A STUDY INVESTIGATING THE CONTRACEPTIVE KNOWLEDGE, ATTITUDES, BELIEFS AND PRACTICES OF COLOURED UNMARRIED PREGNANT TEENAGERS

by

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Abstract

The purpose of this study is to investigate i) the coloured pregnant teenager's perception and experience of parents, church, media, schools, peers and family planning clinics as sources of information with regard to contraceptive knowledge, attitudes, beliefs. ii) methods and messages used to communicate information, and iii) the extent to which these sources of information influenced contraceptive practices.

Substantial research has been devoted to establish why so many teenage girls become pregnant despite widespread education in the use and availability of contraceptives. The response rate would suggest that the views described are representative of teenagers in the respective communities, although this study, by nature of the design, does not consider the views of the successful users of contraceptives.

Permission was obtained from local clinics to conduct the research to access names and addresses of teenagers who attended or had appointments to attend the clinic. The sample was identified and selected as they registered at the clinic. Respondents were interviewed by the researcher making use of an anonymous questionnaire.

The results indicated that there is an increase in the role that peers play in the onset of sexual activity. As socialising agents, same sex friends set standards of conduct and serve as role models that shape the development of sexual

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CHAPTER 1

1.1 Introduction

Many parents erroneously believe that "if you provide a child with knowledge about sexuality it leads to the practice of sex". Incredible as it may seem, most opposition to sex education in this country is based on the assumption that knowledge is harmful. In studies undertaken by the Human Science Research Council (Hall, 1989, Du Toit 1990, Preston-Whyte, 1991) over a period of time, it was revealed that most parents were opposed to their children receiving sex education or given contraceptive advice possibly as most hold true to the above assumption. Preston-Whyte and Allen (1992) argued that these attitudes make schools hesitant to allow sex education, let alone contemplate the provision of contraceptives on school premises.

It becomes clear that the notion prevails amongst most parents, that when matters of sexuality are discussed, it is as good as encouraging the teenager to be promiscuous. Several reasons have been cited for the rise in the rate of the teenage pregnancy in Africa(Lee and Made, 1994) ranging from early marriages to economic hardship, girls becoming pregnant out of ignorance, school dropout, lack of knowledge and the non-use of contraceptives.

De Villiers (1985) suggested that the perception among most researchers is that teenagers who become pregnant hail from under-privileged backgrounds. This notion was reaffirmed by Klugman and Weiner (1990) who, found that teenagers who become pregnant are single and of low socioeconomic status. They get pregnant unintentionally, often as a result of complete ignorance about the process of conception, coupled with a low self image and little sense of personal control. Often the assumption is made that all teenage pregnancies are unintentional.

As Gordon(1996) explained, many researchers believe that education about reproduction and contraception will provide the sexually active teenager with the knowledge he or she will want to use in order to prevent pregnancy. In some instances, pregnancies are welcomed, as having a baby will give purpose and meaning to life. Pregnancy, becomes the desired outcome and therefore can not be seen as unintentional.

Jacobson, Wilkinson and Pill (1995) stated that often several aspects of teenage pregnancy are affiliated to create a problem. Examples include the perception that the pregnancy is unplanned, the girl is usually single, she started sexual activity at a young age, lacks the appropriate knowledge and that she comes from a lower socioeconomic status group. They believe that such perceptions need to be justified more convincingly, as a failure to do so would lead to a lack of precision about the nature of the problem.

Ambivalent attitudes and the lack of taking responsibility by adults, schools, religious organisations and the media for sexuality education has greatly curtailed the management of teenage pregnancies. It is evident that one of the major contributory factors to the high incidence of pregnancies in South Africa has been, our lack of sexuality education informing teenagers about sexuality and contraception. It is society's responsibility to raise sexually healthy children, to help children to become adults who feel good about their bodies, can treat people of both genders with respect, and is comfortable expressing love (Fischel, 1992).

A study undertaken by the World Bank Policy (1986, 10 & 11), highlighted the phenomenon that "the African population, including South Africa, is getting younger and younger. Children less than fifteen years of age now constitute forty five percent per cent of the total population". The implication is that an exceptionally larger proportion of the resources will go to meet the needs of the young, and the population growth has a built-in momentum. Even if there were to be an immediate decrease in fertility rates, the sheer numbers of teenagers will still have an effect on the overall fertility rate and thus continue to have a major impact on the South African population growth for some time to come.

In instances where a pregnancy does occur it holds repercussions for teenagers, their families, and society in general. Young girls often drop out of school, which may

impede the development of their full potential. They may become the responsibility of the family, as well as a burden to the state. Hudson and Ineichen's (1991) stated that there are of those families who find themselves with pregnant teenage daughters who manage to cope, after the initial shock has worn off, however not all families are able to deal with the problem. Birch (1987) argued that the younger the teenager the more crucial the decision-making, of whether to marry, become a single parent, give the child up for adoption or have an abortion; as an unwanted pregnancy has a tremendous impact on her life.

Teenagers are not a homogeneous group. They are widely heterogeneous in terms of age and their social, cultural, and economic backgrounds are so varied that as a result they experience sexual activity, pregnancy, and childbearing in different ways (Meyer & Russell, 1986).

Given the high rate of teenage pregnancy in South Africa, one can assume that social institutions are unsuccessful in addressing this problem. One of the main reasons for this cited by Lewis and Salo (1993, p. 66), is the general avoidance of sexuality education. Because South African society has been characterised by it's overtly narrow-minded view with regard to sexuality, the lack of sexuality education for teenagers and the infrequency of open discussion about sexuality and contraception in families, reflect the prejudice

that sex should be confined to the institution of marriage, to 'responsible adults' and should be aimed at reproduction.

The family, school, church and other institutions have neglected their 'obligation' to educate teenagers about sexuality and contraception. For this reason it is crucial that the experience and perspective of pregnant teenagers inform current initiatives to combat the range of sexuality-related problems.

Whether we are comfortable or not with sexuality and contraceptive knowledge, we need to educate our children. As professionals who are often involved with families and children who need intervention, human ecologists have an obligation to provide parents and their teenagers with the information they need in a manner they will accept to make a positive contribution to all communities (Roosa and Vaughan, 1983).

1.2 Motivation

In South Africa an enormous amount of research has been dedicated to teenage pregnancy. Many studies have covered a wide spectrum associated with teenage pregnancy to obtain a comprehensive view and inform further research. On the international front, the United States has identified teenage pregnancy as a serious social problem(Witte, 1997), with approximately 1300 teens giving birth each day and 1100 who have their pregnancies terminated(Carrera, 1997).The United

Kingdom displays similar trends. The number of teenage pregnancies have increased dramatically over the past decade(Woodward, 1995). Despite the increase of contraceptive use in these countries, there are still increases in the number of pregnancies taking place.

In comparison to these countries, South Africa's teenage pregnancy rate has escalated to such an alarming degree that it has become a great concern amongst researchers (Nash, 1990). Even though, South African family planning facilities were made more accessible to teenagers in 1983, it seemed to have no effect on the teenage pregnancy rate (Schoeman, 1990). Coupled with this, programmes that do provide teenagers with information do not seem to solve the problem. Programmes have to be adapted to the needs of the population in this area. However, sexuality education programmes will never be a cure for preventing teenage pregnancy.

In a policy paper based on case studies in Tanzania (Lee & Made, 1994) recommendations were made that parents, schools, and society educate teenage women on reproductive issues so that they could make informed decisions about their reproductive health.

It is imperative that research be done in this area to provide the South African teenager with high quality appropriate family planning counselling and services, maternal and child health care programmes, educational and legislative

measures to discourage early childbearing as well as alternatives to early marriage and childbearing.

1.3 Statement of the Problem

The purpose of this study is to investigate i) the coloured unmarried pregnant teenager's perception and experience of parents, church, media, schools, peers and family planning clinics as sources of information with regard to contraceptive knowledge, attitudes,- beliefs. ii) methods and messages used to communicate information, and iii) the extent to which these sources of information influence contraceptive practices.

1.4 Research Question

To what extent does the various sources of information, namely, parents, peers, church, media, schools and family planning clinics influence the pregnant teenagers knowledge, beliefs and attitudes pertaining to contraceptive practices ?

1.5 Hypothesis

Parents, peers, church, media, schools and family planning clinics as sources of information have an influence on pregnant teenagers contraceptive knowledge, beliefs, attitudes and practices.

1.6 Terms

Coloured:

Population group used for classification purposes only - Statistics South Africa, 1998

Unmarried Pregnant Teenager:

Any individual between the ages of 13 to 19 years of age who is between conception and birth of her infant

Knowledge:

The psychological result of perception, learning and reasoning whether it be gained formally or non-formally

Attitudes:

A complex cognitive orientation involving beliefs, feelings, values and dispositions to act in certain ways

Beliefs:

Any cognitive content held as true without proof

Media:

Transmissions that are disseminated widely to the public making use of all kinds of devices as a means of communication

1.7 Summary

The purpose of this chapter is to provide an overview of the context of this research. The basic structure is presented to the reader with a systematic view of the researchers ideas and intentions as well as to acquaint the reader with the appropriate background for this research. Chapter two consists of related literature to substantiate the researcher's arguments concerning teenage pregnancy.

CHAPTER 2

LITERATURE REVIEW

OVERVIEW

The high incidence of pregnancies in South Africa has evoked the concern of many (Preston-Whyte & Allen, 1992 & De Villiers, 1985) and there is no denying that it has become a problem in most societies. Along with this, societies throughout the world have been faced to varying degrees, with the problems of increasing numbers of adolescent pregnancies. It has been argued that the feminisation of poverty starts off with unmarried teenagers having babies. Many of them cannot rise above the incident in order to continue their schooling or get skilled jobs (Mfono, 1990, p. 6).

Over the past decade, several changes have taken place, that has increased the likelihood that teenage mothers will complete high school. Butler(1992) reported that it has been made easier for the pregnant teenager to stay in school because of the decrease in stigma associated with the pregnancy of unmarried girls.

Irrespective of age, when pregnancies are unintended it is enmeshed in the personal, interpersonal, social, religious, ethical and economic dimensions of life. The effects of adolescent pregnancy impact on all levels of our society, regardless of race or socio-economic status. According to Mfono (1990), research on teenagers and their sexual activity revealed a lot of ignorance and proliferation of myths about sexuality and pregnancy. Teenagers need to be enlightened about facts of sexuality and reproduction. Instead of hiding information about sex and sexuality from teenagers, programmes need to be set up specifically for teenagers.

2.1 Teenage Pregnancy in South Africa

In every society there are norms and values that dictate when and under what circumstances it is acceptable for women to have children. In many parts of the world as well as South Africa, unmarried teenage parenting is perceived as a problem because it is viewed as culturally inappropriate and, despite the high value placed on pregnancy and childbirth, birth outside of marriage is viewed with disapproval.

Teenage pregnancy in South Africa, is increasingly being recognised as a problem and virtually every major organisation with a worldwide interest in population has expressed concern about it (Institute for Planning Development, 1991). Although some teenage pregnancies are desired and occur within the context of a stable relationship, the consequences of teenage pregnancies are usually negative(Maternal Child Health, 1996).

National statistics show that in 1987, on a national level, of the total percentage of all births that took place in South Africa, 11.4% were born to black teenagers, 13.9% to coloureds, 6.6% to Asians, and 8.4% to white South African teenagers (Klugman and Weiner, 1990).

In 1994, a total of 10117 teenagers became pregnant of which 258 were between the ages of 10 to 14 years of age, and 9859 (97.4%) were between the ages of 15 to 19 years old. The total number of live births were 76120.

According to the 1995 South African Health Review, the teenage pregnancy rate amongst black Africans is 15.2%. However, a recently published survey of 1072 teenage schoolgirls from the Eastern Cape, revealed that at least 250 (23%) had been pregnant before. The same study also found that only 23.3% out of sexually experienced girls had ever used contraceptives (Maternal Child Health News, 1996). For the period 1994 to 1996 there was a steady decline in the teenage pregnancy rate.

In 1996, a total of 7713 of teenagers became pregnant of which 264 were between the ages of 10 to14 years of age and 7490 were aged between 15 and 19 years old. The total number of live births were 56154. These statistics proved that a large proportion of births were born to teenage girls. It was because of the increase of teenage sexual activity in the 1970s that the Department of Health decided that under certain

circumstances, contraceptives would be made available to sexually active teenage girls without parental consent. However, it can be argued that at the time an increase in black teenage pregnancy and births was not a desirable development during the apartheid era. For this reason contraceptive education or use was met with resistance by blacks because it was considered to be another form of oppression.

The report of the Department of Health and Population Development for 1988 saw a decline in black teenage births from 13.8 per cent to 12.4 per cent for the year under review. Similar reports were made at a Human Science Research Council Seminar on teenage pregnancy in 1989, which indicated that black teenage pregnancy was estimated to be 14 percent of all black births. However, for the period in the Western Cape alone the number of births increased to 13.7%. Important as these figures were, the rate of teenage age pregnancies remains alarmingly high. To quote Van Coeverden de Groot (1986):

> **" All our efforts are still required to combat teenage pregnancy, the premier social evil of the Third World. There is, alas, no ray of demographic hope in data presented"** (p. 524).

Visser and le Roux (1996) reported that the percentage of teenagers giving birth before their twenties has remained high. They argue that despite this, a striking change has taken place in marital context of births. Pregnancy and motherhood have become separated from marriage and the concept of `illegitimacy' has according to Preston-Whyte(1991) outlived it's usefulness.

In some circumstances unmarried teenage pregnancy carries many negative consequences, such as low income, poor and unsafe housing, fewer cultural and social advantages, poor quality nutrition, and fewer goods and services of all kinds. Where children are born out of wedlock, it by no means confines the teenager to being social drop-outs. According to Preston-Wythe and Zondi (1992) some women who are successful and respected have not been married, but have children. They report that there are sufficient positive role models today for teenage girls not to feel that a child before marriage will jeopardise their chances of being respected.

Teenage parenthood is a social phenomenon that should be considered as an indicator of quality of life. Hall (1989) took it a step further by arguing that there are three main factors involved in the occurrence or non-occurrence of pregnancy. Firstly, the availability of information on and an adequate source of contraception; restraint exercised successfully by parents and most importantly, a personal incentive or will on the part of the teenager to prevent early

pregnancy. Apart from teenagers' notorious resistance to contraceptive practice, many other reasons have been given to explain the dramatic rise in teenage pregnancies.

In a society governed by sexual repressiveness, making decisions about sexual behaviour and it's consequences is not easy for any adolescent. As it is a period that is filled with mixed feelings of excitement and apprehension about one's new relationship in society outside the family environment.

Teenagers have several choices to make, whether to initiate sexual activity, whether or not to practice contraception, and if so, which one to use. These behaviours and decisions influence her likelihood of becoming pregnant and create a great deal of uncertainty. Old patterns of behaviour, attitudes, values, undergo considerable transformation while painstaking learning of new ones take place. An adolescent's body undergoes physical changes and is flooded with sexual impulses (Drummond, 1991).

Sadly though, despite considerable advances, such as the new constitution, giving precedence to equality, breaking down barriers between the stereotypical roles in our society, it still appears to be true that girls are encouraged by our male dominated society to grow up to be emotionally and economically dependent(Convention toward Eliminating Discrimination Against Women, 1998). The lack of information and discussion of sexual matters for girls is part of the

problem (Hudson & Ineichen, 1991). Both Nash (1990) and Du Toit (1990) after reviewing relevant literature concluded that teenage pregnancies cannot be attributed simply to a single, or even more than one cause. Rather, they occurred as part of a complex and ongoing social situation.

It is hoped that this research will stimulate further discussion and research in the field of teenage pregnancy, to provide some solutions for both unintended and intended pregnancies. For the former to provide alternatives to pregnancy, and the latter to provide contraceptive education and overcome the barriers to using contraceptives.

2.2. Age

South Africa has a young population with 46.7% made up 0-19 year olds, of which 21% are 6-14 years of age(http://www.polity.org.za/govdocs/reports,1998). Adolescence is a stage characterised by a massive increase of sex and growth hormones. It is a time when a girl's sexuality becomes more apparent both to the girl and to others. A time when body changes in conjunction with sexual desires and sexual feelings arise(Oosthuizen, 1990). Adolescents are experiencing sexual intercourse at earlier ages and with greater frequency than in the past (Bingham & Miller, 1990). Understanding the modern teenager necessitates consideration of the current social changes which have ameliorated familial style, roles, parental work patterns and adolescent peer behaviours and sexual patterns. All of these realities have

altered the teenager's approach to sexuality and intimacy. The modern teenager has been affected by the sexual revolution and the new feminism, which many believe complicates the consolidation of late adolescence (Bingham & Miller, 1990).

It is evident that, biologically speaking, late adolescence is considered the ideal years for childbearing. Psychologically, poised between childhood and adulthood, the teenage girl might not always be emotionally ripe to cope with the demands and the realities of parenthood (Clarke and Kalmuss, 1986).

As society becomes more tolerant, adolescent sexual behaviour has also changed over recent decades. What was once accepted as a right for adults, through the process of socialisation and imitation, has been explored by teenagers (Cunningham and Boult, 1996). In their opinion the medical profession has learned to cope with problems associated with childbearing by the very young, neither family nor society has solved the problem of how to cope with "children having children."

Children born to young mothers may be placed at higher risk of becoming abandoned, to become street children, or to be abused. As reported in a study conducted at a local hospital, 66 per cent of abused children were born to mothers under 19 years of age, and that these mothers lacked the

support systems needed to protect their children (Van Leer Foundation, 1995).

Boult and Cunningham(1992) found age and educational level to be most significant. In the first instance, the obstetric problems and the latter the ignorance of contraception, interrupted or discontinued schooling and an uncertain future for mother and child. Their study appears to support the contention that the younger the teenagers are, engaged in sexual activity, the more vulnerable she is for falling pregnant.

Buga and Amoko(1996) supported this argument. In their study they found that the age of sexually experienced girls at first coitus, correlated positively with the age of menarche and the age at the first date, suggesting that sexual maturation and onset of dating were possible risk factors for initiation of sexual activity. Contraceptive use was low and the knowledge of reproductive biology was generally poor. A problem highlighted by De Villiers (1985) is when teenagers are emotionally immature, it brings along social problems and interference with educational plans which result from a pregnancy.

Gunston (1986) argued that many would agree that neither abortion on demand nor freer access to modern contraceptives would solve the problem. In reality, knowledge(or lack of knowledge) about reproduction and contraception is just one

component which may or may not enter into the teenager's decision to have intercourse (Gordon, 1996). Not only is there a need for this to be remedied, but by the time children reach their teens they need to have been exposed to sex education both at primary school level as well as in the family to help decision making.

2.3 Socio-economic Status

Many unmarried teenage mothers in South Africa live in poor social circumstances, with low socio-economic status and poor levels of education. Apart from this, teenage pregnancy leads to the end of schooling, which is itself a cause for continued socio-economic disadvantage.

Jacobson and Pill (1995) suggested that often teenage mothers become embroiled in a "cycle of poverty" and their children are more likely to continue the cycle by becoming teenage parents themselves. Boult and Cunningham (1992)argued that it remains debatable whether the high rate of teenage pregnancy is as a result of poverty and other socio-economic problems or whether it contributes to these problems.

It was cited by Du Toit in Preston-Whyte (1991) that teenage pregnancy in the Western Cape shows the same pattern as in many other societies and are, in the first place, a socio-economic phenomenon which is simultaneously a reason for, and a consequence of, conditions of poverty and relative deprivation in various fields of life.

Conditions of poverty and unemployment are the factors that have a bearing on the class institutions and structures of society. It is argued that since not only values and behavioural patterns, but almost the first perceptions of self, sexuality and personal relationships are formed in the home, it is not surprising that observers consider both the physical and the social environment of the home to be a critical determinant of later attitudes and behaviour. According to a study conducted by Boult and Cunningham(1992), family disorganisation has been noted as a factor in black teenage pregnancy in Africa, South Africa and America.

Burman and Preston-Whyte (1992) reported that poverty, poor and overcrowded housing, few community recreational facilities, and high unemployment are the most striking and consistently reported concomitants of teenage pregnancy in the Cape. In a study undertaken by De Villiers (1979) he commented that most of the girls come from low socioeconomic backgrounds. The parents of this socioeconomic class have little or no control or influence on, or interest in, their daughters. The result is that the family relationship cannot be used meaningfully to prevent this condition (cited in Burman and Preston-Whyte, 1992).

On the other hand, in the more affluent areas, pregnant teenage girls may be placed under undue social and parental pressure to abort. In their study, Pearson, Owen, Phillips, Gray and Marshall(1995), concluded that it is known that

socio-demographic factors are important in the decision to terminate a pregnancy or continue. Teenage pregnancy rates in most cases do tend to be higher in more deprived areas and that teenage pregnancies ending in termination are more likely to occur in affluent areas.

It becomes clear that there is an obvious association between early births, socio-economic status, social, educational and occupational deprivation. Preston-Whyte (1991, p. 29) concluded that this should come as no surprise as the "wages of apartheid" have been to institutionalise deprivation and a lower class status for most black South Africans.

2.4 <u>Race</u>

In a study undertaken by Prinsloo (1984) at Tygerberg Hospital during the ten-year period 1970-1980, there was a steady decline in the pregnancy rate for Coloured adolescents, the rate for blacks increased after a 3-year decline and that for whites also increased after a two-year drop.

During the review period the proportion of White adolescent mothers who were unmarried increased from 19.2% to 22,8%. It is possible that a relaxation of moral standards in recent years and a more understanding and tolerant attitude on the part of the public has resulted in a far more ready acceptance of childbirth out of wedlock among most racial groups.

An average of 81% Coloured adolescent mothers were unmarried, while the average for black adolescent mothers was 67%. When considering adolescent pregnancies in the various racial groups in South Africa, a number of factors should be taken into account. Among these factors, are that each group is steeped in it's own cultural heritage, norms and standards, an example of this, it is often accepted that black women prove their fertility by bearing a child before a marriage takes place.

The rising number of births to unmarried women, both in this country and abroad, and the fact that some women choose to have children outside marriage, has bred a more tolerant attitude to unwed motherhood among white South Africans (Rubinsztein, 1992). In her opinion there is a new generation of "go-it-alone" mothers, who choose to be single mothers. Preston-Whyte and Allen(1992) conducted a study in Natal and the Cape on pregnancy among unwed coloured teenagers. They found that many teenagers were sexually active at a young age, lacked basic knowledge about the mechanics of contraception, and resistance on the parts of parent in discussing sex with children .

In Van Coeverden De Groot and Greathead's (1987) opinion Coloured and Black adolescents do not have a problem securing day care, as most of these families are made up of extended families therefore freeing the teenage mother to be employed. In their opinion the social stigma, guilt and public

disapproval once associated with illegitimacy have declined greatly in recent years. The unmarried mother is given far more recognition, sympathy and tolerance than was the case previously.

Current South African legislation places the age of consent at 16 years while officially prohibiting the use of contraceptives by persons under 18 years of age without prior consent from parents or guardians. Dore and Dumois(1990) concluded that racial and ethnic differences in attitudes toward resolution of unplanned pregnancy are well documented particularly with respect to abortion and adoption.

Evidence suggest that in South Africa black families hesitate to consider adoption as a viable alternative as a child who is not a clan member leads to severe family and social disfavour (Cunningham and Boult, 1996).

2.5 Educational Level

In the Port Elizabeth study, (Institute for Planning Research, 1991) education has proven to be significant. It was argued by Oronsaye (1982), Gunston (1986) and Kulin (1988) that the lower the educational level of the adolescent the less likely she is to understand the physiology of conception and contraception. In the Port Elizabeth study of the 145 respondents the majority of the samples (82.8%) were at school when they became pregnant. However, the educational level of the sample on the whole was fairly low. Earlier studies on

teenage pregnancy by Oronsaye (1982) and Gunston (1986) showed similar low levels of education for their sample. In the Bernard van Leer Newsletter(1995)the lack of commitment to education has been described as the most powerful contraceptive of all, education, employment and self-esteem(Lewis, 1992). Often, pregnant teenagers drop out of school, take on low paying jobs and never complete their education.

In some instances (McGrew and Shore,1991) teenagers who remained in school, received family planning and financial assistance, fared much better than their counterparts. Plotnick(1992) suggested that young women with favourable attitudes toward their current school experiences and with long-term educational goals and aspirations, tend to resist pressures to become sexually involved or at least make them more careful contraceptors.

Butler, Plotnick(1991) and Abrahamse and Hanson(1988) agreed, that positive attitudes toward school reduce the likelihood of premarital childbearing. In contrast, Butler (1992) reported over several decades, teenage mothers are more likely to finish high school than they once were, and they are having fewer children, which should lead to greater economic well-being.

2.6 Family Background

While popular opinion would suggest that the family has very little influence over adolescent children because it has lost many of it's functions to other agencies, such as the school, the church and the state, Fisher (1987) argued that this may not necessarily be the case.

Family background characteristics are significantly associated with premarital pregnancy and it's resolution (Plotnick, 1992). Even though functions performed by the family may be decreasing or rather becoming less important, there is no denying that it remains the most influential institution in every individual life, whether it be negative or positive. As a strong determinant of sexual behaviour, family traits and other personal characteristics as well as attitudes, directly affect the likelihood of premarital pregnancy (Gordon, 1996).

Despite certain points of strain, the family has adapted to social and economic changes and has retained some of the important functions. The chief role being to provide children with a secure foundation upon which culture is built, feeding the community with a steady stream of new citizens. The other functions being, procreation, the socialisation and education of children, the economic function, the health function, recreation, and the emotional-sexual function (Kephart and Jedlika, 1991).

Children learnt from adults by observing, listening and through daily interaction with parents and others around them, wielding a strong influence on adolescents opinions and values (Hauser, 1984; Greenberg, Siegal and Leitch, 1983; Miller & Lane, 1991). Through this process of socialisation adolescents establish an identity of their own.

Many correlations have been demonstrated for characteristics of families of female adolescents who become pregnant, and/or initiate sexual intercourse at an early age (Gordon, 1996). The family has been considered as the ideal location for the dissemination of sex information, however, it is often overlooked that many children do not have both parents available to them and that fathers have always had minimal involvement in the transmission of sex information in two-parent families (Nicholas & Daniels, 1994). According to Beard (1994) approximately forty percent of South African families are made up of single parent families . These families tend to be controlled by women, the maternal head.

Although maternal headship may be the long term result of widowhood, divorce, or separation of a previously married woman, it is also the result of the fact that domestic units develop also around single women who do not marry but who bear children (Beard, 1994). Such women raise the children on their own and provide food, clothing, and shelter for them, if not subsequently married or supported by anyone. In Ziehl's(1994) opinion women have certain expectations of

marriage and men, making single-parenthood a viable option when the chances of these expectations being realised are minimal.

Like our American counterparts, (Height, 1986) the single-parent coloured female-headed family in Africa and South Africa is rapidly becoming the fastest growing sector of society. These families come about due to a variety of factors. Some women choose to become mothers without the disability of unsatisfactory husbands (Van der Vliet, 1984), others have it forced on them. However, the problems of female-headed households in South Africa have attracted a great deal_of attention as the category of family most likely to suffer from deprivation, and this is the primary source of concern about illegitimate children in societies (Burman, 1992).

In a study undertaken by Boult and Cunningham's (1991) at a Hospital in Port Elizabeth it was reported that of the 145 participants, two seventeen-year-old respondents were married and lived with their spouses, while a further two were 'taken as wife' after confirmation of the pregnancy. The remainder were unmarried. Only one third lived in nuclear families. The majority resided in female-headed single parent or complex kin-group families.

The significance of this is that female-headed families are generally on the lowest economic rung of society. The

complex kin-group families were, in the main, maternal kin dependent on self-generated income, old-age pensions and other disability grants. In their study twenty-four percent of the respondents mothers lived some place else. It is these extended family types, with it's strong kinship ties, that cushion any disruptive effects that a pregnant teenager might present the family with (Boult and Cunningham, 1991, p. 305).

When girls become pregnant their parents are upset and often outraged, however in time the child is welcomed into the family and the young mother may even return to school. The crisis is thus accommodated within the domestic sphere, and both the family and the teenage mother learn to cope.

2.7 Developmental Explanations

Developmentally, according to Hobson, Robinson & Skeen, 1983 p.5), adolescence is the time when a teenager is governed by a way of thinking called "the personal fable". This unrealistic view of the world, makes the teenager feel secure in that they never believe that becoming pregnant can happen to them. Teenagers may see themselves as immortal and invulnerable. Thus teenagers do not think that they can get pregnant.

The high value placed on risk taking or having knowledge and not acting on it, reinforces their feelings of invulnerability. However, when the teenager does not view the activity as harmful, then engaging in it cannot be labelled as

risk-taking behaviour, for example when a teenager desires pregnancy and has unprotected intercourse (Gordon, 1996). For those who engage in risk-taking behaviour there is little incentive for them to make use of contraceptives. The failure of teenagers to identify the risks of sexual activity may be due to a discord between physical and mental preparedness for sexual activity(Woodward, 1995).

Adolescence is, at best, a stressful period of time, a period where the teenager moves from dependence to independence and autonomy from their parents. Children are to be nurtured to develop as sexually responsible individuals to avoid problems that plague society as a whole, including unintended pregnancies and the spread of sexually transmitted diseases. Sexual learning is initiated at birth and continues throughout life, resulting from social interaction as well as one surroundings

2.8 Inadequate Sex Education

In many societies it is believed that education about sexual matters encourages sexual activity. In all three the studies undertaken by the Human Science Research Council (1989, 1990,1991) the teenagers and many of the parents interviewed revealed parental resistance to the offering of both sex education and contraceptive advice to young people.

Daughters, at birth, are socialized as girls, against the backdrop of social and cultural boundaries(Oosthuizen, 1990).

According to Burman & Preston-Whyte (1988), one needs only to look at the context in which teenagers are reared. Communities customarily utilise two approaches in an attempt to prevent sexual expression by teenagers. Either they purposefully withhold information based on the assumption that knowledge will encourage sexual intercourse, or the fact that teenagers who do need contraceptive information is denied, as teenagers are not supposed to be engaged in any sexual activities.

Sexual education is ignored or played down by many parents, who often leave sexual education to chance or "natural instinct" (Oosthuizen, 1990 & Etsane, 1996).

Parents who misjudge their teenager's sexual practices and unwisely withhold sexuality information, must assume some responsibility for teenage pregnancies, because when teenage girls are ignorant of such information, the likelihood of them becoming pregnant is great.

Jacobson, Wilkinson and Pill(1995) suggested, that based on available evidence better educated teenagers showed a slight reduction in sexual activity and that teenage girls were more assertive and less passive in merely accepting the status quo set by teenage boys. Battin(1995) reported that in some countries in northern Europe, there is little unintended teenage pregnancies. In these countries, unplanned teenage pregnancies are viewed quite negatively and active sex-

education programmes, widely available contraceptives and strong social sanctions against unplanned pregnancy keep the rate very low.

In other countries, in contrast, sex-education programmes are weaker, access to contraceptives more problematic and social sanctions are mixed. In these countries, traditional patterns of early marriage and immediate childbearing mean that the transition from childhood to adulthood is comparatively immediate, and there are no `teenage' years. It would be presumptuous and counter productive to prescribe an alternative or to dictate a national or regional policy on the basis of findings (Lewis & Salo, 1993 and Cunningham & Boult 1996). Ideally teenagers need to be educated, so that they are able to make informed choices. The principle of choice includes not only the avoidance of an unwanted pregnancy, but the informed choice of a method most suited to the individual or partnership. This means that teenaged girls should be able to choose the contraceptive method most suited to their own social, economic, cultural, psychological and health status.

2.9 Knowledge, Beliefs and Attitudes

It is assumed that teenagers have a patchy and often inadequate knowledge about reproductive health system (Frame, 1991). Many have misconceptions about sexual matters, which is associated with the breakdown of traditional institutions for sex education, poor intergenerational communication, and

limited and inappropriate approach to sexual health education in schools.

It is imperative to study knowledge, attitudes and beliefs towards contraceptive and sexual practices. Naidoo (1991) defined knowledge as the collective body of information possessed by a person and accumulated through a learning process. This would then include, formal instruction, personal experience and the sharing of experiences of other people.

Traditionally there was the assumption that with the possession of knowledge would come the automatic behavioural change. Naidoo (1994) disputed this as research has proven that this notion has been a misconception. In the a Cape study, sex education within the home was found to be rare. Most of the respondents claimed to have been informed by their peers and conveyed the impression that the discussion of sexual matters between parents and daughters is considered taboo (Preston-Whyte & Allen, 1992). The tendency therefore, among adults is to turn a blind eye to teenage sexuality and contraceptive use.

The birth of children to unmarried teenagers presents an inconsistency between expressed attitudes which seemingly reflect certain values, and behaviour which appears to belie them. In some cases the same person might hold conflicting attitudes. In Todt's (1990) study when interviewing the

respondents they agreed that premarital sex was wrong and they felt that both a mother and a father were necessary for the "normal" development of a child.

It can be argued that even though these teenagers did engage in premarital sex, most of them hold the value that it should be preserved for marriage, which leads one to conclude that they are fairly conservative in their way of thinking.

Beliefs can be defined as emotionally accepted propositions or opinions that individuals hold as true, which are used to guide and defend their actions (Reber, 1987, p.88). What is therefore important apart from knowledge, is whether the individuals concerned believe themselves to be at risk. In some cases this kind of risk may be highly valued. If adolescents then do not feel vulnerable, there is little incentive to bring about change in behaviour.

Fisher (1986) found that, while the correlation between the sexual attitudes of early adolescents and their parents was quite high and the correlation for middle adolescents and their parents was insignificant, the similarity between sexual attitudes of late adolescents and their parents was a function of previous parent-child discussion of sex. In the families that reported high levels of communication, the attitudes were highly similar (Fisher, 1987). One way to help adolescents gain a clearer understanding of their beliefs in a system of

values clarification, is to enable them to become more clear on what they believe in.

Values clarification does not necessarily mean that it is a means of judgement. It helps adolescents establish what is important to them. The aims of value clarification is to bring peoples thoughts and behaviours in congruence. In Tauer's (1983) opinion if beliefs, values and behaviours are not congruent, then conflict results, accompanied by a sense of uncomfortability. It is therefore the hope of Tauer (1983) that value clarification would hopefully produce change so that conflict could be eliminated.

Deeply ingrained attitudes and values brought by marital partners from their own families of origin may result in problems that are never adequately resolved. Any strong held sexual attitude can be an occasion for interpersonal conflict in a family. It is important that families discuss their different beliefs and attitudes to maintain a healthy environment.

2.10 Traditional and Non-traditional Beliefs and Attitudes

A particular family may emphasize so extremely "the one right way" to behave, that members cannot adjust to the changing requirements of individual or family life cycles, nor

can they respond well to alterations in their socio-historical context.

Another family may be characterized by randomness and extreme individualism in patterns of sexual behaviour such that members lack any common core of values or standards by which to hold members accountable, resulting in extreme unpredictability and disorganization (Maddock, 1989).

Sexuality has meaning and significance in the relational context in which it occurs. That is, patterns of interaction among family members create a network of shared meanings which in turn serves as a basis for further behavioural sequences between members creating new meanings upon which additional behaviour is based, and so on" (Barton & Alexander, 1981).

In traditional families, the most severe form of sexually neglectful family is one that virtually ignores it's members sexually, except in the case of a marital relationship. Spousal roles and tasks are assigned rigidly based on gender differences. It is these attitudes on women's family roles that are likely to influence behaviour that encourages or prevents premarital childbearing (Plotnick, 1992) In Maddock's (1989) experience the sexually neglectful family is usually cool and distant. When the required sex communication takes place in an abstract manner, no connection is made between personal experiences and family members.

Parents may become obsessed with eliminating ideas and behaviours thought to have sexual significance to their children. As a result of this, children may develop an overbearing conscience that may become generalised enough to create a sense of shame about any form of erotic interest or expression. Webb(1994) found that often due to these cognitive distortions, teenagers who become pregnant report misconceptions about when they became pregnant.

Parents influence their teenager's behaviour through teaching, modelling, and communicating their values through actions and incidental comments on behaviour (Webb, 1994). Finally, the relationship between parent and adolescent influences the likelihood that the teenager will engage in sexual activity. Neglectful or rejecting parents may precipitate a separation manifested by the teenager's pregnancy. According to Trad(1994) teenagers who become pregnant, often come from homes marked by familial discord more frequently than those who do not become pregnant.

In some instances, parent's are often themselves uncertain and insecure and do not provide clear guidelines. Practices and standards have changed, and conventions supported by parents may not seem agreeable with the mores of teenagers, confronted with current peer standards (Notman and Nadelson, 1980). In their opinion many parent's are restrictive about sexuality , presenting a confusing picture. According to Maddock (1989) a sexually healthy family can be defined as the

balanced expressions of sexuality in the structures and the functions of the family, in ways that enhance the personal identities and sexual health of individual members and the coherence of the family as a system.

Parents provide positive sex education for their children, combining accurate information with a specific context of family values. Christopher, Johnson and Roosa (1993) reported a lower incidence of sexual intercourse among daughters in traditional families where parents and adolescents listened to each other and discussed parental decisions compared to daughters whose communication with their parents did not have these qualities.

Sexual attitudes and values are passed down from one generation to the next through positive interaction patterns in everyday life. There can be no single version of family sexual health, nor is there only one means to promote it. Events of sexual significance often accompany individual and family cycle transitions, because sexuality is a fundamental dimension of family experience,. In addition shared sexual meaning and values sometimes fluctuate. Sex therapists attribute many adult sexual functioning difficulties to negative sexual learning, especially from sex guilt and fear instilled in early life by parents (Yarber and Greer, 1986). For these reasons, it is important hallmark of sexual health that a family can master and adapt to new sexual circumstances both inside and outside the home, and so then can also

transform it's own sexual structures and functions to accommodate more fundamental alterations in it's life circumstances. Yet, studies have shown that many parents do not talk to their children about sexuality(Roberts, 1980).

2.11 Influences on Sexual and Contraceptive Behaviour

The attitudes toward contraceptives used seems to be one of reluctance among teenagers (Preston-Whyte & Allen, 1992) because of the unpleasant side-effects and perceived dangers associated with it.

In support of the developmental theory, a similar transformation from an egocentric worldview to recognition of mutual responsibility may occur for contraceptive use. In Reis and Herz(1989) opinion, adults generally use contraceptives more consistently than do adolescents and this behaviour may reflect an evolving cognitive maturity.

Fisher (1987) found that even though it is family discussion about sex, that in the past has been found to be related to sexual activity and contraceptive use, it was the parents' reports about the quality of general family communication that they had with their children that were most related to sexual activity, in particular males.

Reis (1975) reported that early sex education in the family had significant relationships to that of contraceptive use. Adolescents have many different reasons for wanting to be

sexually active. The rapidly changing environment of the adolescent, both internal and external, can lead to confusion about what is understood or believed. In most cases teenagers are unclear about their values, attitudes and beliefs, and are uncertain about the course of action based on their values and beliefs. It is therefore important to note that every attitude, value or belief held, whether consciously or subconsciously, will influence decisions about sexuality, sexual activity as well as contraceptive use.

For adolescents then to make wiser choices in life it is imperative that they become clearer about their values, attitudes and beliefs. Preston-Whyte and Zondi(1992) found in their study that apart from physical enjoyment, there are good reasons why teenagers have intercourse without taking any precautions in order not to fall pregnant.

They further state that in the context of the teenagers' lives, their pregnancies make sense.

2.12 Communication

Communication is a fundamental aspect of family behaviour. It serves as a link between persons and between smaller and larger environments or organisations. Communication can be viewed as a process by which the family develops a self-image and acts as a unit within society. This process uses both verbal and non-verbal messages to convey feelings and information (Gross, Crandal and Knoll (1986). Although relatively few parents are actually the primary sexuality

educators of their children (Fox, 1981), the results of some of these studies have indicated that when parents do talk to their teenagers about sex, they tend to be less likely to engage in premarital sex or are better equipped to make informed decisions (Fisher, 1987).

The part that family plays in sexual socialisation is of particular interest, in that it is the earliest source of socialisation, sexual and otherwise. Healthy families are open and responsive to outside input, expectations and challenges but stable enough to provide a sense of security and continuity. Such families are thoughtfully organised, with good lines of communication between partners and between parents and children (Rothwell, 1994).

There is a growing awareness that sexuality is so integrated with every other aspect of human life that education in human sexuality is a life long process. An integral part of social learning, sexuality education relates to learning sources as diverse as the extended family, the place of worship, work sites, health care services, community, media, law, as well as peers.

Spanier (1975) found that almost two thirds of both males and females reported that independent reading was a primary source of sex information. In addition, 81% of males reported male friends as a major source, 30% reported fathers, and 24%

mothers. Among females, 70% peers(females), 62% reported mothers and 22% fathers.

In Magwentshu's(1990) opinion, many sex educators and researchers believe that individuals acquire their sex education mostly from peers. However, conflicting findings have been reported from existing research that parents are the predominant source and that individual reading has played a particularly strong role(Nielson, 1987).

2.12.1 Different Levels of Communication

Adolescence is a period characterised by pressures from many various channels. Sexual messages communicated by these different sources both verbally and nonverbally are often done in a manner that allows misinterpretations to flourish. Since teenagers are exposed to so many sources of information it is important to explore the manner in which the information is disseminated.

Hepburn (1983) identified three levels of communication regarding sexual topics. Level one communication refers to a specific conversation, usually involving mother and daughter, during which menstruation, reproduction and sexual intercourse are discussed. This generally is the first time mother and daughter have had a serious, private discussion regarding sexual issues.

At level two communication, these discussions involve informal, ongoing mother-daughter conversations. At this level, the daughter is older, usually early to middle adolescence, and the topics may include birth control, abortion, teenage pregnancy, homosexuality, petting and rape. It is often initiated by the child after hearing something at school or after talking to a friend. The focus of the conversation changes from mothers providing information to sharing of information by both mother and daughter. At this time, mothers and daughters discuss sexual values and what constitutes appropriate sexual behaviour.

At level three communication, social issues are discussed. These conversations are usually not private and are never personal, that is, all family members discuss general sexual issues such as fornication, adultery, illegitimacy, abortion, homosexuality, and rape. These informal discussions generally begin during adolescence and last into adulthood. The primary function of level three communication is the development of personal values and the maintenance of socio-sexual norms. Even though the different levels of communication have been identified, many parents remain restrictive in their willingness and ability to impart accurate developmentally appropriate sex information to their children(Daniels, 1994).

They inhibit their sexual talks in the presence of children conveying the message that sex has a "bad"component (Magwentshu's, 1990). In a study undertaken by Jaccard and

Dittus(1993) all the parents in their sample indicated that they discussed sex with their teenager's. When probed further, it was discovered that the content of discussions differed from parents to parent. In some cases nothing was said explicitly and the content remained at level one.

2.12.2 Barriers to Communication

A variety of factors have been identified as an explanation for the limited communication on sexual matters between parents and children. Ram (1975) reported that many parents identified barriers to communication. Among them were, 1) children were too young to receive information 2) lack of information necessary to answer questions 3) personal discomfort 4) perceived discomfort of children 5) uncertainty regarding what, when, how, and the why of providing such information.

Jaccard and Dittus (1991) clearly recognised the need for parent-teenage communication programmes. The advantage of such programmes is that parent and child are learning the facts and new communication skills together. Thus, it enhances and reinforces the factual and skill building learning and together establishes a common frame of reference and terminology that facilitates communication on this subject. Parents become more knowledgeable and often more comfortable providing information and answering questions. Thus, parents get established, in their children's eyes as available and approachable resources.

2.13 Different Sources of Information And Messages Conveyed

Many individuals are raised in families where discussion of sex is not encouraged, supported or condoned. Discussion of safer sex practices, therefore, makes people uncomfortable and as it contradicts cultural or familial values. As the family is the first socializing agency that we are born into, it has become clear that the family conditions the information we receive about sexuality. Fox and Inazu (1980) argued that one might expect some differentiation amongst teenagers in terms of sexual values, attitudes, beliefs and behaviours along the various dimensions of family background, such as religion, social conservatism, or parental marital history.

In recent years the terms family and sexuality have been linked in a particularly negative way. Parents traditionally have attempted to control the opportunities their teenagers have for sexual involvement by restricting permissible social activities, night hours away from home, friendship associations, and by advice. At the same time we may assume that parents attempt to inculcate values in adolescents that would make coitus less likely (Newcomer & Udry, 1984).

Out of this has emerged the notion or the prevailing attitude that sex in all it's manifestations is a problem for families rather than an integral part of the families process (Maddock, 1989). The part that family plays in sexual socialisation is of particular interest in that it is within

this social context where one's earliest socialisation takes place. Woodward(1995) demonstrated that communication within the family about contraception correlated with a increased use of contraception by teenagers, and that parental involvement in clinic appointments enhanced contraceptive compliance.

Jurich and Bowman(1998) advocated that a teenager is a member of a school system, a peer group system, a family system, a community system, and also the larger social system. They purport that integrating the various systems would increase the likelihood of changing adolescents' sexual behaviour if they worked together to offer the same message.

Within the family male and female influences may be valued differently. Gender differences may be accentuated or minimised. Certain ways of perceiving, thinking, communicating and behaving may come to dominate life in a particular family. Communication of parental values is one of the primary means by which parents socialise their children. In view of this, it would seem that sex education in the family might be an important intervention for delaying the transition to sexual activity (Moore and Furstenberg, 1986).

In the studies cited Moore and Furstenberg (1986) (Kahn, Smith and Roberts, 1984; Newcomer and Udry, 1984,1985), they claimed that investigators have assumed that parents are uniformly negative in their attitudes toward premarital sexual activity. As the attitudes of adults toward marriage and

premarital sexual activity have become increasingly diverse over the past decades (Thornton & Freedman, 1982 cited in Moore and Furstenberg, 1986) it can no longer be assumed that all parents feel the same way or equally strong that their children should postpone sexual activity until marriage or even until they finish high school.

Regardless of these values parents may not always be successful in relating their values to their children. The most important substitutory agents for the parental home as guidance and socialization **media** was identified by Preston-Whyte (1991) as the radio, television and the **school**. In this regard the radio was identified as the most important source of knowledge. School came second and both the **peer group** and the **church** seemed relatively uninfluential.

Family planning clinics appeared to play a minimal part in sex education and guidance. It was reported that most the respondents felt uncomfortable with the lack of privacy at these centres and to the lack of a sympathetic atmosphere. In a study undertaken by Karim, Preston-Whyte and Karim (1992) it was highlighted that there were private facilities available for consultation, but these were not used that often. It made the respondents feel uneasy which therefore led to them not returning to the clinic.

2.13.1 Parental Communication

Family influence is a factor affiliated with initial sexual activity among teenagers. Parent's influence their teenagers' behaviours through teaching, modelling and communicating their values by means of actions and incidental comments on behaviour (Webb, 1994). Parental communication with teenage children is often recommended as a means of discouraging early sexual activity. Adolescence is a period in which the family faces the challenge for increased teenage autonomy. As it is a time when the teenager actively seeks to establish psychological independence, more flexible family boundaries are necessary.

The family helps to formulate our ideas and opinions, by means of transferring specific information in a specific way. Whether intentional or not, the family determines to a large extent the information and the tone with which the information is conveyed. According to Inazu (1980), one fear voiced by parents, with discussing topics of sexuality with their children, was that parents felt that they would be giving children tacit encouragement to become sexually active.

Depending on parental orientation, different messages are conveyed to teenagers that might affect their sexual behaviour (Jaccard & Dittus, 1993). In a study conducted by Mayekiso and Twaise(1993), that examined the extent of parental involvement in imparting sexual knowledge to adolescents, none

of the respondents reported communication with parents about sexual matters prior to menarche.

It is because of this that one might expect some differentiation among teens in terms of their sexual values, attitudes, beliefs, and behaviours along various dimensions of family background, such as religiosity, social conservatism, or parental marital history. In studies identified by Inazu (1980) despite parental desires and intentions, few parents gave much direct instruction about sexuality and sexual intercourse.

Parents are often insecure themselves and do not provide clear guidelines for their teenagers to follow. Practices and standards have changed, and the values held by parents may not support the beliefs of young people. However, according to Fox (1980) when parents do talk to their children about sex, the adolescents tend to be less likely to engage in premarital sex. Moore and Furstenburg(1986) contend that attitudes of parents and adults toward premarital sex has become increasingly diverse over the past several decades , and it can no longer be assumed that all parents feel equally strongly that their children should postpone sexual activity until marriage or even until they finish high school.

Families play a particularly important role in sex socialization. Family determines to a large extent the context, the specific informational content and the evaluative

tone of one's initial learning about sexuality(Fox and Inazu, 1980) . Fisher(1987) found that while the relationship between parent-child communication about sex and subsequent sexual behaviour is equivocal, family sexual communication is clearly related to similarity in sexual attitudes between parents and their children.

McDowell (1987) suggested that a close relationship between the teenager and parent often lead to emotional , spiritual and psychological stability, all being essential for an ideal learning climate. What parents communicate both explicitly and implicitly, determines how teenagers will be socialized.

2.13.2 Peer Communication

Adolescence is a period filled with mixed feelings of excitement and apprehension about one's new relationships in wider society outside the family environment. Through learning to negotiate these networks, there is a promise of an assured place in the future world of adulthood. However, in the process, young people are caught by the pull of two powerful forces - the transformation of close relationships with parents, family members, and the challenge of new relations with peers and friends outside the home (Drummond, 1991). During middle and late childhood, children spend an increasing amount of time in peer interaction.

Today's adolescents face demands and expectations that appear to be more numerous and complex than did adolescents only a generation ago. During adolescence, especially early adolescence, teenagers tend to conform more to peer standards. Allegiance to clubs cliques and crowds, exerts powerful control over the lives of many adolescents.

The movement away from strong dependency on family which started in childhood, accelerates at a more rapid pace, accompanied by an increasing significance of the peer group. By relating to others the adolescent learns to acquire a concept of themselves, a perspective of others, and a knowledge of how to act in social situations (Drummond, 1991).

According to Kephart and Jedlicka (1991) wherever parents draw the line of acceptable premarital behaviour, the children's peer group is often on the other side. This disagreement between children and parents is usually called the "generation gap". In the past, schools, churches, the media, and public opinion were unified on the parents side. Peer influence now operates through persuasion, example, and the providing of situations conducive to intercourse. Young people increasingly turn to each other to learn the new ways of behaving, to share their fluctuating moods, to make connections with the opposite sex. They learn to move out of egocentric self-centeredness towards a more balanced recognition of others by communicating more interactively with social group of their kind.

As relationships and friendships develop, they spend more time together, over weekends to watch television, talk about all sorts of things, diet, fashion, sports and puzzlement about sex. Their main concerns are personal and immediate. In Ganter and Yeakel's (1980) opinion, young people are conscious that the people around them can play a significant role in their lives. Peers become a significant reference group, a testing ground for comparing beliefs, values and feelings which are raised to consciousness for re-examination especially for this time of life (Drummond, 1991).

Magwentshu(1990) supported this view by stating that peers are often perceived as less intimidating than adults, because they are equally inexperienced and have to deal with similar problems, sharing and creating new ideas.

Teenagers select friends who have similar values and interests. They have similar aspirations, school results, and spend much the same time at their homework. Certain features such as physical attractiveness is often positively related to positive peer relations. Language usually plays a role in separating one group from another. Conformity is strong. There is an increase in the power of the peer group in middle adolescence, pressure to be a part of a group, to have friends to conform is of utmost importance (Drummond, 1991).

Adolescents have the urgent need to belong. They imitate one another, (Adams and Gullota, 1989). They do the same

things, talk the same way, hold same attitudes, dress in the same style and keep the same interests. The peer group can place tremendous pressure on the adolescent to conform, by competing, to smoke, to drink, take drugs and engage in sexual activities. Deviance from group norms is criticised and can cause rejection (Jensen,1985). Over time friends renegotiate their relationships. There are some adolescent friendships which last a lifetime, but friendships are often subjected to changes.

Young people leave school to join the work force, or study at another institution, some get married, some feel the old friendship is no longer appropriate. Sometimes they break their friendships, or simply drift away from one another. They can be ended by external and internal forces that drive friends apart, a change in values, a shift to another town, the attraction of another friend, marriage, death of a friend, and many more.

2.13.3 Institutions and the Media Communication

Gender stereotypes are reflected in the media and advertising. In a submission to the Commission on Gender Equality during it's Information and Evaluation Workshops in May 1997, the Institute for advancement of Journalism made the following observations. In the South African media, women are often not seen and advertising agencies "skew" the bias towards decorative images of women even further. Some women, girl children, the old, women with disabilities, rural women

are almost completely invisible. They referred to the South African media as an extension to an old boy's club(Convention toward Eliminating Discrimination Against Woman Report2, 1998).

In Strausburger's (1989) opinion the attitudes and behaviours that adolescents adopt are those stereotypes depicted on the screen. The mixed messages that teenagers receive through the media sets a double standard, which prevails in the western culture.

Movies, music, radio and television tell teenagers that sex is romantic, exciting; premarital sex and cohabitation are visible ways of life among adults they see and hear about. Yet at the same time, young people get the message that good girls say "no". Almost nothing they see or hear informs them about contraception or the importance of preventing pregnancy (Jones, 1985). In a cross-section of South African women working in a collective to produce the journal"Agenda" met to discuss culture, tradition and gender. They found that South Africans often speak about traditional African, Indian cultures and Western cultures placing emphasis on differences and distinctions.

There are clear distinctions, but it was discovered that several cultures are very similar with regard to gender-related beliefs and roles. Although there are differences, many women are undervalued and anything associated with women

seems to be evaluated negatively. Another common theme is that from an early age women are held responsible for child rearing and household work.

While the media must largely reform itself and lead rather than react to societal change, it was suggested that the government could take a pro-active role, through strong gender provisions, "which could take up complaints and mete out more than a gentlemanly rap over the knuckles". Messages conveyed lead to an ambivalence about sex that hampers communication and exposes teenagers to an increased risk of unwanted and unplanned pregnancy (De Vries, 1993).

2.13.4 The Church And Schools

Although the need for more information about sexuality has been stressed, school-based health clinics and sex education programmes remains a contentious issue. McGrew and Shore(1991) contended that knowledge is a tool. The knowledge transferred should include information about values, sexual behaviour, responsibility and the right to say no, as well as contraception for those who choose to be sexually active. Many teachers have strong and divergent attitudes about the content of sex education programmes. Sexually active teens are left on their own with few resources to help them make responsible decisions.

Many professionals in Robinson's (1990) opinion, believe that this contributes to ignorance and misinformation about

sex and contraception and ultimately to unplanned adolescent pregnancy. Recommendations based on this information was made by the Guttmacher Institute (1982) that adolescents should be educated about sex, reproduction, contraception and the responsibilities of parenthood before they become sexually active to prevent unwanted pregnancies.

Still, communities and families believe and continue to oppose candid discussions of sex, fearing they will encourage promiscuity and sexual experimentation.

Nash (1990) therefore lays emphasis on the need for clinical services to deal with the behavioural problems with which many of the children of poor, unwed mothers present. Society plays a role in that there is a tendency to blame the girl when she does become pregnant. Teachers, parents, and church ministers as well as health care workers have to address the whole issue of teenage sexuality if they are to make a positive contribution in alleviating the problem. The church and schools need to avoid passing judgement. Such attitudes obscure causes and effects and can lead to backlash rather than cooperation and change. (Edelman, 1987).

Formal sex education in schools and churches has been difficult to evaluate overall. McGrew and Shore (1991) found that a programme that reports success is one made up of teenagers, parents, community leaders, ministers, schools, churches and community groups. School sex education, in their opinion, is only a part of this effort.

2.13.5 Family Planning Clinics

The uneasiness of parents to educate their children about sex results in the continuing problem of teenage pregnancies. According to Mazibuko an educator at Planned Parenthood Association, sex is seen by some parents as a sin and discussion of the subject is taboo in many families (Majola, 1991). A reason for this ongoing problem is the fact that there are no health care centres for the youth.

Further girls under the age of eighteen are not allowed to attend family planning clinics without adult supervision or accompanied by a parent (Preston-Whyte & Allen, 1992). Those who are aware of these clinics are embarrassed by attending these clinics and therefore do not make use of the service which is made available to them. As Preston-Whyte and Allen (1992) reported from their study, girls felt that their attendance might be noticed by a neighbour, who would then in turn inform their parents.

According to Klugman and Weiner (1990) family planning clinics were set up separately from primary health care clinics, in order to ensure that as many members of the population as possible had access to contraception, even if they did not have access to other health care services.

This therefore limits the range of services available to women seeking contraception so that, in addition to curative care, separate family planning clinics treat other problems related to sex. Although contraception would appear to be a

plausible solution, it is widely accepted that there are pitfalls. The customary presentation of contraception is not suited to the adolescent - lack of appropriate information, inaccessible service provision, and adverse professional attitudes all play a negative role (Sapire & Davey, 1979). According to Loening (1992) "teen clinics" at schools could go a long way to filling this large gap.

Traditional health education, a mechanical focus on contraception, appeals to traditional moral values and keeping teenagers in ignorance, have all failed. The need for adults to fulfil their practical responsibilities to young people by providing information, acceptance and services is clear. The time has come to provide teenagers with a non-threatening environment where attitudes may be explored, ignorance dispelled and common ground sought (Ashton, 1994).

As South Africa has a legacy of being overtly repressive for the contraception services for teenagers, such institutions are often viewed as a privilege not a right(Lewis and Salo, 1993). They reported that staff members at clinics often gave simple instructions to the use of different methods of contraception, but failed to give any explanation of how the methods worked.

2.14 Sexual Activity Among Teenagers

As teenagers are becoming sexually active at younger ages, so does the risk of pregnancy increase. In comparison to the character of marriage, sexual attraction and non-marital sexual relationships, including those which represent a long term relationship between two young people, are largely their own affair(Preston-Whyte & Zondi, 1992). The International Planned Parenthood Federation estimates that worldwide, more than 15 million women between the ages of 15-20 years old give birth each year(Lee and Made, 1994).

In a study undertaken by Todt (1991), Head of the Nursing College at Tygerberg Hospital, of 381 pregnant teenagers, 46.6 percent were sexually active before sixteen. It is because of this that one has to take into consideration the fact that teenagers arrive from different backgrounds and from different social environments. Daily they are exposed to images of sexual freedom as portrayed in the media, and it is the very same media that sends messages of sexual responsibility and prevention of teenage pregnancy.

In accordance with Todt's findings, Louw (1990) found that an interest in members of the opposite sex among the girls he interviewed, had started at an average age of thirteen-and-a-half. Significantly, 10 percent of his respondents indicated that they had been sexually active with members of the opposite sex by the age of twelve. Important as these findings are, what is alarming about Louw's (1990) study is

that 85 percent of his sexually active respondents had not used any form of contraception during their first sexual encounter. Sexual intercourse may be associated with growing up and traditionally, with being married. By engaging in sexual activity a teenager could rapidly establish her status as an adult or at least as an individual entitled to the privileges of adulthood (Trad, 1993).

It has become clear from these findings that for any sex education programme to be effective, it has to start where the children are at. Many of these children are still at primary school, and it is here that resistance to sex education is often experienced from both schools and parents.

By advocating safer sex through use of contraceptives and at the same time promoting abstinence for teenagers sends a mixed message. As Mcgrath and Strasburger(1995) contended that abstinence does not provide an adequate safety net for those teenagers who do not comply. Teenagers and young adults need to know how to engage in sexual intercourse in as safe a manner as possible.

2.15 Knowledge About Sexuality and Contraception

Access to safe contraception methods and knowledge about their effectivity and disadvantages are basic prerequisites for the liberation of women. In South Africa, the dispersal of contraceptive services has often adversely affected the

teenager's health and has largely ignored their needs for education and personal choice.

Parents are notoriously bad at discussing sex-related issues with their children. This arises, at least in part, out of a cultural practice in relation to the majority of South Africans in which children learn about sexuality at initiation schools and it was neither necessary or appropriate for parents to take such responsibility (Klugman & Weiner, 1990 p.43). The lack of sex education for adolescents and the infrequency of open discussion about sexuality and contraceptives in families reflect the prejudice that sex should be confined to the institution of marriage (Lewis and Salo, 1991).

The reality and the extent of teenage sexual activity causes such intense revulsion amongst conservative societies that teenage contraception is viewed as an immoral and undesirable compromise. Contraceptive measures are made available, and in Preston-Whyte and Zondi's (1992) opinion, the question remains, as to why so few teenagers make use of them. Despite the widespread education in the use and availability of contraceptives, many teenage girls still become pregnant (Trad, 1994). Reasons given by parents is that they object to allowing their daughters free access to contraceptive clinics, and even more so to the provision of contraception at schools. Their reasons range from moral considerations to fear that contraception will encourage

sexual freedom and experimentation, and in many cases, that it will impair future fertility. Psychological studies undertaken by Conger (1979, p.11) carried out in several countries to compare sexually active adolescent girls who do and do not use contraceptives have found that girls not using contraceptives:

I. Are more likely to feel powerless to control the events of their lives.

II. Have a low sense of personal competence

III. Have a passive, dependent approach to male-female relationships

IV. Are more inclined to take risks, and to cope with the anxiety by attempting to deny possible dangers rather than facing up to them

V. Tend to fear that taking contraceptives is a sign of planning for sex and sex can only be justified if it is "accidental" or spontaneous"

Further, teenagers in a number of studies seem quite knowledgeable about contraception, which methods worked best and how and why some methods might fail (Witte, 1997; Melchert, Kent and Burnett, 1990).

Many of the teenagers believed that "it could not happen to them" In our society it is evident that teenagers are at risk as many of them have become sexually active at an earlier stage and do not make use of any form of contraception. Although knowledge and promoting safe sexual practices remain

important, knowledge does not necessarily lead to behavioural change (Barling and Moore, 1990). It is therefore imperative that in addition to sex and health education, life-skills programmes are urgently needed to help teenagers to develop a sense of their own control over their lives, and the view that making responsible decisions will lead to a better future.

2.16 Sexual and Contraceptive Knowledge and Practices Among South African Teenagers

Often, even when in possession of good knowledge about reproductive health, peer pressure and the desire to have a baby in order to prove one's love, fidelity and womanhood are some of the reasons why unsafe and life threatening practices remain common (Maternal Child Health news, 1996).

Pregnancy is by no means the inevitable result of intercourse. For many adults the connection between intercourse and pregnancy is clear. This connection, however, is not necessarily a reality for many teenagers(Trad, 1993).

The teenager's cognitive awareness may be such that unless an outcome is certain, the teenager will accept the risk. In Preston-Whyte's (1991) study she noted that children born to teenage mothers have not been the result of fleeting or casual sexual encounters. Teenagers are highly knowledgeable about contraceptives, yet an alarming number of teenage girls fall pregnant each year (Singh, 1992). He found that although their knowledge was high, the use of the contraceptives were

low. In a study conducted in Natal, teenage girls revealed high rates of unsafe sexual practice despite good levels of knowledge regarding contraception, reproduction and HIV/AIDS (Varga & Makubalo, 1996).

Other factors that explain these behavioural patterns, such as inaccurate knowledge about the reproductive process and contraception, inaccessibility of services, peer group and other pressures, failure to accept their own sexuality and to acknowledge their need for the use of contraceptives and the adolescent's tendency not to plan ahead have also been cited (Population Bulletin, 1985).

It seems that as far as adolescents are concerned, having intercourse and having contraceptives is not primarily a rational, intellectual process, but rather an outgrowth of interacting social, situational and psychological factors. In Du Toit & Thiele, 1982; Craig & Richter-Strydom, 1983; O'Mahony, 1987; Koegh, 1988 and Nash (cited in Preston-Whyte, 1991) are concerned that South Africa is no different. Contraceptive advice for adolescents is of variable quality as presently available contraceptives may not be suitable for younger users. Furthermore the teenagers tolerates more side-effects poorly and are more easily deterred by external influences such as peer groups and the media about so-called dangers of contraception. The problem is however, more complex, for even where knowledge and adequate contraceptive

facilities are available, individuals may choose not to avail themselves of the opportunity of preventing pregnancy.

Visser and Le Roux, (1996) conducted a study in Knoppieslaagte in which they reported, there was a general lack of knowledge about conception and pregnancy. It is important to bear in mind that sexual contact amongst teenagers, most times is sporadic, making the irregular use of contraceptives a usual phenomenon. Teenagers are either not aware, or fail to grasp the significance of the regularity of contraceptive use (Boult and Cunningham, 1991) in order to prevent pregnancy.

Teenagers tend to have irregular and often inadequate knowledge about their reproductive health system and even when in possession of good knowledge, unsafe sexual practices remain common(Maternal and Child Health News, 1996).

In a study undertaken by Witte (1997), respondents all knew how to prevent pregnancy in a variety of ways, however, all the teenagers in this group were already teen mothers. They admitted that they had learned most of their contraceptive knowledge during their pregnancy and not before. Many conceded that at the time they became pregnant, they did not know much about contraception. It can therefore be deduced that when a lack of knowledge precedes pregnancy it places the teenager at a substantially higher risk.

Sexually active adolescents are often misinformed, unrealistic and confused about contraception. Reis and Herz (1989) argued that the teenager's developmental status influenced their profile of knowledge. They argued that teenagers seek personal gratification with little thought for the consequences and defer to adult authority figures. Developmentally, it is a stage when a teenager is governed by a way of thinking called the "personal fable" (Hobson, Robinson & Skeen, 1983 p.5).

2.17 Pregnant Teenager

An assumption that underpins the intention to change the rate of pregnancy is that each pregnancy is bad for everyone, the girl, her family, the health services, the education authorities and society in general. Teenage pregnancy in these circumstances is perceived as a disaster for all concerned (Jacobson, Wilkinson and Pill, 1995).

There are those adults who disagree about the nature of the teenage pregnancy problem. Some see it primarily as a moral problem, while others view it as an economic problem. Some are concerned because of it's implications for the families' development, infant mortality, and health outcomes; others because it contributes to school dropout and dependency (Edelman, 1987 p.51). Likewise there is just as much disagreement about solutions. The problem is viewed by some as an issue of sex education and family planning; others as a

problem requiring comprehensive and long-term education and economic solutions.

The two main reasons identified by the Department of National Health and Population Development as reasons for not using contraceptives is, that they are confused about the morality of using birth control and their ignorance about reproduction and contraception (Burman & Preston-Whyte, 1992).

Schoeman, (1990) highlighted the aspect of staff at health clinics, that are not sufficiently trained to work with teenagers.

An unplanned and unwanted pregnancy causes major physical, emotional, as well as practical upheaval in any woman's life. When this occurs in the life of an unmarried adolescent the event can be rather traumatic. Among the potential traumas, the teenager may be asked to leave school either by her parents, kinsfolk, or the school authorities. She may want to marry the father of the baby, but this might not be reciprocated. She must also face the reality of being responsible for the well-being of another human-being in addition to attending to her own needs and desires (Institute for Planning Research, 1991).

Teenage mothers are often single mothers. They are seldom able to support their children financially. In a Johannesburg study of 175 teenage mothers only 6% were working, while a

further 47% were unemployed and 47% at school. Only 4.2% provided financial support for the child (Klugman and Weiner, 1990). It becomes apparent that there are many challenges that the teenager is faced with once pregnant. In most cases the teenager is both physically and psychologically unready to assume the burden of reproduction and child care; she will interrupt and most probably discontinue her schooling; as a result, she will not be in a position to support herself and her child and the pregnancy may present health risks to both mother and baby (Boult, 1991).

While teenager pregnancy represents a challenge for the whole society, it is less apparent if it is a problem for the teenager involved. Teenagers may have deep rooted motivations to conceive, or at the very least may feel ambivalent about pregnancy (Jacobson, Wilkinson and Pill, 1995). The assumption that teenage pregnancy is a problem needs to be challenged. It is important to explore the factors which could have an influence on teenage pregnancy if one is to try and combat the problem.

2.18 Consequences of Teenage Pregnancy

The consequences of the nation's high adolescent pregnancy rate are of great concern. The common belief is that adolescent pregnancy increases the health risks of both the child and the mother. Babies born to teenage mothers have

an increased incidence of stillbirth, low birth weight and post natal complications. Since teenage pregnancies are often unplanned, the children may become victims of neglect, abuse and malnutrition. However, Grazioli (1994) reported, after completing a thorough analysis of various research projects, that there appeared to be no adverse effects associated with young maternal age if high prenatal and later health care are available. Creatas (1991) in agreement with this reported, that among the 231 women aged between 12-16 years of age, the vast majority of whom received prenatal care, there was no increase in obstetric complications. However, maternal mortality is almost double for women less than twenty years old compared with women between twenty and twenty-four years old. In addition there is an increased risk of hypertension and difficult labour.

Both Clarke (1986) and Kalmuss (1986) contended, on the basis of available research, that the younger the teenager with her first pregnancy, the greater the likelihood is that she will have repeat pregnancies in rapid succession.

In contrast, Butler (1992) reported over the past few decades, teenage mothers are completing their schooling, they are having fewer children, leading to greater economic stability and well-being.

Adolescent mothers who drop out of school, often fail to gain employment and become dependent on welfare (Dryfoos, 1990). These educational deficits have negative consequences for the young women themselves and for their children (Kenney, 1987). It has therefore become clear that the problems experienced by the teenager, whether married or unmarried, appears to be twofold in nature. The pregnant teenager's body has to adapt biologically to a pregnancy, as well as cope with the adult role of motherhood (Parker, 1987).

Dryfoos (1985) made the recommendation that there is desperate need for sex education, access to contraception and abortion services, and services for adolescent parents and their children. However she also stated that, even if these recommendations are taken into consideration, it still would not take away the problem of teenage pregnancy. This study concluded that, although adolescents certainly need more knowledge about sex and contraception, they also have to be motivated to use that knowledge if they are to be responsible for their sexual behaviour.

Boult (1991) stated that pregnant teenagers need education and information to enable them to make reasonable choices about the spacing of their pregnancies and the prevention of any more unwanted unplanned pregnancies. She stressed the importance of increasing adolescent mothers educational levels. Both the private and the public spheres should take

on the responsibility of training the pregnant teenager and providing them with the skills to cope with their new roles.

In a study undertaken by Christopher and Roosa (1990) they indicated that the social, economic and health consequences of an unplanned teenage pregnancy are almost all adverse. The long-term consequences of unplanned teenage pregnancy included lowered educational achievement, medical complications, higher subsequent fertility, lower labour force participation, reduced earnings, and a life time of economic stress and limited opportunities.

Adolescent sexual activity is occuring at younger ages and use of contraceptives are hazardous. In Robinson's (1990) opinion for a large number of both males and females, lack of information about sexuality and contraception is a major factor in non-use of contraceptives.

In a survey undertaken by Petropoulos (1984) she made the shocking discovery that large numbers of very young teenage girls (13-15) who are sexually active, were having intercourse without contraceptive protection. Given that most adolescents who are unmarried but are sexually active do not want to become pregnant, a puzzling question presents itself. Why do so many adolescents not use contraception? There are many answers, some speculative, some based on careful research. Ignorance of the facts of reproduction or of contraception is

one very important reason. Another is that adolescents' sexual encounters, outside of marriage, are likely to be irregular and often not premeditated. Also when in long term relationships, where a pregnancy is desired, often precautions are not taken. As previously discussed, when teenagers do not perceive themselves to be at risk of becoming pregnant, there is little incentive to use contraception.

Zelnik, Kanter and Ford (1981) found that some teenagers believe pregnancy cannot occur because of the ages or infrequency with which they have sexual intercourse. It is because of this "personal fable", many teens do not feel the need to take any precautions. However, South African society contributes to this, in that many teenagers are not allowed to attend a family planning clinic without the supervision of an adult. In a predominantly traditional society like South Africa, teenagers are usually not adequately equipped or provided with sex education.

For sexuality education to be acceptable for teenagers, it should fit into the subculture of youth, "instead of expecting their lifestyle to adapt to the functioning of the service" (Schoeman, 1990. P17). Considering the multiple factors outlined, adolescent pregnancy can be seen as a part of a larger group of problems some of which at least can be mitigated or even prevented (Chelala, 1990).

2.19 Outcome - Implication of Motherhood

The research done by Thomas and Khumalo(cited in Preston-Whyte, 1990) documented the fact that the birth of a child makes drastic changes to both the lifestyle of the young mother and her family. Even if she returned to school she no longer would be considered a child in the full sense of the word. In the case of those who decide not to return to school, change is even more dramatic when they begin wage employment for the first time.

Poverty is the spectre which hangs over most working class coloured and black households and another child may stretch finances to it's limit. It can seldom be said, however, that the birth is the only cause of poverty. Too many such births, in which the fathers of the children are not supporting their babies, may destroy a family's tenuous grip on survival (Preston-Whyte, 1991). Beside the numerable amount of medical complications associated with teenage pregnancy, there are many implications for both the mother, her baby and her family.

The psycho-social issue of adolescent pregnancy and childbearing are even more overwhelming than the medical issues. McGrew and Shore (1991, p. 19) wrote of adolescent pregnancy as "initiating a syndrome of failure": failure in achieving the developmental tasks of adolescence, failure to complete one's education, failure in limiting family size, and

failure to establish a vocation and become independent. Here again it is important to note that there are the rare occasions, where adolescents do desire to become pregnant whether married or not who do complete their education and who eventually become self-sufficient. They, however, are in the minority.

Two other factors affecting teenage pregnancy, is low self esteem and expectations among some socially and economically disadvantaged youths. For some of these teenagers, pregnancy might be viewed as a positive, as it affirms who they are, and gives meaning to life. Without the possibility of a bright future, it seems difficult for teenagers to develop the skills necessary to delay early childbearing. Another factor contributing to continued childbearing is the lack of resources available to adolescent mothers after giving birth to the first child (Furstenburg, Brooks-Gunn & Morgan, 1987).

Adolescents find it hard to cope with or manage schoolwork, childcare, and peer activities without affordable, accessible daycare, social work services and counselling or support groups. Juggling responsibilities becomes too difficult, and a sense of helplessness ensues.

2.20 Options Available in South Africa

Once pregnant there are important decisions that have to be made by both the pregnant teenager and her family. The rose-coloured spectacles have gone and in the light of experience many girls recognise the very real problems which they are faced with. Some babies may be abandoned, and others might be reared by a distant kin. In some cases babies may have grown and become loved by members of the family and cannot easily be dispensed with.

Grandparents, in particular, value them as they do any other child. Teenagers are caught in a complex circle of pressure and counter-pressure, and to many the result seems almost inevitable-teenage pregnancy (Preston-Whyte & Zondi, 1992 p.236). However it is important to realise that intercourse does not necessarily have to translate into pregnancy. There are many options available to the pregnant teenager

2.20.1 Marriage

Some couples are forced into marriage by their parents, because it is the right thing to do. According to Casey (1986), sixty percent of "shotgun" marriages in South Africa end in divorce within five years. Few teenage relationships are established.

Often the two hardly know each other. Once married they discover their differences and are disappointed, and divorce may follow. However, while not all "shotgun" marriages end up in divorce, a couple's youth, short acquaintance, and incomplete education make it more likely.

Marriage is a difficult situation at the best of times, and on their own such a couple have little chance of success. Despite the apparent desirability of marriage, either culturally, economically or both, the assumption that marriage to the child's father is a positive outcome, needs to be treated with caution(Phoenix, 1991).

Research has shown that teenage mothers who marry when their first child is born, tend to be married for shorter periods of time, compared to older childbearers(Butler, 1992). Thus, women who begin childbearing as teenagers are more likely than other women to become single parents and the sole adult in their household. In addition to other hardships, this frequently means reduced family income.

2.20.2 Single Parenthood

Single parenthood seems to be a popular option amongst teenagers. As discussed before, there are many positive role models that teenagers can look up to. The fate of perpetual poverty does not present itself as the inevitable result of becoming pregnant. What is now referred to as "single

parenthood", has in effect been part of community life for a long time (Preston-Whyte and Zondi, 1992.p232).

In cases where teenagers are unemployed, without their parents' financial support they cannot survive. Some girls believe that the fathers of the child will pay, but not all boys take on the responsibility. In these circumstances being a single parent is not easy as the deficits are large and appear to reflect real consequences of single parenthood.

If the young mother has so many other aspects life to contend with, such as, education, unemployment, peers. In a study conducted in Knoppieslaagte the findings were similar. These findings are supported by Ziehl's(1994) explanation, that women have certain expectations of marriage and of men but that single parenthood only becomes an option when the pregnant teenager feels there is little chance of their expectation being met. Tackling these on their own makes it virtually impossible to do well.

Furthermore, the socio-economic consequences of teenage pregnancy and motherhood have particular consequences for the country as a whole. In these situations teenage girls do not have easy access to financial welfare assistance. They become economically dependent on others in their family or neighbourhood, and are usually forced to interrupt their schooling(Visser and Le Roux, 1996).

When the teenage mother is unable to resume her schooling, but has to work to earn a living in order to care for the child financially, this has an even greater impact on her lifestyle and development into adulthood. They concluded, by agreeing with Seabela(1992), that teenage unwed motherhood retards or prevents the development of the potential and self-fulfilment of the teenagers involved, as well as that of their children.To quote Preston-Whyte and Zondi(1992),

> **"marriage is something which is liked if it occurs; but if it does not, life goes on and takes another route"(p. 234).**

2.20.3 Adoption

Adoption serves as a measure to prevent abandonment of infants by means of alternative displacement. In Boult's (1991) opinion, this option is often shunned by teenagers who think it is selfish. Some parents try and force their daughters to give up the baby, believing that it is in the best interest of the girl. For a girl who has not finished school, adoption may be a good option.

In the African community this option has found very little support (Loening, 1992). There is a growing trend for young unmarried girls not to relinquish their babies for adoption to

childless couples or single persons wishing to adopt a child(Cunningham and Boult, 1996). Where socio-economic or personal circumstances make adoption options advisable, a shortage of adoptive or foster parents is experienced among certain ethnic groups.

2.20.4 Abortion

Abortion can awaken strong emotions in teenagers who undergo this kind of procedure(Trad, 1993). Teenagers often need advice to evaluate the possible outcomes that may be associated with their behaviours. Abortion should not be viewed as an end in itself but rather as an opportunity to guide the teenager in the direction of a more adaptive future so that another unwanted pregnancy is avoided

Peacock (1994) reported that most medical doctors felt that abortion should be legalised. It was also highlighted that the majority of the requests for abortions was between the ages of 16-25 years old. When cases are related of the pathetic conditions some women find themselves in, it is clear why most doctors are pro-abortion.

Cleminshaw (1990) sketched the picture of a nineteen-year-old street girl, who had a baby of two months old. The infant was not well and suffered from pneumonia, syphilis and foetal

alcohol syndrome. The baby was underweight and the mother lived under a bridge and did not want the child.

The South African Abortion and Sterilization Act No.2 of 1975 could not help this young girl, as the Act only permitted abortion under stringent medical conditions, such as rape, incest or where there is a latent threat to the health of the mother and the child.

It became clear that the law needed to be modernised and reviewed as the current status was not helping either mother or child. It was realised that it was important to adopt a holistic approach to the human being within the environment, and to overcome the fear that modernising the approach to abortion and family planning, will raise the spectres of fundamentalism.

Klugman and Weiner (1990), have argued that abortion needed to be legalised in South Africa, so that women and pregnant teenagers could choose to have abortions within the first 12 weeks after conception. At the time it was a very controversial proposal, but had to be considered in the light of the high rate of maternal mortality and prenatal mortality in some groups of women and adolescents.

On October 30, 1996, South Africa's National Assembly passed a bill allowing women to choose abortion on demand, at

state expense, up to the twelfth week of pregnancy. The Choice on Termination of Pregnancy (TOP) Bill provides that "a pregnancy may be terminated during the first twelve weeks of the gestation period of a woman who so requests"(Rosenberg, 1996). It states that between the 13th and the 20th week, a woman may request and obtain an abortion if certain conditions are met:

I. If the pregnancy constitutes a risk of injury to the woman's physical or mental health

II. If there is substantial risk that the foetus would suffer from severe physical or mental abnormality

III. If the pregnancy is a result of rape

IV. If bringing the pregnancy to term would significantly affect the social or economic circumstances of the woman

The legislation also specifies that while counselling may be recommended prior to an abortion, under no circumstances are woman, including minors required to consult with parents, spouses, or anyone else prior to the abortion. The decision is strictly a woman's choice. The Bill reflects the individual's right to govern her own body and her own life.

Woman are in a position to take decisions over their own lives. Since the legalization of abortion, the following statistics was made available by the Department of National

Health(1998), Termination of Pregnancy (TOP) Statistics in the Western Cape: February 1997 - January 1998

	Age <=19yrs	Age>19 yrs	TOP<=12 weeks	TOP 13-20 weeks	Total
Public	724	2007	1923	808	2731
Private	196	1194	1343	47	1390
Western Cape Total	920	3201	3266	855	4121

The above figures give an indication of the number of women both under and above the age of 19 years of age who decided to terminate their pregnancies. Of the many teenagers who became pregnant, 920 opted to terminate their pregnancies. In a study(Webb, 1994) conducted at a family planning clinic in Maryland, it was found that of the teenagers who opted for termination of pregnancy they were more likely to have graduated form high school or would be at an appropriate grade level if they were still in school. For the most, teenagers who decide on an abortion, look very similar to those who never experienced an adolescent pregnancy.

Abortion should be viewed as psychological as well as a medical procedure. In addition teenagers who do become pregnant should be encouraged to discuss and evaluate possible outcomes before making a decision concerning the pregnancy.

2.21 The Role Human Ecologists and Other Educators

As human ecologists there is a need to develop programmes that are both preventative as well as intervention programmes. Preventative programmes targets efforts to prevent teenagers from ever becoming parents in the first place. Facets of this programmes would include sex education, discussions, sexuality counselling, contraceptive availability and life planning. Intervention programmes would be aimed at those adolescents who have already become or will soon become parents (Casey, 1986).

If one is to bring about effective change in the attitudes there has to be entry at a grass-root level. In the South African situation where the structures of apartheid have encouraged the formation of a coloured underclass, bold and positive steps are called for if the tide of coloured pregnancies are to be reversed. Unless they see they have something to lose as adults, few teenagers will be motivated to avoid pregnancies.

2.22 Programme Development

Attitudes to teenage pregnancy can differ widely as not all adolescents or their families see it as a problem, but for those who do, various interventions are possible. Nevertheless, delaying initial sexual encounters should be a goal. However, taking such a stance is too simplistic, as it cannot be expected of programmes of encouraging young people

to say "any" will be effective (Robinson, 1990). Teenagers need to be made aware that the decisions that they make on a daily basis may result in lifelong consequences.

Preventing teenage pregnancy therefore requires investing in comprehensive efforts to bolster the motivation as well as the capacity of teens to prevent premature sexual activity and pregnancy (Edelman, 1987). Besharov and Gardiner (1993) argued that programmes dealing with pregnant teenagers cannot be one dimensional as sexual mores have changed. The challenge that human ecologists and policy makers are faced with, is to pursue two simultaneous goals;

i) to lower the rate of sexual activity

ii) and raise the level of contraceptive use.

However, according to Besharov et al (1993) meeting this challenge will take moral clarity, social honesty and political courage, three components, which in his opinion, are short in supply these days.

2.23 Intervention Programmes

Programmes of intervention are targeted at teenagers who have already become or will soon become parents. It is the aim of such programmes to help the teenager cope as

competently as possible in this difficult period of transition (Robinson, 1988).

The aim of such interventions is to:

I. develop responsible attitudes to sexual behaviour

II. to prevent casual and repeated pregnancy

III. to ensure contraceptive compliance

IV. to reduce the risk of child neglect and abuse providing parental skills

Scattergood (1990) suggested that since the nation's teenage pregnancy problem affects all of us, both economically and socially, teaching the responsibilities involved in parenting to youngsters at an early age is critical. Teenagers need to realize both the pleasures, hardships and responsibilities associated with having a baby.

Once teenagers come to grips with this, and how much time, energy, knowledge, expenses and skills are required for healthy parenting, they will think twice before getting involved in situations they will later regret.

Likewise, parents are in need of support in coping with the reality of teenage sexuality, so that they are able to help their children to be responsible in avoiding sexual abuse, sexually transmitted diseases, aids and pregnancy (Klugman and Weiner, 1990).

In terms of the curriculum of school education, teenagers need to learn about their bodies and sexuality in an environment where they can discuss the sexual relationship. It is therefore vital that sex education programmes do not focus on persuading teenagers to abstain from sexual relations.

As reported by Christopher and Roosa (1990) there may be an inherent insensitivity in programmes that stress abstinence as the only alternative to adolescent pregnancy. This approach ignores students who have already experienced sexual intercourse. The messages conveyed or suggesting that they did something wrong might turn the teenager off.

Therefore, it is vital that all adolescents are encompassed in a sensitive manner. This does not mean that the encouragement of abstinence should be dropped as a goal and forgotten, more likely all programmes should encourage abstinence, but also offer an alternative for those already sexually active or who choose to become so.

2.24 Conclusion

The prevalence of teenage pregnancy and other important aspects documented in literature has been investigated. The following chapter will outline the methodology with regard to sample selection, recruitment and data collection and treatment will be detailed.

CHAPTER 3

METHODOLOGY

At the time of launching this research project, the main aim of this study was to collect information about the contraceptive knowledge, attitudes, beliefs and practices of coloured pregnant unmarried teenagers, using a questionnaire. The questionnaire was pretested in a pilot study and necessary changes were made before final administration. The questionnaire was translated into both English and Afrikaans.

Due to the personal nature of the research it is difficult to know with certainty the reliability of the data collected. Participants may give what they perceive to be socially acceptable rather than factual responses and data may be difficult to extract from teenagers. The research questionnaire (Appendix 1), the construction and administration will be detailed as well as the research hypothesis, treatment of the data and the limitations.

3.1 Sample Selection and Recruitment

Selection of a sample was undertaken at local family planning clinic with the intention of recruiting pregnant coloured unmarried teenagers. Permission was obtained from a local clinic (Appendix 2)to access the names and addresses of teenagers who attended or had appointments to attend the antenatal clinic. The clinic was organised on a drop-in basis and possible participants were identified as they registered at the clinic.

The aims and nature of the study was explained and it was stated clearly that the participation was voluntary and that the identity of participants and information would be kept confidential. Informed consent was obtained from the teenagers and their parents expressing their willingness to participate in this study(Appendix 3). Each respondent was interviewed at their homes and only those respondents who returned the consent form were included in the study. To meet the inclusion criteria, the pregnant teenagers were to be nineteen years and under (not below thirteen), unmarried and willing to participate in the study together with the permission of their parents.

3.2 Data Collection Procedure and Instrumentation

An anonymous questionnaire was designed consisting of scales on the contraceptive knowledge and acquisition; attitudes; beliefs, to gain information on how the unmarried pregnant teenagers' practices were influenced by previous experiences; various sources of information; methods and messages used to communicate information.

The researcher personally interviewed the respondents and ticks were placed in the appropriate boxes of the questionnaire. Questions were `closed' to encourage decisive replies. The questionnaire was divided into two sections. Section A contained questions pertaining to the respondents demographic information such as age, sex, level of education, home language, family background, living arrangements, parent's occupation and educational level, employment details, academic achievement as well as a brief sketch of each individual's sexual history.

Section B was designed to obtain information on the KABP (knowledge, attitudes, beliefs and practices) format (Wilson and Mehryar, 1991). As this format constitutes a well structured, replicable methodology, the researcher decided to utilise this method for the purpose of this research. Quantitative research methods were employed to examine pregnant teenagers, knowledge, attitudes, beliefs, and practices with regard to contraceptives.

The format also helps to:

I. plan and implement teenage pregnancy prevention programmes,
II. provide baseline and follow up data to evaluate programmes
III. over time,
IV. provide data on sexual behaviour,
V. identify vulnerable groups for intensive, focused interventions

In Elkonin's (1993) opinion, knowledge gained through education programmes which leads to changes in attitudes and changes in high risk sexual behaviour remains the only path to prevention.

3.2.1 Contraceptive Knowledge

Section B contained questions pertaining to the contraceptive knowledge of the pregnant teenager, whereby the respondents had to select the correct answer. The purpose of this section is to measure the individual's knowledge of selected natural, mechanical and chemical contraceptive techniques. This was based on an instrument constructed by Delcampo(1976) utilised with a college student sample to gain information on contraceptive knowledge, making it appropriate for groups of high school students.

The items in this section has five response choices per item; each response is mutually exclusive to others. There is only one correct answer per item. Higher scores indicate greater knowledge of contraceptive devices and techniques than do lower ones.

3.2.2 General Knowledge on Conception and Contraception

The above mentioned scale was used in conjunction with the Contraceptive Utilities, Intention, and Knowledge scale (Condelli, 1984). This scale consisted of three different sections, but for the purpose of this research only the third section is applicable. The third part was a multiple-choice knowledge test consisting of an 8-item test of general knowledge on conception and contraception.

The scale was developed to be used in a family planning clinic. It was tested at the clinic on over 600 women ranging in age from 13 - 45, who had highly diverse educational backgrounds, therefore making it appropriate to be used on any population of women. For this portion of the scale respondents circle the letter that indicates what they believe to be the correct answer.

3.2.3 Sources of Information

Items in this section related to the various sources of information and contraceptive knowledge. Ranging from influential to most influential source of information as well

as the most preferred source of information. Furthermore, this section consisted of items based on condom scale (Nicholas, 1994) developed to be used on university students. The instrument tests for an individual's attitudes and beliefs.

3.2.4 Attitudes Toward Contraceptives

Section C of the questionnaire dealt with the pregnant teenagers attitude toward contraceptives. The scale developed by Fisher (1983), was utilised, as it was guided by the assumption that attitudes toward specific behaviours (as opposed to attitudes towards objects, and values) will be most strongly predictive of these behaviours. Each item presented a belief or evaluations about using or acquiring contraception, and subjects responded to a 7-point Likert scale of probably to improbable to indicate the degree of their belief or evaluation.

The items were adapted from research (Jaccard & Davidson, 1972) which elicited salient beliefs about oral contraceptive use in a sample of undergraduate women, and made more suitable for the target population of this research, for pregnant teenagers.

3.2.5 <u>Beliefs about Contraceptives</u>

Section D of the instrument dealt with the pregnant teenagers beliefs about contraceptives. Items were arranged in a manner where there were five response choices per item of Strongly agree, Agree, Don't know, Disagree and Strongly disagree. This was then followed by the item which dealt with the sources of information.

3.2.6 <u>Intrafamilial Communication</u>

Section E dealt solely with the interfamilial communication about contraceptives. The instrument was developed and used on university students (Nicholas, 1993). Of the questionnaire surveyed, questionnaire items were selected from the following scales: Items on contraception were selected from Bauman & Wilson (1974); items on Intra familial communication about contraception from Thompson & Spanier (1978) but using separate items for mother and father instead of 'parents' as used by Thompson & Spanier (1978).

The purpose is to gain an understanding of how teenagers view their parents individually as sources of contraceptive information as well their perception of intrafamilial contraceptive communication. The respondents could select either one of the three responses per question, (True, False, Don't Know).

3.2.7 Contraceptive Practices

Section F of the instrument comprised of questions that pertained to the contraceptive practices of the pregnant teenager as well as possible reasons or events that could have lead to their pregnancy. Respondents had to either select true or false.

This item was followed by an item, pertaining to the sources of information that had the most influence on the contraceptive practices. Adaptations had to be made to the questionnaire so that it could be on a level that it would more understandable to the teenager.

3.3 Data Collection Procedure

The questionnaires were issued to those teenagers who consented to participate in the study at their respective homes. It took approximately one hour to complete. The researcher administered the questionnaire and read through each question aloud.

3.4 Treatment of Data

For the pilot study, the results of the research was reported in the form of frequency tables and percentages. For the main study the data was processed using the Statistical Package for Social Science. Descriptive statistics were analysed and tabulated, including,

frequencies, means, and standard deviations. The Pearson correlation (two sided test) was used to determine the extent to which the variables specified in this study are proportional to each other.

3.5 Limitations

The instruments were derived mainly from American research instruments which may not make the transition to South Africa that readily. Those items assessing Intra familial communication could have been more accurately assessed if interviews with parents could had been arranged and if individual or small group interviews were possible.

The broad scope of the study necessitated the exclusion of indepth investigation of areas of teenage pregnancy affecting the teenagers' lives to make it possible to focus on the problems the teenagers might experience. Given the range and demographics of the sample the results of this study cannot be generalised for teenagers in any other city or country and cannot apply to adults who find themselves in the same situation.

3.6 PILOT STUDY - Results

A sample of ten pregnant teenagers attending the clinic was randomly selected from the clinic register. The teenagers were approached to ascertain their willingness to participate

in the research and to obtain their consent. Their demographic data was obtained from their case files. The sample of ten pregnant teenagers had the following biographical characteristics.

3.6.1 Description of the Demographic Information of the Pregnant Teenagers (Pilot Study).

3.6.1.1 Age

Table 1 Age

AGE	SAMPLE No	PERCENTAGE
	10	100
14	1	10
15	2	20
16	1	10
17	3	30
18	1	10
19	2	20

The age range of the sample was between 14 and 19 years of age.

3.6.1.2 Language

All of the respondents were Afrikaans speaking, but this could be linked to the fact that the pilot study was administered in a predominant Afrikaans speaking community.

3.6.1.3 Educational Level

TABLE 2 Educational Level

	Sample No	Percentage
	10	100
No education	0	0
Some Primary School Education	1	10
Completed Primary School	1	10
Some High School Ed	7	70
Completed High School	1	10
Post - Matric	0	0

Most of the respondents (70%) of them had some high school education and only one (10%) was able to complete high school. The remaining 20% had primary school qualification.

3.6.1.4 Illegitimate Births in Family

Table 3 Illegitimate Births in Family

	Sample No.	Percentage
	10	100
Mother	0	0
Father	0	0
Brother	0	0
Sister	1	10
Cousin	1	10
Aunt	1	10
Uncle	0	0
Other	7	70

Only 30% of the respondents had highlighted that they had family members who had illegitimate births. A further 70% indicated that there were illegitimate births that took place but that it was not family members itself, but friends, or relatives that stayed in the same home and was considered as family members.

3.6.1.5 Parent's Relational Status

Table 4 Parent's Relational Status

	Sample No	Percentage
	10	100
Married	7	70
Single	0	0
Divorced	1	10
Cohabiting	1	10
Widowed	0	0
Other	1	10

The majority (70%) of the respondents parents were married, while only one was divorced (10%), another (10%) cohabitation, and the remaining respondent lived with an aunt and had no further knowledge of her parents.

3.6.1.6 Parents' Educational Level

Table 5 Mother's Educational Level

	Sample No	Percentage
	10	100
No Education	0	0
Some Primary School Education	2	20
Completed Primary School Education	1	10
Some High School Ed	4	40
Completed High School	0	0
Post-Matric	0	0
Don't Know	3	30

Table 6 Father's Educational Level

	Sample No	Percentage
	10	100
No Education	0	0
Some Primary School education	0	0
Completed Primary School Education	2	20
Some High School Education	2	20
Completed High School	0	0
Post-Matric	0	0
Don't Know	6	60

Many of the respondents indicated that they did not know their parent's educational level, 60% did not know their father's educational level and 30% did not know their mother's educational level. It appeared to be the case that most of the parents had a low educational level and nobody had any post-matric education.

3.6.1.7 <u>Parents' Occupational Level</u>

Table 7 Mother's Occupation

	Sample No	Percentage
	10	100
Unskilled	3	30
Semi-Skilled	0	0
Skilled	0	0
Sales	0	0
Administration	0	0
Clerical Work	0	0
Professional	0	0
Semi- professional	0	0
Unemployed	1	10
Other	6	60
Don't Know	0	0

Table 8 Father's Occupation

	Sample No	Percentage
	10	100
Unskilled	2	20
Semi-Skilled	1	10
Skilled	2	20
Sales	0	0
Administration	0	0
Clerical Work	0	0
Professional	0	0
Semi- professional	0	0
Unemployed	0	0
Other	1	10
Don't Know	4	40

The majority of the respondent's parents held unskilled labour jobs as 60% of the mother's charred. Almost half (40%) of the respondents did not know what their father's occupation was while only one was unemployed and the rest held either skilled or unskilled employment.

3.6.1.8 Sexual History

Table 9 First Pregnancy

	Sample No	Percentage
	10	100
Yes	9	90
No	1	10

The majority (90%) of the teenagers indicated that this was their first pregnancy with the exception of one (10%). This respondent had a previous pregnancy but did not carry to full term and therefore had no other children.

Table 10 Age At First Sexual Experience

	Sample No	Percentage
	10	100
Under 10	0	0
10 - 14	2	20
15 - 16	4	40
17 - 19	4	40

A large (80%) proportion of the pregnant teenager's first sexual experience took place at 15 years and above. The remaining 20% first sexual experience took place between the ages of 10 -14 years of age.

Table 11 Number of Partners

	Sample No.	Percentage
	10	100
1 to 5	10	100
6 to 10	0	0
11 to 15	0	0
16 to 20	0	0
21 to 45	0	0
46 to 99	0	0
100 or more	0	0

All the respondents indicated that they had only one partner that they had been sexually involved with.

Table 12 Frequency of Sex

	Sample No	Percentage
	10	100
Less than once a month	0	0
Once a month	0	0
Once a week	2	20
2 to 3 times a week	6	60
4+ a week	0	0
Don't know	2	20

The majority (60%) of the respondents indicated that they had sex at least 2 to 3 times a week, and 20% had sex at least once a week.

RESULTS

3.6.2 Contraceptive Knowledge

The result of the contraceptive knowledge instrument indicates that teenagers are at a high risk of becoming pregnant. Their overall knowledge of contraceptives was fairly poor.

From the eight items, testing the teenager's contraceptive knowledge, only item 23 and item 25 were answered correctly. For item 23, 40% of the respondents selected the correct answer and for item 25 , 80% of the respondents selected the correct answer. However, the overall contraceptive knowledge of the teenagers were very low.

All the respondents answered items 19 through to item 22 incorrectly. The only item that they scored in, were condom related questions.

Table 13 Contraceptive Knowledge

Respondents	Right N	Right %	Wrong N	Wrong %
1	0	0	8	100
2	0	0	8	100
3	0	0	8	100
4	1	12.5	7	77.2
5	1	12.5	7	77.2
6	1	12.5	7	77.2
7	0	0	8	100
8	0	0	8	100
9	0	0	8	100
10	2	25	6	75

3.6.3 Sources of Information

Table 14 Sources of Information

	Received Information From N	%	Most Influential Source N	%	Preferred Source of Information N	%
Same Sex Friend	1	10	2	20	0	0
Opposite Sex Friend	0	0	0	0	0	0
Father	0	0	0	0	1	10
Mother	3	30	2	20	8	80
Readings	0	0	0	0	0	0
Mass Media	0	0	0	0	0	0
School	4	40	4	40	0	0
Church	0	0	0	0	0	0
Clinic	0	0	0	0	0	0
Other	2	20	2	20	1	10

Most of the respondents claimed to have been informed by their schools (40%) and conveyed the impression that the discussion of sexual matter between parents and daughters was considered taboo. At the time of this research no formal sexuality education programmes at the schools were instituted, information was transferred in an informal way by peers and concerned teachers.

An interesting phenomenon of this study is the fact that the media (0%) had no influence as a source of information even though we place great emphasis on television as an influential educational instrument. The sources of information which most

influenced contraceptive practices were the school and other sources such as peers, and relatives.

3.6.4 Contraceptive Attitudes And Beliefs

The findings for contraceptive attitudes and beliefs were similar as 40% were positive about the use of contraceptives, 50% were negative and 10% were undecided. This has implications for programme development as intervention programmes need to include a component which deals with changing attitudes and beliefs about contraceptives.

When asked whether they felt the use of contraceptives were right or wrong many (70%), had a positive attitude by indicating that the "use of it was right". The majority (90%) of the respondents felt that contraceptives was unreliable and indicated that the use of contraceptives would make them feel guilty. Most (80%) of them agreed that "contraceptives takes away the worry of becoming pregnant".

The misconception of the harmful effects that contraceptives might have on unborn children was highlighted as many (80%) of the respondents indicated that "the use of contraceptives could lead to children being born with something wrong" (See Table below).

Table 15 Contraceptive Attitudes and Beliefs

	POSITIVE N	%	NEGATIVN	%
31. Use of contraceptives is good/bad.	3	30	7	70
32. Use of contraceptives is wrong/right	7	70	3	30
33. It is unnatural to use contraceptives	10	100	0	0
34. Leads to negative effects.	9	90	1	10
35. Leads to negative effects on moral values.	7	70	3	30
36. Use of contraceptive is immoral.	4	40	6	60
37. Determines family size.	8	80	2	20
38. Contraceptives are unreliable.	9	90	1	10
39. Makes me feel guilty.	5	50	5	50
40. Children born with something wrong.	2	20	8	80
41. Decreases sexual pleasure.	7	70	3	30
42. Takes away worry of pregnancy.	8	80	2	20
43. Makes sex less romantic.	9	90	1	10

3.6.5 Intrafamilial Communication

The results indicate that little intrafamilial communication about contraception took place within the family. Even though many of the respondents contradict themselves it is evident that there is not much communication about contraception taking place.

Of the respondents 50% indicated that they would not be able to count on their mothers to be understanding and 70% indicated that they could not depend on their fathers with a small percentage indicating that they did not know. Mothers provided information to 70% respondent whereas fathers provided 40% with

contraceptive information. Contradictory to this is the fact that 60% of the respondents indicated that they have not discussed contraceptives with their fathers and a further 80% have not discussed contraceptives with their mothers.

Table 16 Intrafamilial Communication

		TRUE		FALSE		DON'T KNOW	
		N	%	N	%	N	%
1.	If I had a problem concerning contraceptive matters, I could count on my mother to be understanding.	3	30	5	50	2	20
2.	If I had a problem concerning contraceptive matters, I could count on my father to be understanding.	0	0	7	70	0	0
3.	My father has never given me any information about contraceptives.	3	30	4	40	0	0
4.	My mother has never given me any information about contraceptives.	3	30	7	70	0	0
5.	If I were to use a contraceptive, I would prefer that my father not know about it.	5	50	5	50	0	0
6.	If I were to use a contraceptive, I would prefer that my mother not know about it.	3	30	4	40	0	0
7.	I have discussed my contraceptive use thoroughly with my father.	2	20	6	60	0	0
8.	I have discussed my contraceptive use thoroughly with my mother.	1	10	8	80	0	0
9.	If my father knew I used a contraceptive, his estimation of me would go down.	1	10	2	20	6	60

No.	Statement	n	%	n	%	n	%
10.	If my mother knew I used a contraceptive, her estimation of me would go down.	1	10	2	20	5	50
11.	My father has encouraged me to use contraceptives.	2	20	6	60	0	0
12.	My mother has encouraged me to use contraceptives.	1	10	6	60	2	20
13.	I think that my father's ideas and beliefs about contraceptive use are very similar to my own.	8	80	1	10	1	10
14.	I think that my mother's ideas and beliefs about contraceptive use are very similar to my own.	5	50	1	10	1	10

Of the respondents 60% indicated that their mother's and father's has never encouraged them to use contraceptives. Only 20% of the respondents consider their parents to hold a negative view toward their contraceptive use. Many (60% fathers and 50% mothers) did not know what their parents views would be. Few parents encourage their teenagers to use contraceptives. Of the respondents, 80% believed that their fathers ideas about contraceptive use are similar to their own and 50% of the mothers ideas are similar to the pregnant teenage daughters.

3.6.6 Contraceptive Practices

Many South African teenage pregnancy intervention programmes promote the use of contraceptives and several studies indicate that many teenagers are aware of contraceptives (Karim, 1991). Of concern, however, is the low level of contraceptive use despite these high levels of awareness. When taking into consideration the condom scale it presented the researcher with a

clear view of the respondents attitudes, beliefs and practices toward contraceptives (condoms specifically). Of the 10 respondents participating in the pilot study many were aware that the use of a condom can prevent venereal diseases (70%), AIDS (70%), pregnancy (90%) and therefore should be used when having sex with casual partners (80%). However, when asked whether they had ever practised contraception, all the respondents (100%) indicated that none of them had used any form of contraception.

Reasons for the poor use of contraceptives could be due to the fact that many of the teenagers held a serious misconception about contraceptive use. Most of the teenagers knew that contraceptives were available at the clinics yet, many of them indicated that they did not make use of these facilities. Cost and distance could be a cause of this and many mentioned that they felt embarrassed at going to family planning clinics.

Even though all the teenagers indicated that they had never used contraceptives before many of them gave reasons for not using condoms. Among them were that the use of a condom might decrease sexual pleasure and that many condoms would be needed for too many rounds of sex and that condoms were not always present when engaging in sex.

3.7 Pilot Study Recommendations

Even though questions were worded in a straightforward manner, the pilot study results indicated that the language of the questionnaire had to be simplified even further (Appendix 1), as many of the terms used in the original item were too difficult for the respondents to understand.

A further, problem encountered by the researcher when interviewing the teenagers was the lack of privacy. Due to the fact that it was school holidays there were many friends visiting. The respondents seemed to feel comfortable with someone else present. This could have been an inhibiting factor in the truthfulness of responses as teenagers might have felt ashamed to respond truthfully to some of the questions posed.

3.8 DEMOGRAPHIC CHARACTERISTICS - Main Study

This study surveyed 45 coloured unmarried pregnant teenagers who attended family planning clinics in Scottsdene, Bellville, Belhar and Kraaifontein. Demographic information was obtained by means of structured questionnaires which included aspects such as, age, language, educational level, number of illegitimate births in the family, parents' relational status, mother and father's educational level, their occupation, and the sexual history of pregnant teenagers.

3.8.1 Personal Demographic Background

Table 17 AGE

	N	%
14	14	31.1
15	9	20.0
16	8	17.8
17	3	6.7
18	1	2.2
19	10	22.2

Valid cases: 45 Missing cases: 0

The age distribution of respondents is alarming, in that the highest concentration of pregnancies is found among the youngest of the respondents with a mean age of 15.9. Almost a third of the pregnant teenagers were 14 yrs old and a fifth of the respondents were 15 years old.

These teenagers have the least resources, physically, mentally and emotionally, to deal with a pregnancy and raise a child. This result emphasizes the importance of providing sex education as early as possible. In a study undertaken by Nash(1990) at a Cape Town clinic, it was found that more than half the girls (56%) had their first sexual intercourse by age 15 years, placing them at higher risk of becoming pregnant.

Du Toit(1987) reported in his study that girls entering the reproductive age, lacked specificity with regard to sexual

matters. Many of the respondents could not make a clear connection between menstruation and fertility. He argues that because of this lack of knowledge, a large majority of teenage girls are unable to protect themselves from unwanted pregnancies, sexually transmitted diseases and AIDS. Likewise, the respondents of this study originated from the 14 (31.1%) and 15 (20%) year old age category.

While they may be physically ready to have children, the medical and social implications are serious. Both Clarke(1986) and Kalmuss(1986) contend, on the basis of available research that the younger the teenager with her first pregnancy, the greater the likelihood is that she will have repeat pregnancies in rapid succession.

Consequences of this may result in low standard of living for mother and her children. Blum and Goldhagen(1981, 338) explain that what is being seen among teenagers bearing children is what is described as the "syndrome failure: failure to fulfill the functions of adolescence, failure to remain in school, failure to limit family size to establish a vocation and become self supporting, and failure to have children who reach their potential in life".

Jacobson, Wilkinson and Pill(1995) supports this notion suggesting that often teenage mothers become embroiled in a "cycle of poverty". The children of these teen parents are

reared in a relatively impoverished environment, and are more likely to continue the cycle by becoming teenage parents themselves.

Table 18 Area

	N	%
Bellville	14	31.1
Belhar	11	24.4
Scottsdene	10	22.2
Kraaifontein	10	22.2

Valid Cases 45 Missing cases 0

After a pilot study was undertaken to refine the questionnaire, interviews took place. Teenagers were interviewed when attending for bookings at antenatal clinics and the informed consent of the teenager was sought prior to their participation in the study. Questionnaires were administered at specific areas in each of the above mentioned communities

Table 19 Language

	N	%
Afrikaans	43	95.6
English	2	4.4

Valid cases 45 Missing cases 0

The majority of the respondents were Afrikaans speaking (95.6%) and a very small percentage was English speaking. This could have been ascribed to the fact that the study was administered in predominantly Afrikaans speaking communities.

3.9 Conclusion

The main aim of this chapter is to provide the reader with a comprehensive view of the research methodology implemented. It outlined the parameters set for sample selection for ensuring discreteness. An outline of the pilot study and recommendations for the main study. The following chapter details the results and the discussion of the main study. The objective is to acquaint the reader with the problem that has been researched and to explain it's implications. It interprets the data for the reader and demonstrates exactly how the data resolves the problem that has been researched.

CHAPTER 4

RESULTS

OVERVIEW

This chapter explores the pregnant teenager's perception and experience of parents, church, media, school, peers and family planning clinics as sources of information with regard to contraceptive knowledge, attitudes, beliefs and practices.

The response rate would suggest that the views described are representative of teenagers in the specific communities, although this study, by nature of it's design, does not consider the views of the successful users of contraceptives. Further research is needed to determine the importance of these individual factors in preventing unplanned and unwanted pregnancies.

4.1 Research Questions

4.1.1 To what extent do the various sources of information, namely, parents, peers, church, media, schools and family planning clinics influence the pregnant teenager's knowledge, beliefs and attitudes pertaining to contraceptive practices?

4.1.2 Which methods and messages are employed by these sources of information?

4.2 Hypothesis

Parents, peers, church, media, schools and family planning clinics have an influence on a pregnant teenager's contraceptive knowledge, beliefs, attitudes and practices.

4.3 RESULTS

4.3.1 Level of Education

Table 20 Highest Educational Level

	N	%
No Education	0	0
Some Primary School Education	13	28.9
Completed Primary School	8	17.8
Some High School Education	21	46.7
Completed High School	2	4.4
Post-Matric	1	2.2

Valid cases 45

M = 3.3; SD = 0.15

When asked about the level of education achieved, 46,7% of respondents had been to primary school of 17.8% had completed. A total of 51.1% of the respondents had attended high school of which 4.4% had completed and one respondent had a post matric qualification.

4.3.2 Family History

Table 21 Number of Unmarried Children at Home

	N	%
1 child	14	31.1
2 children	12	26.6
3 children	10	22.2
4 children	6	13.3
5 children	2	4.4
6 children	0	0
7 children	1	2.2

Valid cases 45

$\underline{M}$ = 2.4 SD = 0.20

When asked about the number of unmarried children living at home, 31.1% of respondents indicated that there was one unmarried child living at home, 48.8% indicated that there were between 2 and 3 children living at home.

Table 22 Illegitimate Births in Family

	N	%
Mother	3	6.7
Father	2	4.4
Brother	1	2.2
Sister	4	8.9
Cousin	6	13.3
Aunt	8	17.8
Other	21	46.7

Valid cases 45

M = 6.0   SD = 0.33

All of the respondents indicated that one or other family member had illegitimate births. The highest percentage (46.7%)being in the "other" category as many of the respondent had extended members of the non-blood relatives living in the same house.

Table 23 Parents' Relational Status

	N	%
Married	25	55.6
Single	5	11.1
Divorced	6	13.3
Cohabiting	3	6.7
Widowed	5	11.1
Other	1	2.2

Valid cases 45

M = 2.13 SD = 0.22

More than half(55,6%) of the respondents parents were married, 11.1% single(never been married), 13.3% were divorced.

Table 24 Mothers' Educational Level

	N	%
No Education	1	2.2
Some Primary School Education	9	20
Completed Primary School	4	8.9
Some High School Education	16	35.6

Completed highschool	1	2.2
Post-Matric	2	4.4
Doesn't Know?	12	26.7

Valid cases 45

_M_ = 4.3 SD =0.28

Table 25 Fathers' Educational Level

	N	%
No Education	2	4.4
Some Primary School Education	1	2.2
Completed Primary School	4	8.9
Some High School Education	13	28.9
Completed highschool	5	11.1
Post-Matric	2	2.2
Don't Know	18	40

Valid cases 45

_M_ = 5.1 SD = 0.27

When asked about their parents' educational status, 40% of the respondents did not their father's educational status and 26.7% did not know their mother's educational status. In total 31.1% of mother's and 11.1% fathers were in possession of primary school education. The remainder was distributed into high school education and post matric.

Table 26 Mothers' Occupation

	N	%
Unskilled	10	22.2
Semiskilled	2	4.4
Sales	3	6.67
Professional	2	4.4
Unemployed	12	26.67
Other	8	17.78
Do not Know	8	17.78

Valid cases 45

$\underline{M}$ = 7.02 SD = 0.58

Table 27 Fathers' Occupation

	N	%
Unskilled	10	22.2
Semiskilled	3	6.7
Skilled Artisan	3	6.7
Sales	3	6.7
Professional	1	2.2
Unemployed	7	15.6
Other	3	6.7
Do not Know	11	24.4

Valid cases 45 Missing cases 0

Mean: 5.7 Standard Deviation: 0.66

A large percentage of mothers (26.67%) and fathers(15.6%) were unemployed, 22.2% of both mothers and fathers held unskilled employment.

4.3.3 SEXUAL HISTORY OF PREGNANT TEENAGER

Table 28 First Pregnancy

	N	%
Yes	44	97.8
No	1	2.2

Valid cases 45

M = 1.0 SD = 0.02

The majority (97.8%) of the respondents indicated that this had been their first pregnancy. One teenager had been pregnant once before.

Table 29 Age at First Sexual Experience

	N	%
10-14	18	40
15-16	17	37.8
17-19	10	22.2

Valid cases 45

M = 2.8 SD = 0.11

Many of the teenagers had sexual intercourse at an early age, 40% had intercourse between the ages of 10-14, 37.8% between 15-16 and 22.2% between the ages of 17-18 years of age.

Table 30 Number of Partners

	N	%
1 to 5	45	100

Valid cases 45

M = 1.0 SD = 0.02

All respondents indicated that they had between 1 and 5 partners that they had a relationship with and had engaged in intercourse.

Table 31 Number of Casual Partners

	N	%
No casual partners	28	62.2
1 to 3 casual partners	16	35.5
4 to 5 casual partners	1	2.2

Valid cases 45

M = 1.4 SD = 0.08

When asked about casual partners, 62.2% never had casual partners, 35.5% had between 1 t0 3 casual partners and 2.2% had between 4 to 5 casual partners.

Table 32 Frequency of Sex

	N	%
Less than once a month	4	8.9
Once a month	11	24.4
Once a week	17	37.8
2 to 3 times a week	11	24.4
4+ a week	1	2.2
Don't Know	1	2.2

Valid cases 45

M = 2.9 SD = 0.16

When asked how often they engaged in sexual intercourse, 37.8% indicated that they had sex at least once a week, 24.4% indicated between 2 to 3 times a week and 2.2% more than 4 times a week.

4.3.4 Contraceptive Knowledge

Table 33: Which of the following is a contraceptive method?

	N	%
Warm bath	3	6.67
Urine	3	6.67
Exercise	1	2.22
Rhythm method	3	6.67
Do not Know	35	77.78
Column Total Percentage	45	100.00

The majority (77.78%) of the respondents did not know which of the above mentioned was a form of contraception.

Table 34: After ejaculation, sperm cells live, on the average , approximately ________________ in the vagina

	N	%
Less than once a day	4	8.89
One to two days	3	6.67
Three to five days	4	8.89
One week to ten days	2	4.44
Do not Know	32	71.11
Column Total Percentage	45	100.00

A large percentage (71.1%) did not know how long a sperm cell could survive in the vagina

Table 35: Which of the following, when used as a douche, can kill sperm cells ?

	N	%
Coca-cola	0	0.00
Vinegar	2	4.44
Soapy water	6	13.33
All of the above	4	8.89
Do not Know	33	73.33
Column Total Percentage	45	100.00

Many of the respondents (73.33%) did not know which of the above mentioned could be used to destroy sperm cells.

Table 36: Which of the following contraceptives is sold in a chemist without a doctor's prescription ?

	N	%
I.U.D's	3	6.67
Latex Diaphragms	4	8.89
Vaginal Suppositories	0	0.00
Morning after pill	11	24.44
Do not Know	27	60.00
Column Total Percentage	45	100.00

When asked about "over the counter" contraceptives, 60% admitted that they did not know which could be purchased, 6.67% indicated I.U.D, 8.89% latex diaphragms and 24.44% indicated the morning after pill.

Table 37: In general a woman's "safe" period (when she cannot become pregnant even though she has sexual intercourse) is:

	N	%
The first 15 days after menstruation has stopped	10	22.22
The first 15 days before menstruation has started	2	4.44
The first 5 days before and after menstruation	13	28.89
The first 5 days before and after ovulation	0	0.00
Do not Know	20	44.44
Column Total Percentage	45	100.00

Many respondent indicated that they did not know when the safe period was, 22.22% selected 15 days after menstruation, 4,44% , 15 days before menstruation and 28.89% first 5 days before and after menstruation.

Table 38: The pill

	N	%
Prevents ovulation	2	4.44
Keeps cervical mucus very thin	0	0.00
changes the lining of the uterus to make implantation unlikely	0	0.00
both a and c	5	11.11
Do not Know	38	84.44
Column Total Percentage	45	100.00

A large percentage (84.44%) did not know what the purposes or the function of the pill was.

Table 39: The use of an condom when having sexual intercourse is recommended because

	N	%
If used right, it usually prevents gonorrhea	1	2.22
It can be bought in a chemist by both men and women	3	6.67
It does not have dangerous side-effects	13	28.89

All of the above	14	31.11
Do not Know	14	31.11
Column Total Percentage	45	100.00

When asked about the benefits of condoms, 31.11% did not know what the benefits were, while 68.89% knew what some of the benefits were.

Table 40: A woman can get pregnant

	N	%
A few minutes after sexual intercourse	19	42.22
A few hours after sexual intercourse	2	4.44
A few days after sexual intercourse	10	22.22
All of the above	8	17.78
Do not Know	6	13.33
Column Total Percentage	45	100.00

Only a few(13.33%) of the respondents admitted that they did not know when a women could become pregnant.

Table 41: From which of the following sources have you received information about contraceptives

	N	%
Same sex friend	5	11.11
Opposite sex friend	0	0.00
Father	0	0.00

Mother	10	22.22
Reading	1	2.22
Mass Media(T.V, radio)	0	0.00
School	15	33.33
Church	0	0.00
Clinic	12	26.67
Other.........	2	4.44
COLUMN TOTAL AND PERCENTAGE	45	100.00

School(33.33%), mothers(22.22%) and clinics(26.67%) ,rated the highest when asked about who they received contraceptive information from.

Table 42: Which of the following sources was the most influential source of information regarding contraceptives

	N	%
Same sex friend	15	33.33
Opposite sex friend	0	0.00
Father	0	0.00
Mother	6	13.33
Reading	1	2.22
Mass Media(T.V, radio)	3	6.37
School	9	20.00
Church	0	0.00
Clinic	9	20.00
Other.........	2	4.44
COLUMN TOTAL AND PERCENTAGE	45	100.00

When asked about the most influential source of information, same sex friends were regarded as most influential(33.33%), mothers(13.33%) and school and the clinic (20%).

Table 43: Which of the following sources would you most prefer to receive information regarding contraceptives ?

	N	%
Same sex friend	4	8.89
Opposite sex friend	0	0.00
Father	1	2.22
Mother	24	53.33
Reading	0	0.00
Mass Media(T.V, radio)	0	0.00
School	0	0.00
Church	0	0.00
Clinic	15	33.33
Other.........	1	2.22
COLUMN TOTAL AND PERCENTAGE	45	100.00

When asked about who they would prefer to receive information from, more than half (53.33%) of the respondents selected their mothers and 33.3% clinic.

4.3.5 Contraceptive Knowledge

Table 44: Please indicate whether you agree or disagree with the following statements about condoms (FL's, rubbers, kondoom).

	AGREE N %	DISAGREE N %	DON'T KNOW N %	TOTAL N %
1. Condoms can prevent veneral disease	14 31.11	11 24.44	20 44.44	45 100
2. Condoms makes sex less enjoyable	6 13.33	9 20.00	30 66.67	45 100
3. Condoms should be used with casual partners	23 51.11	4 8.89	18 40.00	45 100
4. Condoms should be used with regular partners	15 33.33	15 33.33	15 33.33	45 100
5. Condoms makes my partner think that I don't trust him	12 26.67	9 20.00	24 53.33	45 100
6. Condoms makes me feel embarrassed	12 26.67	18 40.00	15 33.33	45 100
7. Condom use is against my religion	12 26.67	19 42.22	14 31.11	45 100
8. Condoms are too expensive	2 4.44	32 71.11	11 24.44	45 100
9. Condoms are offensive to my sexual partner	6 13.33	15 33.33	24 53.33	45 100
10. Condoms cause conflict with my cultural values	4 8.89	12 26.67	29 64.44	45 100
11. Condoms can prevent AIDS	20 44.44	15 33.33	10 22.22	45 100

12.	Condoms are enjoyable and pleasurable to use	9 20.00	8 17.78	28 62.22	45 100
13.	Condoms can slip off and cause injury to the vagina	27 60.00	5 11.11	13 28.89	45 100
14.	Condoms are not easily available	8 17.78	25 55.56	12 26.67	45 100
15.	Too many condoms are needed for many rounds of sex	25 55.56	8 17.78	12 26.67	45 100
16.	Real men don't use condoms	16 35.56	13 28.89	16 35.56	45 100
17.	Condom use will prevent pregnancy	27 60.00	9 20.00	9 20.00	45 100
18.	Condoms that break are a common occurrence	21 46.67	13 28.89	11 24.44	45 100
19.	Buying a condom is an unpleasant experience	22 48.89	9 20.00	14 31.11	45 100

A large percentage of the respondents are aware of the uses of condoms, "prevents veneral disease"(31.1%), condoms can prevent AIDS (44.44%), condoms will prevent pregnancy (60%).

Table 45: Indicate YES or NO to the following questions.

	YES N %	NO N %	TOTAL N %
20. Was condom use taught at school?	33 73.33	12 26.67	45 100
21. Do you use a condom every time you have sexual intercourse?	8 17.78	37 82.22	45 100
22. You have not had sexual intercourse?	20 44.44	25 56.56	45 100
23. Have you ever used a condom?	8 17.78	37 82.77	45 100
24. Have you ever been treated for a sexually transmitted disease?	6 13.33	39 86.67	45 100

Even though most respondents (73.33%) indicated that condom use was taught at schools, a large percentage (82.22%) did not make use of condoms when engaging in sexual intercourse. When asked if they had ever used a condom, 82.77% reported that they had never used a condom.

Table 46 Mean Contraceptive Knowledge and Standard Deviations

	Mean	Standard Deviation
Contraceptive Knowledge (General)	1.333	1.206
Contraceptive Knowledge (Condom)	39.356	2.217

N=45

The mean score for the general contraceptive knowledge was significantly lower than that of the contraceptive

knowledge(condoms). The results indicate that respondents had less general knowledge about contraceptives and were more knowledgeable about condoms as a contraceptive.

Table 47 Correlation Coefficient of Contraceptive Knowledge, Attitudes, Beliefs and Practices

Variables	Coefficient Contraceptive Knowledge	Coefficient General Knowledge
Contraceptive Knowledge	1.000	.1077
General Knowledge	.1077	1.000
Attitudes	.1347	.0865
Beliefs	.0040	.3217
Practices	-.1328	-.0164
Communication	-.0728	-.2886

$p > 0.05$
df 43
N 45

Table 47 shows the correlation coefficients for Knowledge and the variables of Attitudes, Beliefs, Practices and Communication indicating that the above mentioned variables was not significantly correlated to the pregnant teenagers contraceptive knowledge.

4.4 RESEARCH QUESTION

To what extent do the sources of information namely; parents, peers, church, media, schools and family planning clinics influence the pregnant teenagers' contraceptive knowledge?

4.4.1 Sources of Information

Table 48 Sources of Information

	Received Information form N	%	Most Influential Source N	%	Preferred Source of Information N	%
Same Sex Friend	5	11.1	15	33.3	4	8.9
Opposite Sex Friend	0	0	0	0	0	0
Father	0	0	0	0	1	2.2
Mother	10	2.2	6	13.3	24	53.3
Readings	1	2.2	1	2.2	0	0
Mass Media	0	0	3	6.7	0	0
School	15	33.3	9	20.0	0	0
Church	0	0	0	0	0	0
Clinics	12	26.7	9	20.0	15	33.3
Other	2	4.4	2	4.4	1	2.2

This section is concerned with the various sources of information and which of these sources the teenager received information form, who was most influential as well as which is the preferred source of information.

4.5 Attitudes Towards Contraceptives

Table 49 Mean Attitudes and Standard Deviations

	Mean	Standard Deviation
Attitudes Towards Contraceptive	57.911	8.578

N=45

The mean score for attitudes indicate that the respondents held a positive attitude towards contraceptives. Results indicate that 75.5% of the respondents indicated that it was good to use contraceptives. When responding to the question on the reliability of contraceptive, many of the respondents(48.89%) indicated that they felt that it was unreliable. However, a large percentage (68.89%) reflected that they felt that the use of contraceptives did eliminate the worry of pregnancy.

Table 50 __Attitudes and Sources of Information__

Count Row Pct Column Pct Total Pct	LOW 1.00	HIGH 2.00	ROW TOTAL
Same sex friend	6 75.0 28.6 14.3	2 25.0 9.5 4.8	8 19.0
Opposite sex friend	4 44.4 19.0 9.5	5 55.6 23.8 11.9	9 21.4
Father	1 50.0 4.8 2.4	1 50.0 4.8 2.4	2 4.8
Mother	6 46.2 28.6 14.3	7 53.8 33.3 16.7	13 31.0
Reading	1 50.0 4.8 2.4	1 50.0 4.8 2.4	2 4.8
School	1 50.0 4.8 2.4	1 50.0 4.8 2.4	2 4.8
Clinic	1 33.3 4.8 2.4	2 66.7 9.5 4.8	3 7.1
Other	1 33.3 4.8 2.4	2 66.7 9.5 4.8	3 7.1
Column Total	21 50.0	21 50.0	42 100.0

Number of missing observations:3

Respondents reported that 4.8% of `same sex friends', 11% of opposite sex friend, 2.4% of fathers, 16.7% had the most impact on their attitudes towards contraceptives. Reading (2.4%), school(2.4%) and the clinic (2.4%) showed no significant influence on attitudes.

Table 51: Correlation Coefficient of Attitudes with Contraceptive Knowledge, Beliefs and Practices

Variables	Coefficient
Contraceptive Knowledge	.1347
Knowledge	.0865
Beliefs	.1432
Practices	-.3300
Communication	-.2886

$p > 0.05$
df 43
N=45

The findings display the relationship between contraceptive attitudes and were not significantly correlated. Indicating that even though the teenagers had a low knowledge of contraceptives, the attitude that they held was positive.

4.6 Beliefs About Contraceptives

Table 52: Mean Contraceptive Beliefs and Standard Deviations

	Mean	Standard Deviation.
Beliefs	16.289	3.167

Respondents were asked to indicate their opinions about whether contraceptives are important, immoral, leads to negative side effects, makes them feel guilty, eliminates the "worry" of pregnancy. The mean score indicates that many of the respondents held positive beliefs toward the use of contraceptives.

Table 53: Beliefs and Sources of Information

Count Row Pct Column Pct Total Pct	LOW 1.00	HIGH 2.00	ROW TOTAL
Same sex friend	7 77.8 31.8 19.4	2 22.2 14.3 5.6	9 25.0
Opposite sex friend	3 75.0 13.6 8.3	1 25.0 7.1 2.8	4 11.1
Father	2 100.0 9.1 5.6	-	2 5.6
Mother	5 62.5 22.7 13.9	3 37.5 21.4 8.3	8 22.2
Reading	-	2 100.0 14.3 5.6	2 5.6
School	2 50.0 9.5 5.6	2 50.0 14.3 5.6	4 11.1
Church	-	1 100.0 7.1 2.8	1 2.8
Clinic	1 100.0 4.5 2.8	-	1 2.8
Other	2 40.0 9.1 5.6	3 60.0 21.4 8.3	5 13.9
Column Total	22 61.1	14 38.9	36 100.0

Number of Missing Observations:9

When cross tabulated 19.4% of `same sex', 8.3% of `opposite sex', friend, 5.6% of `fathers' 13.9% of `mothers' 5.6% of schools and 2.8% of clinics, had a low impact on the contraceptive beliefs of the pregnant teenager. A small percentage had a positive impact on their contraceptive beliefs, `same sex friend' (5.6%), `opposite sex friend' 2.8%), `mothers'(8.3%), `readings'(5.6%), `school'(5.6%), `church'(2.8%), `other'(8.3%).

Table 54: Correlation Coefficient of Beliefs with Attitudes, Contraceptive Knowledge and Practices

Variables	Coefficient
Contraceptive Knowledge	.0040
Knowledge	.3217
Attitudes	.1432
Practices	.1918
Communication	-.0851

$p > 0.05$
df43
N=45

When correlated, the variables of contraceptive knowledge, knowledge, attitudes, practices and communication had no significant relationship with beliefs.

4.7 Contraceptive Practices

Table 55: Cross tabulation of Practices

Count Row Pct Column Pct Total Pct	LOW 1.00	HIGH 2.00	ROW TOTAL
Same sex friend		1 100.0 5.0 2.9	1 2.9
Opposite sex friend	4 57.1 26.7 11.4	3 42.9 15.0 8.6	7 20.0
Father	2 50.0 13.3 5.7	2 50.0 10.0 5.7	4 11.4
Mother	2 100.0 13.3 5.7		2 5.7
School	2 100.0 13.3 5.7		2 5.7
Church		1 100.0 5.0 2.9	1 2.9
Clinic	3 20.0 20.0 8.6	12 80.0 60.0 34.3	15 42.9
Other	2 66.7 13.3 5.7	1 33.3 5.0 2.9	3 8.6
Column Total	15 42.9	20 57.1	35 100.0

Number of Missing Observations:10

When cross tabulated, `same sex friend' (2.9%), `opposite sex friend' (8.6%), `fathers' (5.7%), `church' (2.9%) and `clinic' (34.3%) had a positive influence on the teenagers contraceptive practices. `Opposite sex friend' (11.4%), `fathers' (5.7%), `mothers' (5.7%), `school' (5.7%), `clinic' (8.6%) had a low impact on their contraceptive practices.

Table 56 Correlation Coefficient of Practices with Beliefs, Attitudes, and Contraceptive Knowledge

Variables	Coefficient
Contraceptive Knowledge	-.1328
Knowledge	.0164
Attitudes	-.3300
Beliefs	.1918
Communication	-.0421

$p > 0.05$
df43
N=45

Results indicate that statistically the variables of contraceptive knowledge, general knowledge, attitudes, beliefs and communication do not significantly influence contraceptive practices.

4.8 Intra familial Communication with regard to Contraceptives

Table 57: Correlation Coefficient of Communication with Practices , Beliefs, Attitudes, and Contraceptive Knowledge

Variable	Coefficient
Contraceptive Knowledge	-.0728
Knowledge	-.2008
Attitudes	-.2886
Beliefs	-.0851
Practices	-.0421

$p > 0.05$
df43
N=45

When correlated with the variables of Contraceptive Knowledge, Attitudes, Beliefs and Practice, not significant relationship could be established.

4.9 Conclusion

This chapter provided a description of the results in tabular form. The following chapter will discuss the results in further detail as well as make recommendations for further study.

CHAPTER 5

DISCUSSIONS AND RECOMMENDATIONS

OVERVIEW

Teenage pregnancy has been identified as a problem in South Africa that affects everyone. It is one that will increasingly challenge other countries both rich and poor. Even though cultural circumstances differ from country to country, pursuing adequate policies and drawing up strategies in good time can significantly lessen the magnitude of the problem. This chapter will be discussing implications and recommendations for teenage pregnancy by taking into account all the factors in this multifaceted problem. By acting with vision and compassion, we can have hopes for a less troubled future.

5.1 Highest Educational Level

One of the most salient social consequences of teenage pregnancy is school drop out or interrupted education. The mean score for highest educational level was 3.3 with a standard deviation of 0.15. Indicating that a large percentage (46.7%) of the respondents were in possession of at least some high school education. Twenty eight point nine percent had some primary school education. Only two (4.4%) of the respondents had completed high school and one(2.22%) had Post-matric qualification.

Many of the respondents (93.4%) in this study did not complete their high school education. As found in a study conducted by Boult and Cunningham (1991) that teenagers who became pregnant were less likely to return to school as there was a lack of provisions at schools to facilitate resumption of the teenagers education.

These findings are corroborated by other research findings in Africa (Oppong, 1987; Clarke, 1986 & Height, 1987). In a study undertaken by Preston-Whyte(1991) she found that many pregnant teenagers in her sample left school not only because they were pregnant but cited various reasons, among them being, the absence of decent job prospects rendering continued education more or less pointless. Pregnancy was not high on the list of reasons.

5.2 Family History

It is evident in this study that many of the respondents lived in impoverished conditions with 31% of the mothers and 26.7% of the fathers having had illegitimate children ($M = 2.4$, SD 0.20) twenty-two point two percent of the respondent's brothers had illegitimate children and 13.3% of their sisters also had illegitimate children.

Gordon(1996) found that strong correlations have been demonstrated for characteristics of families of female adolescents who become pregnant, and/or initiate sexual

intercourse at an early age. Such correlations include a larger family, other relatives with children, a lower socioeconomic status, a lower level of maternal education, a single parent head, a mother who was herself a teenage mother.

5.3 Parent's relational Status

Fifty point six percent of the respondents' parents were married, (M = 2.13, SD 0.22) while only five came from single parent homes. Thirteen point three percent was divorced and 6.7% was cohabiting. Even though a large (55.6%) portion of the respondents stemmed from homes where the parents were married, many of them had illegitimate children. Eleven point one percent of the respondents came from single-parent backgrounds and 13.3% came from divorced backgrounds.

These findings is supported by various researchers (Miller and Bingham, 1989; Newcomer and Udry, 1987; and Camburn,1987) who found that daughters of divorced mothers were more likely to seek male attention and physical proximity to male peers than daughters of widows or daughters of intact marriages. Concluding that mothers and daughters who had experienced divorce were more sexually permissive in attitudes and behaviours than their counterparts in intact families.

Preston-Whyte(1991) found in her study of household composition, that the majority of households which are female

headed, is not only the result of domestic units that develop around single women with children, who do not marry, but also due to widowhood, divorce and separation.

5.4 Parents' Educational Level

Many of the respondents indicated that they did not know their parent's educational level, as 26.7% did not know their mother's educational level and 40% did not know their father's educational level. It appeared to be the case that most of the parents had a low educational level, with 35.5% of mothers possessed (M 4.35, SD 0.28) some high school education and 28.8% of fathers (M 5.1, SD 0.27). A small percentage for both mothers (4.44%) and fathers(4.44%) had post-matric qualifications.

In a study conducted by De Kock (1980) he reported that there was a positive correlation between low educational level and the incidence of illegitimacy.

5.5 Parents' Occupational Status

Twenty-two percent of the respondents mother and fathers held unskilled jobs. The respondents reported a high incidence of unemployment for both parents, 26.67% mothers and 15.6% fathers. A large percentage of the respondents `did not know' their parents' occupational status, 40% mothers and 24.4% fathers.

These findings are strongly supported by Burman and Preston-Whyte (1992) who reported that poverty, poor and overcrowded housing, lack of recreational facilities and high unemployment are the most striking and consequently reported concomitants of teenage pregnancy in the Cape.

5.6 SEXUAL HISTORY OF PREGNANT TEENAGER

5.6.1 First Pregnancy

The mean score 1.0 and standard deviation 0.02 for first pregnancy indicate that this was their first pregnancy(97.8%) with the exception of one (2.2%). This respondent had a previous pregnancy but did not carry to full term and therefore had no other children.

These findings are supported by research conducted by Clarke, 1986; Height, 1986, who showed that girls are vulnerable to repeat pregnancies, if their fist pregnancy occurred before the age of eighteen. Gillmore, Spencer and White's (1997) research corroborated these findings, as they reported that the younger the teenager at first pregnancy, the greater the risk of rapidly repeating pregnancies.

5.6.2 Age at first Sexual Experience

It is evident that a large (40%) proportion of the pregnant teenager's first sexual experience took place between the ages of 10-14 years with a mean score of 2.8 and standard deviation of

0.11. Thirty-seven point eight had their first sexual experience between the ages of 15-16 and the remaining 22.2% first sexual experience took place between the ages of 17 -19 years of age.

Buga and Amoko(1996) study supported these findings, in their study they found, that the age of sexually experienced girls at first coitus correlated positively with the age of menarche and the age at the first date, suggesting that sexual maturation and onset of dating were possible risk factors for initiation of sexual activity(Miller and Bingham, 1990).

5.6.3 Number of Partners

All the respondents indicated that they had only one ($\underline{M}$ = 1.0, SD 0.02) partner that they had been sexually involved with at the time they became pregnant, indicating that all of them were in a relationship when they became pregnant.

Findings of a number of Cape studies supports this research, that children born to teenage mothers were not the result of fleeting or casual sexual encounter (Preston-Whyte, 1991). Further, Vonregenmortel (1975) noted that although the most of mothers in his research were unmarried their pregnancies were, in most of cases (75%) not the result of promiscuous or casual relationships, but rather the result of a stable and enduring relationship.

5.6.4 Number of Casual Partners and Frequency of Sex

A large percentage (62.2%) of the respondents did not engage in casual sexual intercourse (M = 1.4, SD = 0.08). The remainder indicated that they had more than one casual partner. These findings are strongly by similar findings of Preston-Whyte(1991) in her study.

While popular opinion would suggest that teenagers usually have many sexual partners, it was found in her study that 52% of the respondents who were sexually active stated that they had had only one sexual partner. The majority (37.8%) of the respondents indicated that they had sex at least once a week whereas 24.4% (M = 2.9, SD = 0.16) had engaged in sex at least two to three times a week. Other studies of students report similar findings, where it was reported that 72% of the respondents had a sexual partner(Strebel and Perkel, 1991).

5.7 Impact of Parents, Peers, Church, Media , Schools and Family Planning Clinics on Contraceptive Knowledge

On average the majority of the respondents scored low when asked about general contraceptive knowledge (M = 1.33, SD = 1.2). The majority (84.8%)of the respondents answered the section incorrectly. Gordon (1996) found upon the review of research literature that many teenagers lack accurate knowledge of reproductive health, and in one study, less than half of the teenagers could identify the time of the month with the greatest

risk for conception. In a study conducted by Singh(1991) he found that although contraceptive knowledge of teenagers was high, the uses of contraceptives were low. These contrasting findings are an indication that contraceptive knowledge is not the only skill needed to prevent teenage pregnancy.

A South African study (Boult and Cunningham, 1991) found that 85% of teenage girls were not using contraceptives even though 66% had some prior knowledge. The authors contend that teenagers are handicapped by their youth, low level of education and general lack of knowledge and understanding the relationship between the onset of menstruation, sexual activity, conception and contraception (Visser and Le Roux, 1996; Boult and Cunningham, 1991; Witte,1997).

Contraceptive knowledge is influenced by various sources of information. It is found that the same sex friend proved to be quite influential, as 33.3% of the respondents indicated that they had received information from them. However, only 8.9% selected same sex friends as the preferred source of information. In a study undertaken by Gebhard (1977) he found that the same sex friend was still the single most important sources of contraceptive information. There is an increasing amount of evidence that friends play a central role in the onset of sexual activity.

Although mothers were not cited as the most influential source, they were considered by the majority (54%) of the respondents as the preferred source of information. Several studies identifies mothers as the primary source of sex information (Elias,1978; Fox & Inazu, 1978; Jebhard, 1977; Spanier, 1976; Warren & St. Pierre, 1973).

Churches and fathers did not provide the teenagers with any information, but one of the respondents did indicate that she would prefer her father as a source of information. Twenty-six point seven percent of the respondents indicated that they received information from clinics, while 20% said that clinics was most influential with the remaining 33.3% preferring the clinic as a source of information.

5.8 Impact of Parents, Peers, Church, Media , Schools and Family Planning Clinics on Attitudes to Contraceptives

Results indicated that respondents held a positive attitude toward contraceptives with a mean score of 57.9 and standard deviation of 8.5. Seventy five point five percent of the respondents indicated that it was good to use contraceptives. When responding to the question on the reliability of contraceptive, many of the respondents(48.89%) indicated that they felt that it was unreliable. Preston-Whyte & Allen (1992) found that because of the unpleasant side-effects and the perceived dangers associated with contraceptives, the attitude

toward contraceptive use seems to be one of reluctance among teenagers.

However, a large percentage (68.89%) reflected that they felt that the use of contraceptives did eliminate the worry of pregnancy. Strebel and Perkel (1991) found in a study the sample in their study was aware of the importance of practising safer sex, but very few implemented this into their behaviours.

Respondents indicated that of the 31% of `Mothers' that influenced their contraceptive attitudes, 14.3% had a low and 16.7% a high impact. `Opposite sex friend' 9.5% had a low impact and 11.9% a high impact and `Same sex friend' 14.3% had a low impact and 4.8% had little influence on their attitudes toward contraception. Father, 4.8%, Reading, 4.8%, School, 4.8%, Clinic, 7.1% had the least influence on the contraceptive attitudes of the pregnant teenagers.

5.9 Impact of Parents, Peers, Church, Media , Schools and Family Planning Clinics on Beliefs about Contraceptives

The majority scored quite high when asked about contraceptive beliefs with mean score of 16.2 and a standard deviation of 3.1, indicating that the respondents held positive beliefs about contraceptives. Many respondents (42.22%) indicated that they felt that contraceptives did take away the

worry of falling pregnant. When asked whether they thought contraception was important, 48.89% strongly agreed with this statement, 26.67% did not know and 11.11% disagreed with this statement.

Twenty-two point two percent agreed with the statement that the use of contraceptives was immoral and 24.44% disagreed. Fisher (1979) found in a study that, for contraceptive precautions to be made, there must first be some prior awareness or self-admission on the part of the individual that she may soon have sexual intercourse, and in instances leaving the teenager with sex guilt. Tauer's(1983) reported in a study that if beliefs, values and behaviours are not congruent, then conflict results, accompanied by a sense uncomfortableness. Many believe they cannot get pregnant the first time they have sex.

When beliefs were cross tabulated with the various sources of information there was more or less an even distribution of responses. A small percentage of same sex friends (5.6%), opposite sex friends (2.8%), mothers(8.3%), reading(5.6%), school(5.6%), church(2.8%)and other(8.3%) was reported to have a positive influence on the pregnant teenager's contraceptive beliefs. A larger percentage of the sources of information had very little impact on the teenager's contraceptive beliefs, same sex friend, 19.4%, opposite sex friend, 8.3%, fathers, 5.6%, mothers, 13.9% school, 5.6% and clinic, 2.8%.

5.10 Impact of Parents, Peers, Church, Media , Schools and Family Planning Clinics on Contraceptive Practices

When assessing the frequency distribution tables, 66.67% of the respondents have used contraceptives, and 73.33% did indicate that they had intentions of having sex. Fifty-five percent of the respondents indicated that they did not want to seem to prepared to have sex by having some form of contraceptive on them. These findings are supported by a study conducted by Nash (1990) who reported that teenagers admitted that their pregnancies were unplanned, sexual information was insufficient, and that contraceptive options were ignored and that they had not realised the implications of intercourse and pregnancy either for themselves or for their infants.

Contraceptive practices was positively influenced by clinics (34.4%). The three sources of information, namely `fathers' (5.7%), `mothers' (5.7%) and `school' (5.7%) had little influence of the teenagers contraceptive practices. `Mothers' seemed to not have had any positive influence on the contraceptive practices of the pregnant teenagers. The media in each case was reported to have had no influence.

5.11 Intra familial Communication with regard to Contraceptives

When asked who they could depend on when experiencing contraceptive problems, 60% indicated they felt that they could

depend on their mothers and 13.33% on their fathers, while 20% indicated they could not depend on their mothers and 46.67% could. Respondents were asked if the parents provided them with any contraceptive information, 42.2% of the fathers and 35,56% of mothers had not provided them with any information.

When asked if they felt that their parents' opinion of them would be lowered if they knew that they used contraceptives, 51.1% of the respondents felt that it would not change for their mothers, 22.22% for their fathers and 42.22% did not know for their mothers and 57.78 did not know for their fathers.

Christopher, Johnson and Roosa (1993) have examined the relationship between parent-child communication and adolescent sexual attitudes and behaviour, finding that poor family communication was more typical of sexually experienced teens than others. While common opinion would suggest that parents have little influence over their teenage children, research indicates that parents continue to be important consultants in complicated and important decisions with long-term consequences (Fisher,1987).

5.12 RECOMMENDATIONS

Based on the findings the researcher would like to make recommendations for the various sources of information as well as recommendations for further study. The general thrust of programmes should be to impart and improve knowledge of all role

players involved in educating the teenager. Programmes need to be multi-levelled to provide children and teenagers with the information they need and deserve to make informed choices to protect themselves, and render them less vulnerable.

5.12.1 Recommendations for Parents as a Source of Information:

I. Parents need to access and secure the knowledge and the resources to raise sexually informed and responsible children.

II. Parents need to empower themselves as sexuality educators of their children.

III. Parents need to be encouraged to clarify their own values specifically relating to human sexuality.

IV. A communication component has to be included.

V. Parents' need to enhance their skills in parent-child communication and strive to keep the channel of communication open, especially during the difficult period of adolescence.

5.12.2 Recommendations for School as a Source of Information:

I. Human sexuality education in schools needs to be started early; between the time that teenagers make the transition form junior school to senior school.

II. Discussions of sex should be initiated at earlier ages, as the onset of sex begins sooner than before.

III. Teenagers require specific and appropriate information on sexuality and contraception which should be provided in schools.

IV. Programmes should thus be implemented at school level and include:

a. information on sexuality and information on physiological, developmental, emotional and cognitive factors that impact sexual behaviour.

b. must be incorporated as a regular part of the curriculum and offered on a yearly basis, instead of isolated experiences.

c. should reflect the developmental changes that occur in adolescence since information take on a new meaning as they grow older.

d. programmes should include a life skills component such as decision making skills, problem solving skills, peer pressure resistance training, behaviour skills and cognitive restructuring.

e. Schools need to network with the surrounding communities, i.e., churches, members of the community, parents.

f. Parent education courses need to be offered to empower parents to be active in educating their children with regard to sexuality.

5.12.3 Recommendations to Peers as a Source of Information:

I. Volunteer services and linked classroom activities may thus offer young people a relatively non-threatening opportunity to see themselves as competent individuals who can be both autonomous and successful in relating to peer pressure in the adolescent stage of their lives.

II. Teenagers who previously experienced pregnancy themselves need to be involved in programmes, as powerful motivational speakers

III. The importance of peers in the initiation of sexual behaviour can be discussed in an open manner.

IV. A feature of Peer Facilitation is that it should not focus on problem behaviours it seeks to prevent but should enhance participants competence in decision making, in interacting with peers and adults and in recognising and handling their own emotions.

V. A combination of volunteer community service opportunities with classroom discussion about life options might reduce the rate of teenage pregnancy.

VI. Programmes which deal with sexuality and teenage pregnancy and peer pressure has to be included

5.12.4 Recommendations to the Mass Media as a Source of Information:

I. The mass media in all forms is a useful tool and should be fully utilised to educate teenagers.

II. The use of these different forms of media allow very young as well as teenaged children to be reached

III. The media should work in conjunction with schools, communities and other organisations that have a vested interest in societies well-being.

IV. Emphasis should be placed on life options available as one of the most powerful contraceptive is activated when young people believe that they are valuable individuals who can and should make plans for a brighter future.

5.12.5 Recommendation to Family Planning Clinic as a Source of Information:

I. Consideration should be given to the development of teenage or adolescent school based clinics.

II. The staff could consist of a multi-disciplinary team, made up of parents, teachers, peers, nursing staff and members of the community to ensure comprehensive care for the teenager.

III. These clinics are not only helpful in providing medical services to teenagers who would not otherwise see a doctor, but they are instrumental in reducing teenage pregnancy.

IV. Nursing staff should be trained to promote respect for sexually active teens who are using contraceptives responsibly

V. Delivery of health care to teenagers should be flexible

5.12.6 Recommendations to the Church as a Source of Information:

I. Churches need to clarify their values relating to sexuality

II. Teenagers within the context of the church should be made to feel comfortable when seeking guidance

relating to matters of sexuality and not made to feel guilty.

III. Churches should be involved in programmes that promote sexually responsible behaviours by providing contraceptive knowledge building programmes.

5.13 <u>Recommendation for further research</u>:

I. Indepth study with regard to the nature of sexual partnerships i.e. length and strength of relationships need to be investigated further. Partners need to be interviewed to gain a complete perspective.

II. Research into the sexual history of the pregnant teenagers to establish, time and reason for sexual activity and initiation.

III. The impact of teenage pregnancy on the family as a unit needs to be researched to gain further insight into coping mechanisms and strategies

IV. A longitudinal study from the time of conception to later years, of how the teenager dealt with pregnancy and the outcomes of it.

V. Further research is required into the role of the church, and various sources of information in this study.

5.14 Conclusion

Teenage pregnancy has complex economic and social roots. It cannot be seen simply as a form of deviant behaviour on the part of teenagers. Teenage mother's right to have a fulfilled life should not be hampered by pregnancy, if there are more support programmes.

The social and economic cost of unplanned pregnancies for South Africa are huge. No coherent national plans are in place to manage the problem. In the late 1990's the recommendations presented in this study form the basis of intervention that should have been implemented long ago.

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Appendix 1

Research Group Questionnaire/Interview

The purpose of this interview is to obtain a comprehensive view of your background and to ascertain your perception about matters that are important to you concerning sexuality. The information obtained will be used to facilitate a better service to other teenagers.

It is understandable that you might be concerned about what happens to this information because much of it is highly personal. No outsider is permitted to see your responses. The interviews will remain anonymous so that confidentiality is ensured. Please answer each question to the best of your ability. Thank you for your participating in this research.

Biographical Information

Directions:
Circle the number which best describes your response.

DEMOGRAPHIC BACKGROUND

1. Age

2. Which area do you live in ?

3. Home Language

1.	Afrikaans	3.	African Language
2.	English	4.	Other

4. Highest Level of Education

1. No Education
2. Some Primary School Education
3. Completed Primary School
4. Some High School Education
5. Completed High School
6. Post-Matric

5. Number of unmarried children at home at present (including respondent).

6. Whom of the following family members were unmarried and had children ?

1. Mother
2. Father
3. Brother
4. Sister
5. Cousin
6. Aunt
7. Uncle
8. Other (please specify)........................

7. Parents Relational Status

1. Married
2. Cohabitating
3. Single
4. Widowed
5. Divorced
6. Other

8. Mother's level of education ?

1. No Education
2. Some Primary School Education
3. Completed Primary School
4. Some High School Education
5. Completed High School
6. Post-Matric

9. Father's level of education ?

1. No Education
2. Some Primary School Education
3. Completed Primary School
4. Some High School Education
5. Completed High School
6. Post-Matric

10. Mother's Occupation

1. Unskilled
2. Semi-skilled
3. Skilled Artisan
4. Sales
5. Admin.
6. Clerical
7. Professional
8. Semi-prof.
9. Unemployed
10. Other

11. Father's Occupation

1. Unskilled
2. Semi-skilled
3. Skilled Artisan
4. Sales
5. Admin.
6. Clerical
7. Professional
8. Semi-prof.
9. Unemployed
10. Other

12. Is this your first pregnancy ?

Yes
No

13. If no, please indicate the number of previous pregnancies

14. Please indicate the number of children you have.

15. Age at first sex

1. Under 10
2. 10 - 14
3. 15 - 16
4. 17 - 19

16. Number of partners ever.

1. 1 to 5
2. 6 to 10
3. 11 to 15
4. 16 to 20
5. 21 to 45
6. 46 to 99
7. 100 or more

17. Number of casual partners

1. 0
2. 1 to 3
3. 4 to 5

4. 6 to 10
5. 11 to 25
6. 26 to 150

18. Frequency of sex

1. Less than once a month
2. Once a month
3. Once a week
4. 2 to 3 times a week
5. 4+ a week

SECTION B

Contraceptive Knowledge

Answer each of the following questions by circling the letter that corresponds to the correct answer.

19. Which of the following is a contraceptive method ?

a. hot bath
b. urination
c. exercise
d. rhythm method
e. breast feeding

20. After ejaculation, sperm cells live, on the average, approximately__________________ with the vagina

a. less than one day
b. one to two days
c. three to five days
d. one week to ten days
e. do not know

21. Which of the following, when used as a douche, can kill sperm cells.

a. Coca-cola
b. vinegar
c. soapy water
d. all of the above
e. do not know

22. Which of the following contraceptives is sold in a chemist without a doctor's prescription ?

a. I.U.D's
b. latex diaphrams
c. vaginal suppositories
d. "morning after" pills
e. do not know

23. In general a woman's "safe" period (when she cannot become pregnant even though she has sexual intercourse) is:

a. the first 15 days after menstruation ceases
b. the first 15 days before menstruation begins
c. the first five days before and after menstruation
d. the first five days before and after ovulation
e. do not know

24. The pill:
a. prevents ovulation
b. keeps cervical mucus very thin
c. changes the lining of the uterus to make implantation unlikely
d. both a and c
e all of the above

25. The use of a condom when having sexual intercourse is recommended because:

a. if used right, it usually prevents gonorrhea
b. it can be bought in a chemist by both women and men
c. it does not have dangerous side effects
d. all of the above
e. none of the above

26. A woman can get pregnant:

a. a few minutes after sexual intercourse
b. a few hours after sexual intercourse
c. a few days after sexual intercourse
d. all of the above
e. a and b

27. From which of the following sources have you received information about contraceptives.

1. Same-sex friend	
2. Opposite sex friend	
3. Father	
4. Mother	
5. Reading	
6. Mass media (television, radio etc)	
7. School - teacher, nurse	
8. Church	
9. Clinic	

10.Other	

28. Which of the following sources was the most influential source of information regarding contraceptives.

1. Same-sex friend	
2. Opposite sex friend	
3. Father	
4. Mother	
5. Reading	
6. Mass media (television, radio etc)	
7. School - teacher, nurse	
8. Church	
9. Clinic	
10.Other	

29. Which of the following sources would you most prefer to receive information regarding contraceptives.

1. Same-sex friend	
2. Opposite sex friend	
3. Father	
4. Mother	
5. Reading	
6. Mass media (television, radio etc)	
7. School - teacher, nurse	
8. Church	
9. Clinic	
10.Other	

30. Please indicate whether you agree or disagree with the following statements about condoms (FL's, Rubbers, Kondoom).

	AGREE	DISAGREE	DON'T KNOW
1. Condoms can prevent veneral diseases			
2. Condoms makes sex less enjoyable.			
3. Condoms should be used with casual partners.			
4. Condoms should be used with regular partners.			
5. Condoms makes my partner think that I don't trust him.			
6. Condoms makes me feel embarrassed.			
7. Condom use is against my religion.			
8. Condoms are too expensive.			
9. Condoms are offensive to my sexual partner.			
10. Condoms cause conflict with my cultural values.			
11. Condoms can prevent AIDS.			
12. Condoms are enjoyable and pleasurable to use.			
13. Condoms can slip off and cause injury to the vagina.			
14. Condoms are not easily available.			
15. Too many condoms are needed for many rounds of sex.			
16. Real men don't use condoms.			
17. Condom use will prevent pregnancy.			
18. Condoms that break are a common occurance.			
19. Buying a condom is an unpleasant experience.			

31. Indicate whether yes or no.

		YES	NO
1.	Was condom use taught at school ?		
2.	Do you use a condom every time you have sexual intercourse ?		
3.	You have not had sexual intercourse ?		
4.	Have you ever used a condom ?		
5.	Have you ever been treated for a sexually transmitted disease ?		

Section C

Attitudes

Circle the number which best describes your feelings on the following:

32. Using a method of birth control is:

Good 1 2 3 4 5 6 7 Bad

33. Using a method of birth control is:

Wrong 1 2 3 4 5 6 7 Right 2

34. Using birth control methods is unnatural

True 1 2 3 4 5 6 7 Untrue

35. Using birth control leads to major negative side effects:

Probable 1 2 3 4 5 6 7 Improbable

36. Using birth control would have a negative effect on my sexual morals.

Probable 1 2 3 4 5 6 7 Improbable

37. Using birth control is immoral

Probable 1 2 3 4 5 6 7 Improbable

38. Using birth control would enable me to regulate the size of my family.

Probable 1 2 3 4 5 6 7 Improbable

39. Birth control methods are unreliable.

Probable 1 2 3 4 5 6 7 Improbable

40. Using birth control would give me guilt feelings.

Probable 1 2 3 4 5 6 7 Improbable

41. Using birth control will produce children who are born with something wrong with them.

Probable 1 2 3 4 5 6 7 Improbable

42. Using birth control would decrease my sexual pleasure.

Probable 1 2 3 4 5 6 7 Improbable

43. Using birth control would remove the worry of becoming pregnant.

Probable 1 2 3 4 5 6 7 Improbable

44. Using birth control would make sex less romantic.

Probable	1	2	3	4	5	6	7	Improbable

45. Which of the following sources do you feel influenced your contraceptive attitudes.

1. Same-sex friend	
2. Opposite sex friend	
3. Father	
3. Mother	
4. Reading	
5. Mass media (television, radio etc)	
6. School - teacher, nurse	
7. Church	
8. Clinic	
9. Other	

Section D

BELIEFS

The statements below describes various contraceptive beliefs that a person might have. Please circle the number on the scale below each statement according to how strongly you agree or disagree with the belief. Please mark each statement.

1 - Stongly agree (SA)
2 - Agree (A)
3 - Undecided (UN)
4 - Disagree (D)
5 - Strongly Disagree (D)

46. Using a method of contraceptive is essential.

1	2	3	4	5

47. Using contraceptives is immoral

1 2 3 4 5

48. Using contraceptives leads to major negative side effects:

1 2 3 4 5

49. Using contraceptives would give me guilt feelings.

1 2 3 4 5

50. Using contraceptives would remove the worry of becoming pregnant.

1 2 3 4 5

51. Which of the following sources do you think influenced your contraceptive beliefs.

1. Same-sex friend	
2. Opposite sex friend	
3. Father	
4. Mother	
5. Reading	
6. Mass media (television, radio etc)	
7. School - teacher, nurse	
8. Church	
9. Clinic	
10.Other	

Section E

INTERFAMILIAL COMMUNICATION ABOUT CONTRACEPTION

Try and answer the following statements as mostly true or mostly false. Mark the answer that best represents your present opinion. If you really don't know the answer mark " I don't know". (contraceptives: condoms, the pill, I.U.D., etc.).

		TRUE	FALSE	DON'T KNOW
1.	If I had a problem concerning contraceptive matters, I could count on my mother to be understanding.			
2.	If I had a problem concerning contraceptive matters, I could count on my father to be understanding.			
3.	My father has never given me any information about contraceptives.			
4.	My mother has never given me any information about contraceptives.			
5.	If I were to use a contraceptive, I would prefer that my father not know about it.			
6.	If I were to use a contraceptive, I would prefer that my mother not know about it.			
7.	I have discussed my contraceptive use thoroughly with my father.			
8.	I have discussed my contraceptive use thoroughly with my mother.			
9.	If my father knew I used a contraceptive, his estimation of me would go down.			
10.	If my mother knew I used a contraceptive, her estimation of me would go down.			

11.	My father has encouraged me to use contraceptives.			
12.	My mother has encouraged me to use contraceptives.			
13.	I think that my father's ideas and beliefs about contraceptive use are very similar to my own.			
14.	I think that my mother's ideas and beliefs about contraceptive use are very similar to my own.			

Section F

PRACTICES

52. Which of the following reasons contributed to your pregnancy ?

	True	False
1. I used a contraceptive.		
2. I did not intend to have sex.		
3. I wanted to cause a pregnancy.		
4. I was drunk.		
5. I thought I was sterile.		
6. I thought it was the wrong time of the month.		
7. I only had sex a few times.		
8. I feared that my mother would discover my use of contraceptives.		
9. I feared that my father would discover my use of contraceptives.		
10. I feared my partner would be displeased.		
11. I was uncomfortable being too prepared.		
12. Contraceptives was against my religion.		

13. There were no contraceptives available.		
14. Contraception is not my responsibility.		
15. I did not think about contraception.		
16. I feared the side effects of contraceptives.		
17. Contraceptives are too expensive		
18. Contraceptives makes sex unpleasant.		
19. I felt uncomfortable asking for contraceptives at the clinic.		
20. The clinic was too far.		
21. I did not know how to use contraceptives.		
22. I experienced contraceptive failure.		
23. I did not know where to get contraceptives.		

53. Which one of the following sources do you feel most influenced your contraceptive practices.

1. Same-sex friend	
2. Opposite sex friend	
3. Father	
3. Mother	
4. Reading	
5. Mass media (television, radio etc)	
6. School - teacher, nurse	
7. Church	
8. Clinic	
9. Other	

NAVORSING VRAELYS/ONDERHOUD

Die doel van hierdie onderhoud is om 'n geheel beeld van u agtergrond vas te stel, en om vas te stel u persepsie omtrent onderwerpe wat belangrik vir u is met betrekking tot sekualiteit. Die informasie wat bevind sal word sal gebruik word om 'n beter diens aan ander tieners te vergemaklik.

Dit is verstaanbaar dat u besorg sal wees oor wat met die informasie sal gebeur sienende dat dit hoogs persoonlik is. Geen buitestaander sal toegelaat word om u antwoorde te sien nie. Die onderhoude sal anoniem bly so dat konfidensialiteit behoud kan bly. Antwoord asseblief elke vraag tot die beste van u vermoee. Dankie vir u deelname in hierdie navorsing.

AFDELING A

Biografiese Informasie

Aanwysings:

Sirkel asseblief die geskikte nommer in elke area. Baie dankie

1. Ouderdom

2. In watter area in bly jy in ?

....

3. Huis Taal

1.	Afrikaans	3.	Afrika/Inheemse taal
2.	Engels	4.	Ander

4. Hoogste Opvoedingsvlak

1. Geen opvoeding
2. 'n Bietjie Primere Skool Opvoeding
3. Klaar Primere Skool Opvoeding
4. 'n Bietjie Hoer Skool Opvoeding
5. Klaar Hoer Skool Opvoeding

6. Na- Matrik

5. Aantal ongetroude kinders tuis op die omblik (insluiting uself).

6. Wie van die volgende familielede was ongetroud en het kinders gehad.

1. Moeder
2. Vader
3. Broer
4. Suster
5. Niggie/Neef
6. Tante
7. Oom
8. Ander.......................................

7. Ouers se Verhouding Status

1.	Getroud	3.	Enkele	5.	Geskei
2.	Saambly	4.	Weduwee/Wewenaar	6.	Ander

8. Moeder se Hoogste Opvoedingsvlak

1. Geen opvoeding
2. 'n Bietjie Primere Skool Opvoeding
3. Klaar Primere Skool Opvoeding
4. 'n Bietjie Hoer Skool Opvoeding
5. Klaar Hoer Skool Opvoeding
6. Na- Matrik
7. Weet nie

9. Vader se Hoogste Opvoedingsvlak

1. Geen opvoeding
2. 'n Bietjie Primere Skool Opvoeding
3. Klaar Primere Skool Opvoeding
4. 'n Bietjie Hoer Skool Opvoeding
5. Klaar Hoer Skool Opvoeding
6. Na- Matrik
7. Weet nie

10. Moeder se beroep

1. Ongeskool
2. Semi-geskool
3. Geskoolde ambagsvrou
4. Verkope
5. Admin
6. Klerikal
7. Professioneel
8. Semi-professioneel
9. Werkloos
10. Ander
11. Weet nie

11. Vader se beroep

1. Ongeskool
2. Semi-geskool
3. Geskoolde ambagsman
4. Verkope
5. Admin
6. Klerikal
7. Professioneel
8. Semi-professioneel
9. Werkloos
10. Ander
11. Weet nie

12. Is dit u eerste swangerskap ?

13. Indien, nie dui aan asseblief die aantal vorige swangerskappe.

14. Dui asseblief die aantal kinders wat jy het.

15. Hoe oud was jy toe jy vie die eerste keer seks gehad het ?

1. Onder 10
2. 10 - 14
3. 15 - 16
4. 17 - 19

16.* Met hoeveel seuns ("ouens") het jy al seks gehad ?

1. 1 tot 5
2. 6 tot 10
3. 11 tot 15
4. 16 tot 20
5. 21 tot 45
6. 46 tot 99
7. 100 of meer

17. Aantal toevallige (casual) maats

1. 0
2. 1 tot 3
3. 4 tot 5
4. 6 tot 10
5. 11 tot 25
6. 26 tot 150

18.* Hoe dikwels het jy seks gehad ?

1. Minder as een keer 'n maand
2. Een keer 'n maand
3. Een keer 'n week
4. 2 tot 3 keer 'n week
5. 4+ 'n week

AFDELING B

VOORBEHOEDMIDDEL KENNIS

Beantwoord die volgende vrae deur die korrekte letter te omsirkel.

19. Watter een van die volgende is 'n voorbehoedmiddel ?

a. warm bad
b. urinering
c. oeffening
d. ritme metode
e. weet nie

20. Na uitstorting, sperma (saad) selle kan gemiddeld, omtrent ______________________ in die vagina bly lewe.

a. minder as een dag
b. een tot twee dae
c. drie tot vyf dae
d. een week tot ten dae
e. weet nie

21.* Watter een van die volgende as dit gebruik word as 'n spuit, kan sperma (saad) dood maak.

a. coca-cola
b. asyn
c. seep water
d. almal van bostaande
e. weet nie

22. Watter een van die volgende voorbehoedmiddels word in 'n apteek verkoop sonder 'n voorskrif van 'n dokter ?

a. I.U.D's
b. melksap diafragma
c. vaginal steekpil
d more agter na pill
e weet nie

23. Oor die algemeen, 'n vrou se "veiligste" periode (wanneer sy nie swanger kan word nie ten spyte van seks) is:

a. die eerste 15 dae na menstruasie gestop het.
b. die eerste 15 dae voor menstruasie begin.
c. die eerste 5 dae voor en na menstruasie.
d. die eerste 5 dae voor en na ovulasie.
e. weet nie.

24. Die pill:

a. voorkom ovulasie
b. hou halswerwel slym baie dun.
c. verander die lyning van die baarmoeder om inprenting moeilik te maak.
d. albei a en c.
e. almal van bostaande.

25.* Die gebruik van 'n kondoom word hoogs aanbeveel gedurende seks want:

a. as dit reg gebruik word voorkom dit gonorrhea
b. dit kan in 'n apteek gekoop word deur beide man en vrou
c. dit het geen gevaarlike nuwe effekte
d. almal van bostaande
e. geen van die bostaande nie.

26. 'n Vrou kan swanger word:

a. 'n paar sekondes na seks
b. 'n paar ure na seks
c. 'n paar dae na seks

d. almal van bostaande
e. a en b

27. Van watter van dir volgende bronne het jy informasie omtrent voorbehoedmiddels gekry ?

1. Dieselfde geslag vriend	
2. Teenoorgestelde geslags vriend	
3. Vader	
4. Moeder	
5. Lees	
6. Massa Media (televisie, radio)	
7. Skool (onderwyser, verpleegster)	
8. Kerk	
9. Kliniek	
10. Ander....................................	

28. Watter van die volgende bronne was die mees invloedrykste bron van informasie omtrent voorbehoedmiddels ?

1. Dieselfde geslag vriend	
2. Teenoorgestelde geslags vriend	
3. Vader	
4. Moeder	
5. Lees	
6. Massa Media (televisie, radio)	
7. Skool (onderwyser, verpleegster)	
8. Kerk	
9. Kliniek	
10. Ander....................................	

29. Watter van die volgende bronne sal jy verkies om informasie te kry oor voorbehoedmiddels ?

1. Dieselfde geslag vriend	
2. Teenoorgestelde geslags vriend	

3. Vader	
4. Moeder	
5. Lees	
6. Massa Media (televisie, radio)	
7. Skool (onderwyser, verpleegster)	
8. Kerk	
9. Kliniek	
10. Ander..................................	

30. Dui aan asseblief as jy met die volgende stellings oor kondome, saamstel, nie saam stel, of nie weet nie (FL's, Rubbers, Kondoom).

	Saamstel	Stel nie saam	Weet Nie
1. Kondome kan veneriese siekte voorkom.			
2. Kondome maak dat ek seks minder geniet.			
3. Kondome moet gebruik word met toevallige/ongereelde maats.			
4. Kondome moet gebruik word met gereelde maats.			
5. Kondome laat my maat voel dat ek hom nie vertrou (trust) nie.			
6.* Kondome laat my skaam voel.			
7. Die gebruik van kondome gaan teen my geloofs (religious) oortuiging.			
8. Kondome is te duur.			
9.* Kondome is 'n beledigend ("offend") vir my maat.			
10.* Kondome kom in conflik met my waardes (values).			
11. Kondome voorkom VIGS.			
12.* Kondome is lekker en prettig (fun) om te gebruik.			

13. Kondome kan afgly en kan die vagina seer maak.			
14. Kondome is nie so maklik beskikbaar nie.			
15. Te veel kondome is benodig vir baie rondtes van seks.			
16. "Regte" mans (ouens) gebruik nie kondome nie.			
17. Die gebruik van 'n kondoom kan swangerskap voorkom.			
18. Kondome wat breek gebeur baie keer.			
19.* Om kondome te koop laat my nie lekker voel nie.			

31. Dui aan asseblief of dit ja of nee is.

	JA	NEE
1. Was die gebruik van kondome op skool geleer ?		
2. Gebruik jy 'n kondoom elke keer as jy seks het ?		
3. Jy het nie seks gehad nie ?		
4. Het jy al ooit 'n kondoom gebruik ?		
5. Was jy al ooit vir 'n veneriese siekte behandel ?		

AFDELING C

HOUDINGS

32. Die gebruik van 'n voorbehoedmiddel ("birth control") is:

Goed 1 2 3 4 5 6 7 Sleg

33. Die gebruik van 'n voorbehoedmiddel is:

Verkeerd 1 2 3 4 5 6 7 Reg

34. Die gebruik van voorbehoedmiddels lei tot negatief effekte

Waarskynlik 1 2 3 4 5 6 7 Onwaar skynlik

35. Die gebruik van 'n voorbehoedmiddel sal 'n negatiewe effekte op my seksuele morele waardes

Waarskynlik 1 2 3 4 5 6 7 Onwaar skynlik

36. Die gebruik van voorbehoedmiddel immoreel

Waarskynlik 1 2 3 4 5 6 7 Onwaar skynlik

37. Dit is onnatuurlik om 'n voorbehoedmiddel te gebruik

Waar 1 2 3 4 5 6 7 Onwaar

38. Die gebruik van 'n voorbehoedmiddel sal my toelaat om die grote van my familie te bepaal

Moontlik 1 2 3 4 5 6 7 Onmoontlik

39. Voorbehoedmiddels is onbetroubaar

1 2 3 4 5 6 7

Moontlik ⌊___|___|___|___|___|___⌋ Onmoontlik

40. Die gebruik van voorbehoedmiddels laat my skuldig voel

Moontlik 1 2 3 4 5 6 7 Onmoontlik

41. Die gebruik van voorbehoedmiddels kan veroorsaak dat kinders gebore word met iets verkeerd

Moontlik 1 2 3 4 5 6 7 Onmoontlik

42. Die gebruik van 'n voorbehoedmiddel sal my sekuele genot verminder.

Moontlik 1 2 3 4 5 6 7 Onmoontlik

43. Die gebruik van 'n voorbehoedmiddel vat die die bekommernis (worry) van swangerskap weg

Moontlik 1 2 3 4 5 6 7 Onmoontlik

44. Die gebruik van 'n voorbehoedmiddel maak seks minder romanties

Moontlik 1 2 3 4 5 6 7 Onmoontlik

45. Watter van die volgende bronne voel jy het jou houding tenoor voorbehoedmiddels beinvloed.

1.	Dieselfde geslag vriend	
2.	Teenoorgestellde geslags vriend	
3.	Vader	
4.	Moeder	
5.	Lees	
6.	Massa Media (televisie, radio)	
7.	Skool (onderwyser, verpleegster)	
8.	Kerk	
9.	Kliniek	
10.	Ander....................................	

AFDELING D

OORTUIGINGS

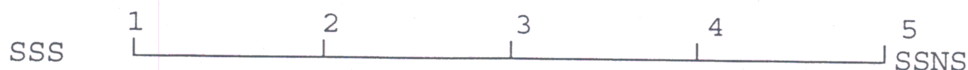
Die stellings onder beskryf verskillende oortuigings wat 'n persoon kan het. Sirkel asseblief die nommer.

1 - Stem Sterk Saam (SSS)
2 - Stem Saam (SS)
3 - Weet Nie (WN)
4 - Stem Nie Saam Nie (SNSN)
5 - Stem Sterk Nie Saam Nie (SSNSN)

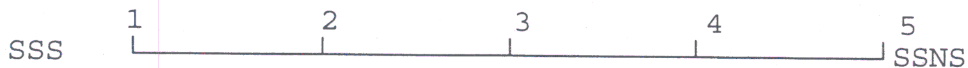
46. Die gebruik van 'n voorbehoedmiddel("birth control") is hoofsaaklik

47. Die gebruik van 'n voorbehoedmiddel("birth control") is immoreel

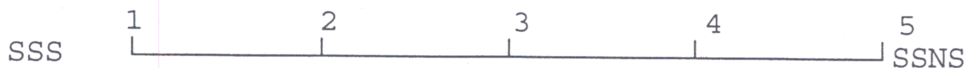
48. Die gebruik van voorbehoedmiddels ("birth control") lei tot negatief effekte



49. Die gebruik van voorbehoedmiddels ("birth control") laat my skuldig voel



50. Die gebruik van 'n voorbehoedmiddel vat die bekommernis (worry) van swangerskap weg



51. Watter van die volgende bronne voel jy het jou oortuigings tenoor voorbehoedmiddels (birth control) beinvloed.

1.	Dieselfde geslag vriend	
2.	Teenoorgestellde geslags vriend	
3.	Vader	
4.	Moeder	
5.	Lees	
6.	Massa Media (televisie, radio)	
7.	Skool (onderwyser, verpleegster)	
8.	Kerk	
9.	Kliniek	
10.	Ander...................................	

AFDELING E

INTERFAMILIERE KOMMUNIKASIE OOR VOORBEHOEDMIDDELS

Probeer die volgende stellings te beantwoord as meestal waar of meestal onwaar. As jy nie die antwoord ken nie merk die "Ek Weet Nie kolom. (voorbehoedmiddel, kondoom, die pill, I.U.D., ens.).

	WAAR	ONWAAR	EK WEET NIE
1. As ek 'n probleem omtrent voorbehoedmiddels gehad het, kan ek op my moeder staat maak (depend) om te verstaan.			
2. As ek 'n probleem omtrent voorbehoedmiddels gehad het, kan ek op my vader staat maak (depend) om te verstaan.			
3. My vader het nog nooit enige informasie omtrent voorbehoedmiddels aan my gegee nie.			
4. My moeder het nog nooit enige informasie omtrent voorbehoedmiddels aan my gegee nie.			
5. As ek 'n voorbehoedmiddel sou gebruik het verkis ek dat my vader daarvan weet.			
6. As ek 'n voorbehoedmiddel sou gebruik het verkis ek dat my moeder daarvan weet.			
7. Ek het my voorbehoedmiddel deeglik met my vader bespreek.			
8. Ek het my voorbehoedmiddel deeglik met my moeder bespreek.			
9. As my vader weet dat ek 'n voorbehoedmiddels gebruik het sal sy denk van my afneem.			
10. As my moeder weet dat ek 'n voorbehoedmiddels gebruik het sal sy denk van my afneem.			

11.	My vader het my aangemoedig om voorbehoedmiddels te gebruik.			
12.	My moeder het my aangemoedig om voorbehoedmiddels te gebruik.			
13.	Ek dink dat my vader se idees en oortuigings van voorbehoedmiddels is baie eners na my eie.			
14.	Ek dink dat my moeder se idees en oortuigings van voorbehoedmiddels is baie soos my eie.			

AFDELING F

GEBRUIKER

52. Watter van die volgende redes het bygedra tot jou swangerskap ?

		Waar On=waar	
1.	Ek het 'n voorbehoedmiddel gebruik.		
2.	Ek was nie van plan om seks te het nie.		
3.	Ek wou swanger geword het.		
4.	Ek was dronk		
5.	Ek het gedink ek was onvrugbaar.		
6.	Ek het gedink dat dit die verkeerde tyd van die maand.		
7.	Ek het omgang 'n paar keer gehad.		
8.	Ek was bang dat my ma sou uitvind dat ek voorbehoedmiddels gebruik.		
9.	Ek was bang dat my ma sou uitvind dat ek voorbehoedmiddels gebruik.		
10.	Ek was bang dat my maat ongelukkig sou wees.		
11.	Ek het ongemaklik gevoel om te voorberied te wees.		
12.	Voorbehoedmiddels is teen my geloof.		
13.	Daar was geen voorbehoedmiddels beskikbaar nie.		

14.	Voorbehoedmiddels is nie my verantwoordlikheid nie.		
15.	Ek het nie aan voorbehoedmiddels gedink nie.		
16.	Ek was bang vir die effekte van voorbehoedmiddels.		
17.	Voorbehoedmiddels is te duur.		
18.	Voorbehoedmiddels maak omgang onaangenaam.		
19.	Ek het te ongemaaklik gevoel om vir voorbehoedmiddels by die kliniek te vra.		
20.	Die kliniek was te ver.		
21.	Ek het nie geweet hoe om voorbehoedmiddels te gebruik nie.		
22.	Ek het voorbehoedmiddel mislukking ervaar.		
23.	Ek het nie geweet waar om voorbehoedmiddels te kry nie.		

1.	Dieselfde geslag vriend	
2.	Teenoorgestellde geslags vriend	
3.	Vader	
4.	Moeder	
5.	Lees	
6.	Massa Media (televisie, radio)	
7.	Skool (onderwyser, verpleegster)	
8.	Kerk	
9.	Kliniek	
10.	Ander....................................	

Appendix 2

DEPARTMENT OF HUMAN ECOLOGY AND DIETETICS

DIVISION : HUMAN ECOLOGY

Dear Sir/Madam

RE: **A RESEARCH STUDY PROJECT**

The objectives of the Human Ecology Department is to improve the quality of life of individual, families and communities through education, research and community service. This department and university has taken a stance of supporting the Primary Health Care system in the Western Cape.

Presently, I am a lecturer in the community and a Master's student at the University of Western Cape. I am currently doing a study on teenage pregnancy within the Bellville, Kasselvlei, Scottsdene and Belhar community.

I wish to interview unmarried pregnant teenagers these areas who are attending or who have made appointments to attend your clinic. As Bellville does not have an official support group for the pregnant teenagers, I would like to gain entry to this population by means of obtaining the names logged on to the register. The survey will be done anonymously and will be treated as highly confidential. All responses will be summarised in such a way that no details about any individual being revealed.

I hereby request your permission to utilise the clinic as a sample for my research project.

Yours sincerely

....
X. Hendricks(Miss)

Appendix 3

21 Belmont Ave
Lansdowne
7780

Dear Parents

CONSENT FORM

The main aim of the study is to investigate the coloured unmarried pregnant teenager's perception and experience of parents, church, media, schools, peers and family planning clinics as sources of information with regard to contraceptive knowledge, attitudes, beliefs and practices. As the sample group ranges between 13-19 year olds, we therefore have to request the permission of parents for the daughters to be interviewed and to participate in this research.

I........................ (parent, guardian) hereby grant permission for .... (daughter) to be interviewed for this research project.