatal and postpartum depression: prevalence and associated risk factors among adolescents’ in KwaZulu-Natal, South Africa. *Depression Research and Treatment*, *2020*.

Granlund, S. and Hochfeld, T., 2020. ‘That child support grant gives me powers’–exploring social and relational aspects of cash transfers in South Africa in times of livelihood change. *The Journal of Development Studies,* 56(6), pp.1230-1244.

Grant, C. and Osanloo, A., 2014. Understanding, selecting, and integrating a theoretical framework in dissertation research: Creating the blueprint for your “house”. *Administrative Issues Journal*, *4*(2), pp.4.

Gunawardena, N., Fantaye, A.W. and Yaya, S., 2019. Predictors of pregnancy among young people in sub-Saharan Africa: a systematic review and narrative synthesis. *BMJ global health*, *4*(3), pp.e001499.

Gupta, A. and Gupta, N., 2022. *Research methodology*. SBPD Publications.

Gierczyk, M.K., Gromkowska-Melosik, A., Scott, S. and Parker, C., 2023. The Snowball Sampling Strategy in the Field of Social Sciences. Contexts and Considerations. Contexts and Considerations. *Przegląd Badań Edukacyjnych*, *43*(2).

Hall, M., & Farkas, G., 2011. Adolescent cognitive skills, attitudinal/behavioral traits and career wages. *Social Forces,* 89(4), 1261-1285.

Hancock, D.L., 2012. *Predicting the risk of teenage pregnancy among African Americans: an investigation of a social contextual model* (Doctoral dissertation, University of Georgia).

Harries, J., Daskilewicz, K., Bessenaar, T. and Gerdts, C., 2021. Understanding abortion seeking care outside of formal health care settings in Cape Town, South Africa: a qualitative study. *Reproductive Health*, *18*, pp.1-8.

Hultstrand, J.N., Tydén, T., Jonsson, M. and Målqvist, M., 2019. Contraception use and unplanned pregnancies in a peri-urban area of eSwatini (Swaziland). *Sexual & Reproductive Healthcare*, *20*, pp.1-6.

Jacobsen, K. and Nichols, R.F., 2011. Developing a profiling methodology for displaced people in urban areas: Final report. *Feinstein International Center*.

Jaén-Sánchez, N., González-Azpeitia, G., Saavedra-Santana, P., Saavedra-Sanjuán, E., Manguiza, A.A., Manwere, N., Carranza-Rodriguez, C., Pérez-Arellano, J.L. and Serra-Majem, L., 2020. Adolescent motherhood in Mozambique. Consequences for pregnant women and newborns. *Plos One*, *15*(6), pp.e0233985.

Janighorban, M., Boroumandfar, Z., Pourkazemi, R. and Mostafavi, F., 2022. Barriers to vulnerable adolescent girls' access to sexual and reproductive health. *BMC Public Health*, *22*(1), pp.1-16.

Jonas, K., Crutzen, R., van den Borne, B., Sewpaul, R. and Reddy, P., 2016. Teenage pregnancy rates and associations with other health risk behaviours: a three-wave cross-sectional study among South African school-going adolescents. *Reproductive Health*, *13*(1), pp.1-14.

Jones, C., Whitfield, C., Seymour, J. and Hayter, M., 2019. 'Other girls': A qualitative exploration of teenage mothers' views on teen pregnancy in contemporaries. *Sexuality & Culture*, *23*(3), pp.760-77.

Kabwigu, S. and Nsibirano, R., 2016. Financial *limitations and economics of survival-predictors of adolescent pregnancies: evidence from teenage boys and girls in Luuka District, Uganda.*

Kassa, G.M., Arowojolu, A.O., Odukogbe, A.A. and Yalew, A.W., 2018. Prevalence and determinants of adolescent pregnancy in Africa: a systematic review and meta-analysis. *Reproductive Health,* 15(1), pp.1-17.

Kaswa, R. and Yogeswaran, P., 2020. Abortion reforms in South Africa: An overview of the Choice on Termination of Pregnancy Act. *South African Family Practice*, *62*(4).

Keeton, V., Soleimanpour, S. and Brindis, C.D., 2012. School-based health centers in an era of health care reform: Building on history. *Current Problems in Pediatric and Adolescent Health Care*, *42*(6), pp.132-156.

Kilburn, K.N., Pettifor, A., Edwards, J.K., Selin, A., Twine, R., MacPhail, C., Wagner, R., Hughes, J.P., Wang, J. and Kahn, K., 2018. Conditional cash transfers and the reduction in partner violence for young women: an investigation of causal pathways using evidence from a randomized experiment in South Africa (HPTN 068). *Journal of the International AIDS Society*, *21*, pp.e25043.

Khoa, B.T., Hung, B.P. and Hejsalem-Brahmi, M., 2023. Qualitative research in social sciences: data collection, data analysis and report writing. *International Journal of Public Sector Performance Management*, *12*(1-2), pp.187-209.

Khoza, N., Zulu, P. and Shung-King, M., 2019. Acceptability and feasibility of a school-based contraceptive clinic in a low-income community in South Africa. *Primary Health Care Research & Development*, *20*, pp.e22.

Kirchengast, S., 2016. Teenage pregnancies: a worldwide social and medical problem. *An Analysis of Contemporary Social Welfare Issues, 13*.

Kostere, S. and Kostere, K., 2021. *The generic qualitative approach to a dissertation in the social sciences: A step by step guide*. Routledge.

Kriel, Y., Milford, C., Cordero, J., Suleman, F., Beksinska, M., Steyn, P. and Smit, J.A., 2019. Male partner influence on family planning and contraceptive use: perspectives from community members and healthcare providers in KwaZulu-Natal, South Africa. *Reproductive Health*, *16*(1), pp.1-15.

Krisch, M., Averdijk, M., Valdebenito, S. and Eisner, M., 2019. Sex trade among youth: A global review of the prevalence, contexts and correlates of transactional sex among the general population of youth. *Adolescent Research Review*, *4*, pp.115-134.

Kurevakwesu, W., Mthethwa, E., Chirangwanda, K. and Mabeza, T., 2023. Parental perceptions towards reintegration of pregnant girls and teenage mothers into the education system in Zimbabwe. *Cogent Social Sciences*, *9*(1), pp.2186564.

Lambani, M.N., 2015. Poverty the cause of teenage pregnancy in Thulamela municipality. *Journal of Sociology and Social Anthropology, 6*(2), pp.171-176.

Lebese, R.T., Maputle, M.S., Mabunda, J.T. and Chauke, P.K., 2015. Knowledge, attitudes and perception of students on teenage pregnancy: a case study of rural based University students in South Africa. *Journal of Human Ecology*, *51*(1-2), pp.55-65.

Lince-Deroche, N, Shochet, T, Sibeko, J, Mdlopane, L, Pato, S, Makhubele, Q S, & Bessenaar, T., 2018.You can talk about condoms [with younger men] while older men ... beat you for that': Young women's perceptions of gender-based violence within intergenerational relationships in South Africa. *SAMJ: South African Medical Journal*, *108*(8), pp. 682-686.

Loja, S.L.M., 2022. *Media's influence on the 21st century society: A global criminological systematic review* (Master's thesis).

Maharaj, N.R., 2022. Adolescent pregnancy in sub-Saharan Africa–a cause for concern. *Frontiers in Reproductive Health*, *4*, pp.984303.

Maibvisira, C., 2019. *"Sex… is a good thing": Creating a space for the voices of young Zimbabweans to shape school-based HIV prevention-orientated sexuality education* (Doctoral dissertation, Auckland University of Technology).

Malakoane, B., Heunis, J.C., Chikobvu, P., Kigozi, N.G. and Kruger, W.H., 2020. Public health system challenges in the Free State, South Africa: A situation appraisal to inform health system strengthening. *BMC Health Services Research*, *20*, pp.1-14.

Malisa, J.N., 2015. *Factors contributing to teenage pregnancies in Tunduru district council* (Doctoral dissertation, Mzumbe University.).

Mathewos, S. and Mekuria, A., 2018. Teenage pregnancy and its associated factors among school adolescents of Arba Minch town, southern Ethiopia. *Ethiopian Journal of Health Sciences,* 28(3), pp.287-298.

Matlala, A. 2022. 'More than 11 000 Limpopo learners impregnated', *The Citizen*, 15 July 2022. https://www.citizen.co.za/letaba-herald/news-headlines/2022/07/15/more-than-11-000-limpopo-learners-impregnated/.

Maromo, J. 2023. *15-year-old among 50 Limpopo teenagers who gave birth on Christmas Day*. Independent Online. Available at: https://www.iol.co.za/news/south-africa/15-year-old-among-50-limpopo-teenagers-who-gave-birth-on-christmas-day-efc28d35-7a02-4053-9cb9-c5dc67e328fe. (Accessed: 27 December 2023).

Mavodza, C.V., Bernays, S., Mackworth-Young, C.R., Nyamwanza, R., Nzombe, P., Dauya, E., Dziva Chikwari, C., Tembo, M., Apollo, T., Mugurungi, O. and Madzima, B., 2022. Interrupted access to and use of family planning among youth in a community-based service in Zimbabwe during the first year of the COVID-19 Pandemic. *Studies in Family Planning*, *53*(3), pp.393-415.

McElroy, S.W., and Moore, K.A., 2018. *Trends over time in teenage pregnancy and childbearing: the critical changes*. In Kids having kids (pp. 23-53). Routledge.

Mchunu, G., Peltzer, K., Tutshana, B. and Seutlwadi, L., 2012. Adolescent pregnancy and associated factors in South African youth. *African Health Sciences*, *12*(4), pp.426-434.

McLeod, J. and O'Connor, K., 2020. Ethics, archives, and data sharing in qualitative research. *Educational Philosophy and Theory*, *53*(5), pp.523-535.

McLeod, S., 2011. *Albert Bandura's social learning theory.*

Mdluli, P. and Dunga, S., 2022. Determinants of poverty in South Africa using the 2018 general household survey data. *Journal of Poverty*, *26*(3), pp.197-213.

Mehrad, A. and Zangeneh, M.H.T., 2019. Comparison between qualitative and quantitative research approaches: Social sciences. *International Journal for Research in Educational Studies, Iran*, *5*(7), pp.1-7.

Mezmur, H., Assefa, N. and Alemayehu, T., 2021. Teenage pregnancy and its associated factors in eastern Ethiopia: a community-based study. *International Journal of Women's Health*, pp.267-278.

Mkhonta, Z., Kaplan, L., Nxumalo-Magagula, N.N., Faye, A., Gary, F.A., Zanele, C., Mhlongo-Manana, Z.C., Percis, P., Khumalo, P.P., Mkhonta, R.N. and Mathunjwa-Dlamini, T.R., 2019. Knowledge and attitudes of female adolescents' regarding contraceptive use in one high school in Manzini, Swaziland. *Multidisciplinary Journal of Language and Social Sciences Education*, *2*(2), pp.145-169.

Mkwananzi, S., 2013. Poverty-an explanation for teenage pregnancy in South Africa? *Review of Development Economics*, *8*, pp.198-222.

Mkwananzi, S., 2020. The role of family dynamics in teenage pregnancy and childbearing in Sub-Saharan Africa. *Family Demography and Post-2015 Development Agenda in Africa*, pp.355-377.

Mmari, K., Kalamar, A.M., Brahmbhatt, H. and Venables, E., 2016. The influence of the family on adolescent sexual experience: A comparison between Baltimore and Johannesburg. *PloS one*, *11*(11), pp.e0166032.

Mosley, E.A., King, E.J., Schulz, A.J., Harris, L.H., De Wet, N. and Anderson, B.A., 2017. Abortion attitudes among South Africans: findings from the 2013 social attitudes survey. *Culture, Health & Sexuality*, 19(8), pp.918-933

Mostert, K., Sethole, K.M., Khumisi, O., Peu, D., Thambura, J., Ngunyulu, R.N. and Mulaudzi, M.F., 2020. Sexual knowledge and practice of adolescent learners in a rural South African school. *African Health Sciences*, *20*(1), pp.28-38.

Mothiba, T.M. and Maputle, M.S., 2012. Factors contributing to teenage pregnancy in the Capricorn district of the Limpopo Province. *Curationis*, *35*(1), pp.1-5.

Mthembu, Z., Maharaj, P. and Rademeyer, S., 2019. "I am aware of the risks, I am not changing my behaviour": risky sexual behaviour of university students in a high-HIV context. *African Journal of AIDS Research*, *18*(3), pp.244-253.

Mudau, T.S., 2019. Redressing marginalisation among teenage mothers through university community engagement approach. *Gender and Behaviour*, *17*(3), pp.13539-13548.

Munyai, H.S., Makhado, L., Ramathuba, D.U. and Lebese, R.T., 2023. Challenges on sexual health communication with secondary school learners, Limpopo province. *Curationis*, *46*(1), pp.1-9.

Murewanhema, G., Moyo, E. and Dzinamarira, T., 2023. Teenage pregnancy in Zimbabwe: A call for expedited interventions. *Children and Youth Services Review*, *150*(C).

Musanshiko, R., 2019. *Influence of teenage pregnancy on school completion rates among girls at mulekatembo secondary school* (Doctoral dissertation, Cavendish University).

Musetha, N., 2013. *Teenage pregnancies in Limpopo worrying.* Retrieved: 20 April 2021.https://health-e.org.za/2013/11/04/teenage-pregnancies-limpopo-worrying/.

Mushwana, L., Monareng, L., Richter, S. and Muller, H., 2015. Factors influencing the adolescent pregnancy rate in the greater Giyani Municipality, Limpopo

Province–South Africa. *International Journal of Africa Nursing Sciences,* 2, pp.10-18.

Mutara, N.M.G., 2015. Factors contributing to teenage pregnancies in a rural community of Zimbabwe. *Journal of Biology, Agriculture and Healthcare*, *5*, pp.14.

Muthukrishna, N. and Nkabinde, R., 2021. The journey into motherhood and schooling: narratives of teenage mothers in the South African context. *International Journal of Inclusive Education*, *25*(10), pp.1125-1139.

Mvune, N. and Bhana, D., 2023. Caring masculinities? Teenage fathers in South Africa. *Journal of Family Studies*, *29*(3), pp.1346-1361.

Ncube, D. and Mudau, T.J., 2018. An exploration into the challenges faced by pregnant teenagers: a case study of Kgapane Township around Mamokgadi village of the Limpopo province of South Africa. *Gender and Behaviour*, *16*(2), pp.11593-11603.

Ndinda, C., Ndhlovu, T. and Khalema, N.E., 2017. Conceptions of contraceptive use in rural KwaZulu-Natal, South Africa: lessons for programming. *International Journal of Environmental Research and Public Health*, *14*(4), pp.353.

Netshikweta, M.L., Olaniyi, F.C and Tshitangano. T.G., 2018. Reproductive health choices among adolescents in secondary schools: a case study of selected schools in Limpopo, South Africa. *The Open Public Health Journal,* 11(1).

Neville, S.E., Saran, I. and Crea, T.M., 2022. Parental care status and sexual risk behavior in five nationally-representative surveys of sub-Saharan African nations. *BMC Public Health*.

Ngonso, B.F., 2019. Effect of social media on teenagers and youths: A study of rural Nigerian teenagers and youths in secondary schools. *Global Media Journal*, *17*(32), pp.1-6.

Ngubane, N. and Maharaj, P., 2018. *Childbearing in the context of the child support grant in a rural area in South Africa.* SAGE Open, 8(4), pp.2158244018817596.

Ninsiima, L.R., Chiumia, I.K. and Ndejjo, R., 2021. Factors influencing access to and utilisation of youth-friendly sexual and reproductive health services in sub-Saharan Africa: a systematic review. *Reproductive health*, *18*(1), pp.1-17.

Nkosi, N.N. and Pretorius, E., 2019. The influence of teenage pregnancy on education: perceptions of educators at a secondary school in Tembisa, Gauteng. *Social Work,* 55(1), pp.108-116.

Ngwenya, T., & Moeketsi, Z. (2022). Evaluating the Effectiveness of Media Campaigns in Reducing Teenage Pregnancy in South Africa. *Health Communication*, 37(5), 341-356.

Nyoni, J. and Rapeta, S.J., 2022. Ethnic Culture, Human Rights, and Social Justice: A Dilemma for School Teenage Pregnancy and Policy Implementation. *African Perspectives of Research in Teaching and Learning*, *6*(1), pp.18-33.

Ochen, A.M., Chi, P.C. and Lawoko, S., 2019. Predictors of teenage pregnancy among girls aged 13–19 years in Uganda: a community-based case-control study. *BMC Pregnancy and Childbirth*, *19*(1), pp.1-14.

O'Connor, T.G., Monk, C. and Burke, A.S., 2016. Maternal affective illness in the perinatal period and child development: findings on developmental timing, mechanisms, and intervention. *Current Psychiatry Reports*, *18*, pp.1-5.

Orben, A., Tomova, L. and Blakemore, S.J., 2020. The effects of social deprivation on adolescent development and mental health. *The Lancet Child & Adolescent Health*, *4*(8), pp.634-640.

Paton, D., Bullivant, S. and Soto, J., 2020. The impact of sex education mandates on teenage pregnancy: International evidence. *Health Economics, 29*(7), pp.790-807.

Pieterse, C.E., 2019. *Life orientation lecturers' experiences of sexuality education: implications for curriculum development* (Doctoral dissertation, North-West University (South Africa)).

Qolesa, S.K., 2017. *Factors influencing teenage pregnancy in Heidedal location, Mangaung district*.

Ramalepa, T.N., 2023. The role of community health nurses in promoting school learners' reproductive health in North West province. *Health SA Gesondheid (Online)*, *28*, pp.1-8.

Ramathuba, D.U. and Mashapha, V.A., 2019. Community perceptions of media influence on adolescent sexual health in, Mutale Municipality of Limpopo province. *Gender and Behaviour*, *17*(2), pp.12801-12808.

Raphael-Leff, J., 2018. *The psychological processes of childbearing*. Routledge.

Risenga, P.R. and Mboweni, S.H., 2022. Adolescent girls' experiences regarding teenage pregnancy in the rural villages of Limpopo Province, South Africa. *Adolescents*, *3*(1), pp.60-71.

Roberts, K.J., Smith, C., Cluver, L., Toska, E. and Sherr, L., 2021. Understanding mental health in the context of adolescent pregnancy and HIV in Sub-Saharan Africa: a systematic review identifying a critical evidence gap. *AIDS and Behavior*, *25*, pp.2094-2107.

Rohmah, N., Yusuf, A., Hargono, R. and Laksono, A.D., 2020. Determinants of teenage pregnancy in Indonesia. *Indian Journal of Forensic Medicine & Toxicology*, *14*(3), pp.2105-2110.

Rotter, J.B., 2021. Social learning theory. In *Expectations and actions* (pp. 241-260). Routledge.

Salmona, M., Lieber, E. and Kaczynski, D., 2019. *Qualitative and mixed methods data analysis using Dedoose: A practical approach for research across the social sciences*. Sage Publications.

Savage-Oyekunle, O.A. and Nienaber, A., 2015. Female adolescents' evolving capacities in relation to their right to access contraceptive information and services: a comparative study of South Africa and Nigeria. *Comparative and International Law Journal of Southern Africa*, *48*(1), pp.98-123.

Save the Children.Org South Africa., 2021. *Save the Children South Africa | Teen pregnancies increase during Covid-19.* Available at:

https://www.savethechildren.org.za/news-and-events/news/teen-pregnancies-increase-during-covid-19. [Accessed 6 April 2022].

Shuger, L. (2020). Teen Pregnancy and High School Dropout: What Communities Can Do to Help. *Public Health Reports*, 135(3), 345-350.

Sepeng, N.V., Mulaudzi, F.M., Mathivha, P., Musie, M.F. and Seretlo, R.J., 2023. Strategies to enhance sexual health education for prevention of teenage pregnancy in Vhembe District, Limpopo Province: different stakeholder's perspectives, a co-operative Inquiry qualitative protocol paper. *Reproductive Health*, *20*(1), pp.1-5.

Shaikh, N., Grimwood, A., Eley, B., Fatti, G., Mathews, C., Lombard, C. and Galea, S., 2021. Delivering an integrated sexual reproductive health and rights and HIV programme to high-school adolescents in a resource-constrained setting. *Health Education Research*, *36*(3), pp.349-361.

Sileyew, K.J., 2019. Research design and methodology. *Cyberspace*, pp.1-12.

Sithole, S.L., Higson-Smith, C. and Bless, C., 2013. *Fundamentals of social research methods: An African perspective.* Cape Town: Juta.

Skobi, F. and Makofane, M., 2017. Reflections of social workers on the experiences of pregnant teenagers during group work sessions. *Social Work*, *53*(2), pp.224-249.

Skosana, I., 2013. *Stuck in a destructive cycle of poverty and teen pregnancy*. The Mail & Guardian. Available at: https://mg.co.za/article/2013-08-16-00-stuck-in-a-destructive-cycle-of-poverty-and-teen-pregnancy/. [Accessed 12 April 2022].

Skosana, M.T., Peu, M.D. and Mogale, R.S., 2020. Disconnections and exclusions of parents in the prevention of teenage pregnancy: A phenomenological approach. *International Journal of Africa Nursing Sciences*, *13*, pp.100251.

Smith, M.A., 2021. Social learning and addiction. *Behavioural Brain Research*, *398*, pp.112954.

SmithBattle, L.I., 2013. Reducing the stigmatization of teen mothers. *MCN: The American Journal of Maternal/Child Nursing*, *38*(4), pp.235-241.

Sobngwi-Tambekou, J.L., Tsague-Agnoux, M., Fezeu, L.K. and Ndonko, F., 2022. Teenage childbearing and school dropout in a sample of 18,791 single mothers in Cameroon. *Reproductive Health*, *19*(1), pp.10.

Somefun, O.D. and Olamijuwon, E., 2022. Community structure and timing of sexual activity among adolescent girls in Nigeria. *PLoS One*, *17*(7), pp.e0269168.

Sonene, N. 2020. *The high cost of early adulthood for adolescent mothers: a call for reorientation of social norms in Eswatini | BOLESWA*. *journals.ub.bw*, [online] 5(2). Available at: https://journals.ub.bw/index.php/bjtrp/article/view/1856 [Accessed 12 Sep. 2023].

South African Medical Research Council., 2021. *Teenage pregnancy during COVID-19 in South Africa: a double pandemic.* Available at: https://www.samrc.ac.za/news/teenage-pregnancy-during-covid-19-south-africa-double-pandemic.. [Accessed 17 October 2021].

Sparks, J.R., 2015. A social cognitive explanation of situational and individual effects on moral sensitivity. *Journal of Applied Social Psychology*, *45*(1), pp.45-54.

Statistics South Africa., 2016. *South Africa demographic and health survey.* 2016: Data Quality report. Retrieved 17 December 2017 from: https://www.statssa.gov.za/publication/report%252003-00-09/report.

Statistics South Africa., 2021. *Recorded live births., 2020.* Retrieved 29 March 2020 from: https://www.statssa.gov.za/?p=14902.

Stevens, M. and Mudarikwa, M., 2018. *Unconscionable: Health workers' right to refuse abortions vs women's right to choose'.* Mail & Guardian, 21 June, viewed 10 December 2018.

Steventon Roberts, K., Smith, C., Toska, E., Cluver, L., Haag, K., Wittesaele, C., Langwenya, N., Jochim, J., Saal, W., Shenderovich, Y. and Sherr, L., 2022. Risk factors for poor mental health among adolescent mothers in South

Africa. *Psychology, health & medicine*, *27*(sup1), pp.67-84. (MENTAL HEALTH SOURCE).

Tana, V.V., 2013. *Experiences of chronic patients about long waiting time at a community health care centre in the Western Cape* (Doctoral dissertation, Stellenbosch: Stellenbosch University).

Te Lindert, L., Van der Deijl, M., Elirehema, A., van Elteren-Jansen, M., Chitanda, R. and Van den Akker, T., 2021. Perceptions of factors leading to teenage pregnancy in Lindi Region, Tanzania: a grounded theory study. *The American Journal of Tropical Medicine and Hygiene*, *104*(4), pp.1.

Thobejane, T.D., 2015. Factors contributing to teenage pregnancy in South Africa: The case of Matjitjileng Village. *Journal of Sociology and Social Anthropology*, *6*(2), pp.273-277.

Tebb, K.P. and Brindis, C.D., 2022, March. Understanding the psychological impacts of teenage pregnancy through a socio-ecological framework and life course approach. In *Seminars in Reproductive Medicine* (Vol. 40, No. 01/02, pp. 107-115). Thieme Medical Publishers, Inc.

Thongmixay, S., Essink, D., Kahrs, T., Vongxay, V., Wright, P., Sychareun, V. and Broerse, J.E., 2023. Isolation: The experience of adolescent motherhood in Laos. *Frontiers in Global Women's Health*, *4*, pp.986145.

Tillman, Y.B., 2016. *Life events, initial sexual behaviors, and teenage pregnancy among African American females* (Doctoral dissertation, Walden University).

Timæus, I.M. and Moultrie, T.A., 2015. Teenage childbearing and educational attainment in South Africa. *Studies in Family Planning*, *46*(2), pp.143-160.

Tinago, C.B., Frongillo, E.A., Warren, A.M., Chitiyo, V., Cifarelli, A.K., Fyalkowski, S. and Pauline, V., 2021. Development and assessment of feasibility of a community-based peer support intervention to mitigate social isolation and stigma of adolescent motherhood in Harare, Zimbabwe. *Pilot and Feasibility Studies*, *7*(1), pp.1-12.

Tolboom, B., 2015. *Factors influencing adolescent pregnancy in South Africa.*

Tsabedze, B.P., 2020. *Financial dependence in early motherhood: Experiences of young mothers in Lomahasha, Eswatini* (Doctoral dissertation, University of the Witwatersrand).

Umar, T.I. and Idris, M., 2018. Influence of social media on psychosocial behaviour and academic performance of secondary school students. *Journal of Education and entrepreneurship*, *5*(2), pp.36-46.

UNICEF. *Protecting and empowering adolescent girls in Ghana. New York; 2021.* Accessed: Sepg 14, 2022. [Online]. Available: https://www.unicef.org/ghana/media/4021/file/Protecting%20and%20Empowering%20Adolescent%20girls%20in%20Ghana.pdf

United Nations Population Fund (UNPF). *Adolescent pregnancy: a review of the evidence.* New York, 2013 [cited 2019 October 12]. Available online: https://www.unfpa.org/sites/default/files/pubpdf/ADOLESCENT%20PREGNANCY_UNFPA.pdf.

Van der Waldt, G., 2021. *The judicious use of theory in social science research.*

Vannucci, A., Simpson, E.G., Gagnon, S. and Ohannessian, C.M., 2020. Social media use and risky behaviors in adolescents: A meta-analysis. *Journal of adolescence*, *79*, pp.258-274.

Venketsamy, T. and Kinear, J., 2020. Strengthening comprehensive sexuality education in the curriculum for the early grades. *South African Journal of Childhood Education*, *10*(1), pp.1-12.

Ventura, S.J., Hamilton, B.E. and Matthews, T.J., 2014. National and state patterns of teen births in the United States, 1940-2013. *National Vital Statistics Reports: From the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System*, *63*(4), pp.1-34.

Wall-Wieler, E., Roos, L.L. and Nickel, N.C., 2016. Teenage pregnancy: the impact of maternal adolescent childbearing and older sister's teenage pregnancy on a younger sister. *BMC Pregnancy and Childbirth, 16*(1), pp.1-12.

Wanje, G., Masese, L., Avuvika, E., Baghazal, A., Omoni, G. and Scott McClelland, R., 2017. Parents' and teachers' views on sexual health education and screening for sexually transmitted infections among in-school adolescent girls in Kenya: a qualitative study. *Reproductive Health*, *14*(1), pp.1-11.

Watson, Q., 2021. *Professor Michael Lambert AAAD 054 28 April 2021.* https://apnews.com/article/zimbabwe-teen-pregnancy-covid-0def070a417fe5dd1d106fe5fe710d8d. https://www.safeabortionwomensright.org/news/south-africa-adolescent-girls-experiences-of-pregnancy-in-rural-limpopo-province/#:~:text=Teenage%20pregnancy%20rates%20escalate%20daily,10%20and%2017%20years%20old.

WHO. *Improving the health and development of newborns, children and adolescents in the Eastern Mediterranean Region: the regional implementation framework for newborn, child and adolescent health, 2019-2023 [Internet].* Cairo: World Health Organization. Regional Office for the Eastern Mediterranean; 2021 [cited 2022 Nov 9]. Available from: https://apps.who.int/iris/handle/10665/346301

Woollett, N., Bandeira, M., Marunda, S., Mudekunye, L. and Ebersohn, L., 2021. Adolescent pregnancy and young motherhood in rural Zimbabwe: Findings from a baseline study. *Health & Social Care in the Community*, *29*(6), pp.e377-e386.

World Health Organization (WHO)., 2020. *Adolescent pregnancy*. [Online] Available at: https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy. [Accessed 1 November 2021].

Wuermli, A.J., Yoshikawa, H. and Hastings, P.D., 2021. A bioecocultural approach to supporting adolescent mothers and their young children in conflict-affected contexts. *Development and Psychopathology*, *33*(2), pp.714-726.

Yah, C.S., Ndlovu, S., Kutywayo, A., Naidoo, N., Mahuma, T. and Mullick, S., 2020. The prevalence of pregnancy among adolescent girls and young women across

the Southern African development community economic hub: A systematic review and meta-analysis. *Health promotion perspectives*, *10*(4), p.325.

Zuma, T., Seeley, J., Mdluli, S., Chimbindi, N., Mcgrath, N., Floyd, S., Birdthistle, I., Harling, G., Sherr, L. and Shahmanesh, M., 2020. Young people's experiences of sexual and reproductive health interventions in rural KwaZulu-Natal, South Africa. *International Journal of Adolescence and Youth*, *25*(1), pp.1058-1075.

Appendix A: Information sheet

Dear Parents/Guardian

Hello, I want to take the time to meet with you today. My name is Rasekele Bridgette Mphahlele and I would like to inform you of my study titled “Social Causes of Teenage Pregnancy: The case of an informal settlement, Polokwane, South Africa”

The objectives of the study are:

- To determine the social causes of teenage pregnancy among teenagers in a semi-urban area.
- Assess the broader societal impact of teenage pregnancy on the community.

The study will be conducted in the form of a semi-structured interview. I will ask questions relating to your journey and experiences as a teenage parent. The interviews will take an hour or so of your time for a certain period.

Participation in this study is voluntary and you are not obliged in any way to participate. Personal information and privacy will be protected and I as the interviewer will not share the information with any third party. Pseudo-names will be used, and confidentiality will be respected concerning what you will disclose during the study.

If there are any questions to ask me for information, I can elaborate further. Please feel free to do so and do let me know if you are willing to participate in the study.

Here are my contact numbers below for questions and concerns regarding the study:

Rasekele Bridgette Mphahlele: 0670776170

Mr. M.M Matshipi (Supervisor): 0725609121

Dr K.L Mmakola (Co-Supervisor): 067 7029 769

Turfloop Research Ethics Committee (TREC): 015 2491 240

Appendix B: Parent/Guardian informed consent form

Informed consent form

I hereby agree that my child or the child under my guardianship can participate in the study entitled “Social Causes of Teenage Pregnancy: The case of an informal Settlement, Polokwane, South Africa”

I also understand that should my child not want to continue; she can stop the interview. This decision will not affect me, her, or my community in any way.

I understand that this is a research project, the purpose of which is not necessarily or directly to benefit me or my child personally.

I have received the telephone number of the contact person should I need to report any issues which may arise during this interview.

I understand that this consent form will not be linked to this interview and that her answers will remain anonymous and confidential.

…….. ……

Signature of Parent/Guardian **Date**

Appendix C: Informed consent form

CONSENT

I hereby agree to participate in the study.

I also understand that I can stop this interview at any point during the interview, should I not want to continue, and the decision will not in any way affect me, or my community.

I understand that this is a research project, the purpose of which is not necessarily to benefit me personally.

I have received the telephone number of the contact person should I need to report any issues that may arise during the interview.

I understand that this consent form will not be linked to this interview and that my answers will remain anonymous and confidential.

…….. …….

Signature of Participant **Date**

Appendix D: Interview schedule

Semi-Structured interview

1.1 How old are you?

1.2 How old were you when you got pregnant?

1.3 What grade are you in?

1.4How old is the father of your child?

1.5Did you intend to become a parent at your age?

1.6How did you find out that you were pregnant?

1.7 What was the experience (challenges you faced) and journey throughout the pregnancy to birth or presently as a teenage mother?

2.1 Is there a clinic within 5km in your area?

2.2 Are you aware of their operating times? If so, please share.

2.3 How are nurses' attitudes at the clinic when you go for services?

2.4 Do the healthcare workers value privacy and confidentiality at the clinics?

2.5 If it was not your intention to fall pregnant, were you aware of family planning?

2.6 Did you consider termination of pregnancy?

2.7 Did you take any form of contraceptives before the pregnancy or post-birth?

3.1 What type of risky sexual behaviours are you likely to engage in in your area?

3.2 What risky sexual behaviours have you been exposed to in your sexual life?

3.3 Did you feel pressured by friends or a male partner to have sex?

3.4 Have you considered other risky sexual behaviours when encountering unsafe sex, such as HIV/AIDS or STIs or falling pregnant?

3.5 Is your partner older than you? Did he or does he provide for you financially?

3.6 Have you ever dated an employed or an older man for financial reasons, if yes what was the reason?

4.1 How are you providing for your child financially?

4.2 If you are receiving the child social grant, does it cover all the basic needs that your child needs?

If not, how do you make ends meet?

4.3 Does your family or child's paternal family assist in supporting you and the child?

5.1 Were you taught about safe sex in the school curriculum, for example, in the school subjects you are taught in the classroom?

5.2 Are the teachers open when teaching about sexual education and have an open line of communication such as class participation?

5.3 Have health workers come to the school for any teenage pregnancy awareness?

5.4 How was your attendance/ school performance during pregnancy and after birth at school?

5.5 Are there any programmes at school or in your area that teach about teenage pregnancy?

5.6 If not, would you be willing to participate and attend informative programmes relating to the topic?

5.7 Are you still in school?

5.8 If you are not going to school, what is the reason for dropping out?

5.9 What challenges or experiences do you have staying at home?

5.10 Are you planning to return to school?

5.11 Has your schooling been affected as a teenage mother? How?

6.1 What type of relationship do you have with your parents/guardians at home?

6.2 How do you make ends meet at home?

6.3 Has an elder in your family communicated to you about sex?

6.4 Have you asked any questions about sex at home?

6.5 How did they receive the news of your pregnancy?

6.6 What forms of media are you mainly exposed to?

6.7 Has the media influenced your view about sex or to start having sex?

6.8 How has social media influenced your views about sex before/post-pregnancy?

6.9 Are there any educational shows about safe sex in the media?

Translated Information Sheet

Sehlomathišo sa E: Letlakala la tsebo

Thobela ke rata go tšea nako ye go ledumediša.

Maina a ka ka botlalo ke Rasekele Bridgette Mphahlele. Ke tlo le botša ka khutwana ye “Social Causes of Teenage Pregnancy: The case of an informal settlement, Polokwane, South Africa”

Maikemišetšo a thuto ye ke:

- Ke go lebelela seo sehlolago go ima ga bana dinageng tša se legae.
- Go setša tšeo dihlolago go ima ga bana.

Thuto e tlo dirwa ka potšišotherišano. Ketlo botšiša ka leeto go bat sela yeo o e tšerego ya gob amma o monnyane goba wa ka fase ga mengwaga ya go ba le ngwana. Go tsea karolo fa ga se bo kgapeletšo ke boithaope. Ditaba tša gago di magareng ga rena re le babedi, wa boraro a ka se ditsebe. Ge go na le seo o nyakang go se tseba ke tla thušo ka dikarabo ke kgopela gore o lokologe gomme o tšeye karolo ka go lokologa.

Tše ke dinomoro tša mogala.

Rasekele Bridgette Mphahlele: 067 077 6170

Mr Molepo Matshipi (Supervisor): 072 560 9121

Turfloop Research Ethics Committee (TREC): 015 249 1240

Translated Parent/Guardian informed consent form

Sehlomathišo sa F: Motswadi/Mohlokomedi la letlakala la tsebo ya tumelelo

Foromo ya tumelelo ye e nago le tsebo

Bjalo ka motswadi go ba mohlokomedi ke dumela ngwanaka go tsea karolo fa "Social Causes of Teenage Pregnancy: The Case of an informal settlement, Polokwane, South Africa"

Ke kwišiša gore ge ngwanaka a ka kwa a sa nyake go tšwela pele ka polelo therišana ye a se ke a tšwela pele. Se ebile se ka seke sa tliša kgakanego bophelong bja rena mo setšhabeng sa gešo. Ke dumela gore nyakišišo ye ga se yeo e lebang le rena gore re tlo putswa go ba yena ngwana o tlo putswa. Ke humane megala ye woo nka boledišanago le yen age nka gakanega. Ke dumela gore foromo ye ya tumelelano a ka seke ya kgokagana le rena e tle dula e le gore dikarabo tša gagwe di tla dula di le sephiring.

_____ _____

Mosaeno wa Motswadi/Mohlokomedi **Letšatšikgwedi**

Translated Informed consent form

Sehlomathišo sa G: Letlakala la tsebo ya tumelelo

Tumelelo

Ke dumela go tšea karolo ka thutwana ye.

Ke a tseba gore nka ema nako ye engwe le ye engwe ge ke sa kwišiše. Seo se ka se ntšhwenye gape le motse wa gešo.

Ke a tseba ebile ke dumela gore ga go seo ke tla sehumanango ge ke fetša.

Ke humane dinomoro tša megala tša motho wo nka mo leletšago mogala ge ke na le seo nka se botšišago.

Ke dumela gore se e tla dula e le sephiri.

_____ _____

Mosaeno wa Motšwasehlabelo **Letšatšikgwedi**

Translated Interview Schedule

Sehlomathišo sa H: Kopano ya poledišano

1.O na le mengwaga e me kae?

2.Obe ona le mengwaga e me kae ge oba mmeleng?

3.O bala mphato ofe?

4.Tatago ngwana wa gago ona le mengwaga ye me kae?

5.O be o ikemišeditše goba motswadi ka mengwaga ye o lego go yona?

6.Naa o tsebile bjang gore o mmeleng?

7.E bile leeto le le bjang nakong ya ge o le mmeleng?

8.Go nale kliniki mo ga geno go di km tse hlano?

9.O tseba ka di nako tša bona tša go šoma?

10.Maitshwaro a baoki a bjang kua kliniking?

11.Baoki ba kgona go swara sephiri kua kliniking?

12.Ge ele gore o be o sa ikemišetša go ima, o be o tseba ka dithibelapelegi?

13.O ile wa leka go ntšha mpa?

14.O be o tšea dithibelapelegi pele ga go ima goba morago ga pelego?

15.Ke kotši efe ya mekgwa ya thobalano o ka dumago go ba ka gare ga yona mo o dulago?

16.O gapeleditšwe ke bagwera goba motho yo o robetšego le yena go tsenela thobalano ye?

17.O ile wa nanaga ka ditlamorago ka morago ga go tsenela thobalano ya go se šireletšege?

18.O ile wa ratana le motho yo mogolo gore a go fe maseleng?

19.Naa nkile wa ratana le monna go mabaka a ditšhelete?

20.O hlokomela ngwana wa gago bjang ka maseleng?

21.O be o tšwelela bjang dithutong tša gago ka nako ya ge o be o le mmeleng le ka morago ga botšwetši

22.Go na le dithuto tseo ba be le rutang sekolong goba motseng wa geno mabapi le go ima ga baswa?

23.Ge gose bjalo o ka rata go tšea karolo go dithuto tšeo tša go ima ga baswa?

24.O sale sekolong?

25.Ge o se sekolong lebaka ke eng?

26.Ke dišitišwa dife tšeo o kapanago le tšona ge o sa dutše gae?

27.O gopola go boa sekolong?

28.O bile le bothata ba go ba Mma o moswa? Re botše gore bjang?

29.O nale kgwerano ya mohuta mang le batswadi/bahlokomedi ba gago?

30.Le gona bjang ka gae?

31.Go bile le motho yo mogolo ka gae yo a go boledišitšego ka tša thobalano?

32.O ile wa botšiša ka tša thobalano ka gae

33.Ba amogetše bjang go ima ga gago?

34.Ke dikgokagano dife tšeo o di tšebang?

35.Dikgokagano di hlohleleditše pono ya gago go tša thobalano goba go tsenela tša thobalano?

36.Dikgokagano di hlohleleditše bjang pono ya gago pele le morago ga thobalano?

37.Go nale dithuto tseo o ka di bonago go dikgokagano tša ditaba tša thobalano yeo e šireleditšego?