

**AN ECOLOGICAL PERSPECTIVE OF ADOLESCENTS'  
NEED FOR SUPPORT DURING PREGNANCY**

by

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Thesis presented in fulfilment of the requirements for the degree of  
Master of Social Work in the Faculty of Arts and Social Sciences at  
Stellenbosch University

The image shows the crest of Stellenbosch University, which is a shield with various symbols, topped with a crown and surrounded by a decorative border. The crest is positioned behind the text of the thesis statement.

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**March 2011**

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## **ABSTRACT**

According to South African policy documents, social welfare services, health care providers and schools should place special focus on supporting pregnant adolescents to avoid the possible deleterious effects of early unplanned pregnancies. This implies that pregnant adolescents require support, from multiple levels, in order to adjust positively to their pregnancy so as to promote their well-being and the well-being of their unborn child.

This study explores and describes the support needs of pregnant adolescents in three low-income communities. This was done by examining the support that was currently available and utilised by pregnant adolescents, as well as identifying areas that required improved support. By adopting an ecological approach to the study, the need for support could be investigated on multiple levels.

A combination of a quantitative and qualitative research approach was used in the study. The study further assumed an exploratory and descriptive research design in order to provide a detailed description of the phenomenon being studied, namely adolescent pregnancy. Data was gathered by means of a semi-structured questionnaire, which was administered during an individual interview. This allowed for data to be collected that was both measurable as well as rich in description. The design of the semi-structured questionnaire was based on the information obtained from the literature review.

The findings of the empirical investigation reveal that adolescents have limited knowledge of formal support services, particularly social welfare services, support groups and health care services, which results in poor utilisation of these services. Consequently, limited support is attributed to these particular services.

The findings further indicate that informal sources of support, such as family, friends and partners, were relatively supportive during the adolescent's pregnancy. However, the adolescents' relationships with their parents and partners were particularly strained during the pregnancy, especially the relationship with their father. Of significance is the finding that fathers were considered those who offered the adolescents the least amount of support during the pregnancy.

As a result of their pregnancy, the adolescents were stigmatised on multiple levels. There was stigmatisation from their friends and peers at school, which had an impact on their social

adjustment. Stigma experienced at health care services led to chastising experiences, which deterred the adolescents from utilising such services. Furthermore, pregnant adolescents are stigmatised by their community, and the widespread judgement leads to increased tension and apprehension when seeking formal and informal support.

The most important recommendations resulting from the study indicate that many resources of support would be better utilised during pregnancy if adolescents had greater knowledge of the support available to them. This is of particular significance with regard to social welfare services, which play a key role in educating adolescents, their parents and the community about sexuality, adolescent pregnancy and the significance of support.

In addition, the recommendations emphasise the importance of promoting and facilitating peer education and support services, which could be of great value for pregnant adolescents. Receiving support and education from peers can be highly effective, but also allows pregnant adolescents to make a valuable contribution to other adolescents in similar situations. In doing so, pregnant adolescents are empowered and encouraged, which is much needed in an environment where they are typically shunned and branded as failures.

## OPSOMMING

Volgens Suid-Afrikaanse beleidsdokumente moet maatskaplike welsynsdienste, gesondheidsdiensteverskaffers sowel as skole 'n spesiale fokus plaas op die ondersteuning van swanger adolessente om sodoende die nadelige gevolge van vroeë, onbeplande swangerskappe te beveg. Dit veronderstel dat swanger adolessente hulp benodig uit vele vlakke ten einde 'n positiewe aanpassing tot hulle swangerskap te maak om sodoende hulle eie welstand en dié van hulle ongebore kind te bevorder.

Hierdie studie ondersoek en beskryf die ondersteuningsbehoefte van swanger adolessente in drie lae-inkomste gemeenskappe. Dit is gedoen deur die huidige ondersteuning wat wel beskikbaar is en deur swanger adolessente gebruik is, te ondersoek, asook om aspekte te identifiseer wat meer ondersteuning benodig. Deur die gebruik van 'n ekologiese benadering tot hierdie studie kon die behoefte aan ondersteuning dus op veelvoudige vlakke ondersoek word.

'n Kombinasie van kwantitatiewe en kwalitatiewe navorsingsmetodes is in hierdie studie gebruik. Die studie veronderstel verder 'n verkennende en beskrywende navorsingsontwerp om sodoende 'n uitvoerige beskrywing van die verskynsel wat ondersoek word, naamlik adolessente swangerskap, te verskaf. Data is ingevorder deur die gebruik van 'n semi-gestruktureerde vraelys wat tydens individuele onderhoude toegedien is. Dit het toegelaat dat data ingevorder kon word wat beide meetbaar sowel as ryk in beskrywing was. Die ontwerp van die semi-gestruktureerde vraelys is gebaseer op inligting verkry uit die literatuurstudie.

Die bevindinge vanuit die empiriese ondersoek dui daarop dat adolessente beperkte kennis het oor die formele ondersteuningsdienste, veral maatskaplike welsynsdienste, ondersteuningsgroepe en gesondheidsdienste, wat dan swak gebruik van bogenoemde dienste tot gevolg het. Gevolglik word beperkte ondersteuning aan hierdie dienste toegeskryf.

Die bevindinge dui verder dat informele bronne van ondersteuning, soos familie, vriende en metgeselle, relatief ondersteunend was tydens die adolessent se swangerskap. Nietemin was die adolessente se verhoudings met hulle ouers en metgeselle besonder gespanne, veral dié met hulle vaders. Van aansienlike belang was die bevinding dat veral vaders beskou is as dié persone wat die minste ondersteuning tydens die swangerskap gebied het.

Daarbenewens word adolessente as gevolg van hulle swangerskap op veelvoudige vlakke gestigmatiseer. Daar is stigmatisering deur vriende en portuurgroepe op skool, wat 'n impak

het op die adolessente se sosiale aanpassing. Stigmatisering deur gesondheidsdienste het gelei tot tugtgingsondervindings wat die adolessente daarvan weerhou het om hierdie dienste te gebruik. Verder word adolessente ook deur hulle gemeenskappe gestigmatiseer, waar die algemene veroordeling lei tot verhoogde spanning en vrees wanneer hulle formele of informele ondersteuning benodig.

Die belangrikste aanbevelings van hierdie studie, dui daarop dat vele bronne van ondersteuning beter gebruik sou geword het tydens swangerskap indien die adolessente meer kennis van die beskikbare ondersteuning gehad het. Dit is veral opmerklik ten opsigte van maatskaplike welsynsdienste, wat 'n vernames rol speel in die opvoeding van adolessente, hulle ouers en die gemeenskap aangaande seksualiteit, adolessente swangerskap en die belangrikheid van ondersteuning.

Daarby benadruk die aanbevelings die belangrikheid van die bevordering en fasilitering van portuurgroepopvoeding en ondersteuningsdienste, wat van groot waarde vir adolessente kan wees. Om ondersteuning van portuurgroepe te ontvang, kan nie slegs hoogseffektief wees nie, maar ook toelaat dat swanger adolessente 'n positiewe bydrae aan ander adolessente kan maak wat hulle in dieselfde situasie mag bevind. Sodoende word swanger adolessente bemagtig en bemoedig, wat noodsaaklik is in 'n omgewing waar hulle tipies vermy en as mislukkings beskou word.

## **ACKNOWLEDGMENTS**

I would like to express my sincere appreciation to the following people:

- Professor Sulina Green, for her support, encouragement and knowledgeable guidance.
- The Department of Social Work and Stellenbosch University for providing me with a postgraduate bursary in order to further my studies in Social Work.
- Ms Marisa Honey, for the professional editing of this thesis.
- My family for their love and encouragement, and the interest they have shown in my studies.
- My husband Ian, for motivating, supporting and loving me throughout my studies.

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# CHAPTER 1

## INTRODUCTION

### **1.1. PRELIMINARY STUDY AND RATIONALE**

When an adolescent falls pregnant it creates a dilemma for the young mother to be. Her immediate and long-term interests, needs and development are threatened, and a host of psychological, economic and social problems are raised (Furstenberg, 1976:1; Joubert, 2007:5). Adolescent pregnancy not only affects the individual but also has extensive effects and consequences on families, communities and society as a whole. Adolescent pregnancy seemingly is a complex and convoluted issue facing society.

Adolescent pregnancy is socially constructed as a problem for the individual and for society. When an adolescent falls pregnant she deviates from the expected path of behaviour and development set out by cultures and society. As a result, she is propelled into a state that she is unready or unprepared to assume (Daniels & Nel, 2009:62; Furstenberg, 1976:4; Hudson & Ineichen, 1991:62).

Research indicates that, in addition to giving rise to developmental problems, adolescent pregnancy has resonating effects that instigate a lower quality of life for the adolescent and her child (Mohase, 2006:22). It has financial implications for the individual and the community, and it adds to the ever rising predicament of a growing fatherless generation (Smith, 2006:79-86).

South African statistics reveal that, in 2003, 12% of adolescents between the ages of 15 and 19 had been pregnant (Department of Health, 2003). This is a decrease from the pregnancy rate in 1998 of 16%. Adolescents at the age of 19 appear to have the highest rates of pregnancy. In 1998, 35% of adolescents aged 19 were mothers; this rate had decreased to 27% in 2003. However, in 2006 the percentage of adolescents who had been pregnant increased to 39% (Children's Institute, 2009). This means that two in five girls has been pregnant by the age of 19.

Whilst there are many strategies aimed at reducing and preventing adolescent pregnancy, very few strategies and policies are in place for the adolescent when she discovers that she is pregnant (Department of Education, 2007). However, the issue of adolescent pregnancy is not

ignored, as South African policies do recognise the need to address the issue of adolescent pregnancy. One of the key areas that the White Paper on Population Policy (Department of Welfare and Population Development, 1998) seeks to address is that of adolescent pregnancy. The policy recognises that adolescent pregnancy is an issue of concern and that it cannot be ignored. However, despite recognition of the need to address adolescent pregnancy, there are few policies in place that distinctly protect and support pregnant adolescents.

The Department of Education holds the only policies aimed specifically at adolescents when they fall pregnant. The Measures for the Prevention and Management of Learner Pregnancy is the main policy that is implemented by the Department of Education (2007). The focus is on prevention and, “in cases where prevention measures fail and learners do fall pregnant...” the policy states that it is “...obliged to manage the situation by balancing the best interests of the individual against those of other learners, educators, the school and its community” (Department of Education, 2007). In reality, the prevention measures do fail because there is still a high rate of adolescent pregnancy. Policies need to be developed that focus on supporting the adolescent whilst she is pregnant and once she has had her baby.

From the above it is clear that pregnant adolescents urgently need the support and protection of adequate national policies. When falling pregnant, the adolescent is often removed and disconnected from sources of support and resources that are more readily available to women who delay parenthood until marriage (Furstenberg, 1976:13). Support services in local communities are inaccessible to adolescents as they feel judged and rebuked for falling pregnant (Furstenberg, 1976:15; Hudson & Ineichen, 1991:63). This results in pregnant adolescents receiving minimal to insufficient support and care during the term of their pregnancy. Having sufficient policies and support systems in place could help adolescents to adjust to and cope with the enormity of the change they are experiencing (Holgate, Evans & Yuen, 2007:1).

In the ecological perspective, life transitions, such as falling pregnant prematurely, can act as a source of stress for any individual. The stress reduces the person’s ability to cope and adapt to their changing needs, both personally and in the environment (Payne, 2005:151). In order to adapt to transitions, individuals need to achieve a goodness-of-fit between themselves and the environment. This is necessary, because, according to Germain and Gitterman (1996:8), the relationship between the environment and the person is reciprocal in that each influences the other over time through multiple exchanges.

The role of the social worker is to enhance the fit between the person and the environment. The social worker needs to help individuals meet their life tasks that are associated with developmental stages, status and role demands, and crisis events within their culture. This enhanced person-environment fit is achieved by alleviating life stressors, increasing the personal and social resources available to the individual, and influencing environmental forces so that they respond to the person's needs (Germain & Gitterman, 1996:156; Payne, 2005:152).

From the above it can be deduced that social workers have a valuable role to play in facilitating the adjustment of adolescents in the life transition of falling pregnant. The personal functioning of pregnant adolescents, as well as their interactions with their environment, is affected by this premature developmental crisis (Germain & Gitterman, 1996:156). Social workers can assist the transition by facilitating access to resources and advocating for improved support services and policies that are currently inadequate and inaccessible.

It is clear that pregnant adolescents require support, not only the support that every pregnant woman needs, but also support to help them adjust to the life transition of falling pregnant prematurely. This is a field that requires literature and research in order to gain knowledge of the problem and to address it. Although a great deal of research has been done on adolescent pregnancy, there is a gap in research on and literature in the field of support for adolescents during pregnancy. Very little literature is South African and, although similarities and assumptions can be drawn from non-South African sources, these do not consider the particular history and context of the participants (Bless, Higson-Smith & Kagee, 2006:24-25; Lawson & Rhode, 1993).

Furthermore, the literature on adolescent pregnancy focuses more on the implications for the adolescent when she becomes a mother, or has a strong focus on abortion (Evangelisti, 2000; Furstenberg, 1976). There is insufficient relevant South African literature that pertains to adolescents support needs during pregnancy and this is an indication that there is a gap in the research field (De Vos, Strydom, Fouche & Delpont, 2005:124; Joubert, 2007:23).

## **1.2 PROBLEM STATEMENT AND FOCUS**

Statistics indicate that the number of adolescents who have ever been pregnant has increased over the past five years. The literature (Furstenberg, 1976:4; Holgate *et al.*, 2007:1; Hudson & Ineichen, 1991:62) confirms that adolescents require support during their pregnancy as they experience a life transition which is a deviation from their expected path of development. Various authors (Furstenberg, 1976:13; Payne, 2005:152) agree that there are insufficient support services available to pregnant adolescents and that, by improving support and facilitating access to support services, it will be possible for adolescents to adjust better to the stress related to the pregnancy.

Due to the lack of relevant literature and insufficient support services (Daniels & Nel, 2009:71-74) related to the specific support needs of adolescents during pregnancy, the need for research in this field was expressed by Connect Network. They are a network that facilitates the networking of local organisations to collaborate an effective response to women and children at risk. One of the key issues that they focus on is crisis pregnancy. The information will provide them with guidelines on how to improve current support services and develop the needed services for pregnant adolescents.

## **1.3 AIMS OF RESEARCH PROGRAMME AND THEORETICAL POINTS OF DEPARTURE**

The aim of the research is to gain an understanding of the support needs of female adolescents during pregnancy from an ecological perspective, in order to provide guidelines for social work interventions with these adolescents.

In order to achieve this aim, the following objectives were formulated:

- To present an overview of the adolescent life phase and to describe the consequences of unplanned pregnancy on the adolescent
- To discuss the ecological perspective and explore the relevance of the theory to adolescent pregnancy
- To describe from an ecological perspective how support can be provided for female adolescents during pregnancy
- To investigate the resources available to pregnant adolescents and their experiences in utilising support services

- To offer guidelines for social work interventions to improve support for adolescents who are pregnant

## **1.4 CLARIFICATION OF KEY CONCEPTS**

For the purpose of this study the following concepts will be clarified.

### **1.4.1 Ecological perspective**

The ecological perspective focuses on the interactions between the environment and the individual. The primary principle is that people shape their environment and are shaped by it. Hence, problems in social functioning are the result of people-environment exchanges (Sheafor, Horejsi & Horejsi, 2000:92). The systems perspective complements the ecological perspective in that it focuses on the individual as part of multiple systems in the environment. By combining the ecological and systems perspectives one is able to assess social and personal elements in a social situation, and assess how these elements interact with each other to integrate into a whole (Payne, 2005:142).

### **1.4.2 Early adolescence**

Wait, Meyer and Loxton (2005:149) refer the period between the ages of 12 and 18 years as the early adolescent life phase. This is a phase of transition from childhood to adulthood. The period is characterised by physical maturation, emotional development, advances in formal operational thought, establishing sexual relationships and increased sensitivity with regard to peer approval (Newman & Newman, 1997:632). For the purpose of this study, the term adolescent is used to refer to people between the ages of 12 and 18 years.

### **1.4.3 Support**

Support can be understood as offering help, encouragement or approval to an individual, and showing an active interest in them (Reber & Reber, 2001, s.v. 'support'). Letourneau, Stewart and Barnfather (2004:515) go further to explain support as the interactions with family members, friends, peers and health professionals that communicate information, understanding and respect for the individual.

#### **1.4.4 The individual**

Due to the fact that the study explores support for pregnant adolescents, the adolescent or individual will be referred to in the female form unless otherwise specified.

### **1.5 RESEARCH DESIGN AND METHODS**

#### **1.5.1 Research approach**

The research approach used for the study was a combination of quantitative and qualitative methods. Research based on the quantitative method is conducted using a range of methods that use measurement to investigate and record aspects of social reality. This means that the quantitative findings are measurable and can be presented numerically and graphically (Bless *et al.*, 2006:184). Furthermore quantitative research is highly formalised, controlled and based on specific standardised procedures (De Vos *et al.*, 2005:73).

In contrast to the quantitative approach, the qualitative approach is concerned with naturalistic observation and understanding experiences, rather than explaining phenomena and using controlled measurement (De Vos *et al.*, 2005:74). Bless *et al.* (2006:184) refer to qualitative research as a method that uses qualifying words and descriptions to record and investigate facets of social reality.

Although it is argued that these approaches differ judiciously with each other (Bless *et al.*, 2006:44; De Vos *et al.*, 2005:73), the quantitative and qualitative research approaches can be used together in a complementary fashion. Mouton and Marais (1988:169-170) state that the phenomena investigated by the social sciences are so enmeshed that a single approach to research would not succeed in encompassing participants in their entirety. By using the quantitative approach measurable recordable information can be gathered, and can be complemented by the rich description of social phenomena that is retrieved from qualitative research.

In view of the abovementioned descriptions of a combined quantitative and qualitative approach, it was concluded that this was the most appropriate approach for achieving the goal of the study.

### **1.5.2 Research design**

The study assumed an exploratory and descriptive research design. Exploratory research endeavours to inquire into or discuss in detail that which is being investigated (South African Pocket Oxford Dictionary, 2002, s.v. 'explore'). According to Bless *et al.* (2006:47), exploratory research explores phenomena with the goal of understanding a situation, phenomena, a community or an individual. This is complemented by a descriptive research design, which focuses on collecting accurate information about a phenomenon and providing an in-depth description of a social phenomenon, group interaction or individual (Mouton & Marais, 1988:43-44).

The necessity for exploratory research, according to De Vos *et al.* (2005:106), arises from a lack of basic information on a new area of interest, or in order to become familiar with a phenomenon so as to develop a hypothesis or to formulate a problem. The answer to a "what" question would constitute an exploratory study (Mouton, 2001:53).

The intention of this study was to explore the support needs of female adolescents during pregnancy, and very little literature pertaining directly to the topic could be found. The available literature focused predominantly on the needs of young mothers after pregnancy, and not on their specific support needs during the pregnancy period (Holgate *et al.*, 2007; Hudson & Ineichen, 1991; Joubert, 2007). As little relevant or recent literature could be found, the exploratory design was chosen in order to gain insights and to gather information regarding the topic of interest (De Vos *et al.*, 2005:106; Mouton and Marais, 1988:43).

### **1.5.3 Research methodology**

#### **1.5.3.1 Literature study**

The literature review contributes to gaining a clearer understanding of the nature and meaning of the problem that has been identified (De Vos *et al.*, 2005:106). The literature review is necessary so that the researcher can envisage the topic in a way that sanctions a clear formulation of the problem and the hypothesis. The review aims to avoid the duplication of previous studies and suggests possibilities to be explored in the research field (Bless *et al.*, 2006:24; Mouton, 2001:87).

A literature study was conducted in the research field in order to gain an understanding of the research topic and to establish a frame of reference from which to proceed. Literature

concerning the adolescent life phase, pregnancy and support needs during pregnancy, as well as the ecological and systems perspectives was reviewed thoroughly. Study materials were obtained from the J. S. Gericke Library and the Erica Theron Reading Room at the University of Stellenbosch. Both local and international literature was studied in order to gain an accurate and thorough understanding of the support needs of female adolescents during pregnancy. Literature from the social and medical fields were incorporated into the study and provided a holistic approach to understanding the research topic.

### **1.5.3.2 Sampling**

Sampling refers to taking a portion of a population or universe as representative of that population or universe. The universe can be understood as the total of all the subjects in the field of enquiry (Hansrajh, 2007:2). The subjects in the universe possess all the attributes that the researcher is interested in. The population is defined as a group that has one or more characteristics in common which are of interest to the researcher. The sample is the smaller section or set of individuals selected from a population (De Vos *et al.*, 2005:193).

Sampling is necessary because the universe and population to be studied are of too great a magnitude to be studied effectively. The researcher, as a result, selects a small group that is still representative of the larger group and that includes all the elements of the larger group (Brynard & Hanekom, 1997:43). The population for the proposed study was defined as all female adolescents in the early adolescent life phase that had a full-term pregnancy in the last year. Adolescents who had had a full-term pregnancy were chosen, as opposed to adolescents who were currently pregnant, because they would be able to reflect back meaningfully on their pregnancies, and identify areas that required improved support.

Non-probability, purposive sampling methods were used to select the sample. Non-probability sampling is done when the population size or the members of the population are unknown. It is a sampling technique according to which the probability of including each element of the population in the sample is not known (Bless *et al.*, 2006:184). Purposive sampling is based entirely on the judgement of the researcher. The sample is composed of elements that contain the most characteristic and representative attributes of the population (De Vos *et al.*, 2005:201).

The sampling method was the most suitable method for the study, as the researcher did not know the population size and needed to select a sample that was most representative of the population. Participants were gathered from three different sources, namely the Bethesda Evangelical Church, Emyezweni Pre-School Community Group, and Hands on Prayer and Evangelism - home based care. The researcher obtained the identifying particulars of potential participants from the mentioned agencies, and then selected participants appropriately according to the criteria of inclusion. The results based on the sample could then be generalised to the population group.

The sample consisted of 32 participants. The criteria for inclusion were the following:

- Female participants
- Adolescents in the early adolescent life phase
- Adolescents who had a full-term pregnancy within the last year
- Adolescents whose pregnancies were unplanned
- Adolescents who lived in a low-income community within a metropolitan area

### **1.5.3.3 Data collection**

#### **(i) Research instrument**

Data was collected by means of a semi-structured questionnaire. The semi-structured questionnaire is a quantitative method of data collection. According to Bless *et al.* (2006:184), a questionnaire is a data collection instrument consisting of a series of questions relating to the research topic. The objective of a questionnaire is to obtain facts and opinions about a phenomenon (De Vos *et al.*, 2005:166).

The questionnaire was semi-structured and included both open and closed questions. The questionnaire was administered by the researcher by means of an interview (De Vos *et al.*, 2005:174). The questions for the questionnaire were compiled on the basis of the literature in the literature review chapters. Hence the research followed a deductive approach, in which knowledge progressed from the general to the specific. Deductive reasoning moves from a pattern that may be theoretically expected to observations that test whether the pattern truly occurs (Brynard & Hanekom, 1997:20; De Vos *et al.*, 2005:47).

As the questionnaire contained both open and closed questions, the data that was collected was both quantitative and qualitative. Some of the data was measurable and specific, whilst

the remaining data provided a richer description of the topics being explored. This allowed for data that was both scientific and descriptive to be collected.

### **(ii) Pilot study**

A pilot study was conducted for the semi-structured questionnaire. According to De Vos *et al.* (2005:206-211), a pilot study is a small study that is conducted prior to the main research to determine whether the methodology, sampling instruments and analysis are adequate. The pilot study highlights the feasibility of the project and brings possible deficiencies to the attention of the researcher. This is of particular importance, as it allows the researcher to make adjustments to the research instrument in order to make it more effective in gathering the required data (Bless *et al.*, 2006:184).

The pilot study was conducted with three participants. This allowed for the researcher to ensure that the research instrument gathered all the appropriate data. It further ensured that the participants understood the questions and terminology used in the semi-structured questionnaire.

### **(iii) Method of data analysis**

According to De Vos *et al.* (2005:333), data analysis is the process of bringing meaning and structure to the data that is collected. Analysis enables the researcher to detect consistent patterns within the data (Bless *et al.*, 2006:163)

The data collected by means of the questionnaire was coded and represented by means of graphs and figures. This allowed for the data to be interpreted and for trends to be identified in the findings. (Bless *et al.*, 2006:163; De Vos *et al.*, 2005:337). The data was then summarised and interpreted in the research report and compared to the existing data in the literature study.

#### **1.5.3.4 Ethical considerations**

Ethics, according to De Vos *et al.* (2005:57), is a set of moral principles that are widely accepted and offer rules and expectations for behaviour. The ethics of science is concerned with what is right and what is wrong in the conduct of research. Research ethics places emphasis on the humane and sensitive treatment of research participants, and provide expectations about the most correct manner of conduct towards participants (Bless *et al.*, 2006:140; Mouton, 2001:238). The researcher is registered with the South African Council of Social Service Professions. This means that the researcher adheres to a strict code of ethics that influences the research process and particularly the course of data collection.

The following ethical considerations were relevant whilst conducting the study:

- **Informed consent**

Informed consent refers to the participant's right to know what the research is about, what research procedures will be adopted, and any related risks or disadvantages. It includes the opportunity for participants to discontinue their involvement in the research at any time (Bless *et al.*, 2006:142; De Vos *et al.*, 2005:59; Mouton, 2001:244).

The participants were provided with relevant, accurate information concerning the study that they would participate in. The purpose of the study, as well as how it would be published, was clearly explained to all the participants. The researcher did not coerce the participants in any way, and ensured that all the participants were competent to give informed consent. The participants were given an informed consent form once they understood the information pertaining to the research and had expressed that they were willing to participate voluntarily in the research (Appendix 2).

- **Confidentiality**

Confidentiality refers to the privacy of the participants in the research. Participants have the right to remain anonymous and to be assured that their data will not be associated with their identity in any way (Bless *et al.*, 2006:143; Mouton, 2001:243).

The participants' confidentiality was maintained throughout the course of the research. All information was regarded as private and protected. The information was not made available to anyone besides the researcher and supervisor, unless the participants had given written consent for the information to be disclosed. The research data was stored in a secure place and the participants' personal information was removed.

- **Debriefing**

Debriefing allows participants to work through the experience of the research, and minimises the possibility of harm. Through debriefing, problems that are generated by the research experience can be corrected and the participants can discuss their feelings (De Vos *et al.*, 2005:66).

The nature of the research was such that it could have raised negative emotions or memories of difficult experiences. In order to compensate for this, the researcher allowed time at the end of each interview for debriefing. If it should be necessary, the researcher was prepared to make an appropriate referral if the participant required further follow up or support.

#### **1.5.3.5 Limitations of the study**

The literature study indicates that research material was not easily available. Relatively little literature could be found pertaining directly to the support needs of adolescents during pregnancy. Hence literature had to be used from related fields of study.

Adolescents were reluctant to participate in the research study. This posed a limitation as they did not want to attend interviews.

## **1.6 TIME FRAMEWORK AND PROVISIONAL CHAPTER LAYOUT**

The research report includes six chapters. Chapter 1 serves as an introduction to the study and presents a plan for how the research will be undertaken. Chapter 2 provides an overview of the adolescent life phase and explores the consequences of pregnancy for the female adolescent. In chapter 3 the ecological perspective is discussed in relation to adolescent pregnancy. Chapter 4 focuses on describing the support needs of pregnant adolescents and explores how support can be provided from an ecological perspective.

In chapter 5 the data from the empirical study is presented in order to indicate the support needs of female adolescents during pregnancy. The conclusions and recommendations based on the findings of the empirical study are presented in the final chapter.

The investigation took place over the period from 8 February to 1 November 2010. The final proposal was concluded by 30 May. The literature study chapters were completed one a month, and were finalised by 30 August. The data for the research was gathered by means of a questionnaire. This was done over the period from 1 to 22 September. This information was presented by means of an empirical study, which was completed by 1 October, after which the conclusions and recommendations were submitted. The final research report was submitted on 1 November.

## **CHAPTER 2**

### **THE ADOLESCENT LIFE PHASE AND THE CONSEQUENCES OF PREGNANCY**

#### **2.1 INTRODUCTION**

Adolescence is the period of transition from childhood to early adulthood. It is the time when the individual makes a conversion from childhood dependency to adult self-sufficiency (Specht & Craig, 1982:185; Wait *et al.*, 2005:149). This stage is characterised by rapid physical change, emotional and cognitive maturation, sexual awakening and an increased sensitivity to peer relations.

Adolescents can be described as being in a state of crisis due to the impact of the many personal and social changes they go through. They have to adapt to changing roles, values and behaviours in order to adapt to their new phase in life. At the same time they are dealing with conflicting pressures from their parents and peers (Trad, 1999:221; Wait *et al.*, 2005:157).

When an adolescent falls pregnant it can lead to the experience of more problems than that which is experienced by an adult who has an unplanned pregnancy, because of the many changes and adaptations that the adolescent is faced with (Evangelisti, 2000:11). As most adolescent pregnancies are unintended and not planned it usually gives rise to a personal crisis. In order for this crisis to be resolved and for support to be rendered, unplanned pregnancies must be considered within the context of the adolescent's developmental life tasks and challenges (Marecek, 1987:89).

This chapter will meet the first objective of the study, which is to present an overview of the adolescent life phase and describe the consequences of unplanned adolescent pregnancy. In order to achieve this aim the chapter will discuss the adolescent life phase and related developmental tasks. It will then explore adolescent sexuality and how an unplanned pregnancy impacts on the adolescent.

## **2.2 ADOLESCENT LIFE PHASE**

Human beings are constantly growing and developing, from conception through to very old age. There are different stages of development, which are characterised by emerging abilities, emotions, behaviours and motives. Stages, or phases, refer to a period when there are noticeable differences in how life is experienced. Human beings go through eleven stages of development, namely the prenatal, infancy, toddlerhood, early school-age, middle school-age, early adolescence, later adolescence, early adulthood, middle adulthood, later adulthood and the very old age life stages (Newman & Newman, 1995:4; Wait *et al.*, 2005:14-18).

The early adolescent life phase is the stage in which the individual is between the ages of 12 and 18 years. During this time, the individual goes through numerous physical, cognitive and emotional, changes that result in the individual being able to adapt to the changing demands of the environment (Wait *et al.*, 2005:150).

In order for individuals to develop they must master the developmental tasks that are associated with their life stage. The following section will explore the adolescent life phase by discussing the related developmental tasks.

### **2.2.1 Developmental tasks**

Developmental tasks are a set of skills and competencies that are acquired at each stage of development. They contribute to the individual's increased social competence and define what is normal and healthy in terms of societal expectations. The adolescent's developmental tasks are to accept physical maturation, develop formal operational thought, develop emotionally, and establish membership of a peer group and sexual relationships. These tasks are said to be the different domains of development, namely physical, cognitive, emotional and social (Louw & Louw, 2007:279; Wait *et al.*, 2005:150). The different domains of development cannot truly be separated, as they take place as an undifferentiated event.

Development in one domain influences development in the other domains. Pregnancy forms part of the physical domain. For an adolescent, pregnancy could also cause scholastic problems within the cognitive domain, as well as lead to social and emotional problems (Gouws, Kruger, & Burger, 2000:5). It is clear that all domains of development are connected and have an impact on each other. Therefore it is important to understand the developmental tasks of the adolescent when exploring the impact and consequences of adolescent pregnancy.

The developmental tasks of the adolescent will be discussed in the following section. These developmental tasks include physical maturation, as well as cognitive, emotional and social development.

### **2.2.1.1 Physical maturation**

The adolescent period is characterised by accelerated physical change, including a rapid height spurt, maturation of the reproductive system, the appearance of secondary physical characteristics, and the redistribution of body weight. The period of time when these changes take place is commonly referred to as puberty.

Puberty is one of the most important aspects of the adolescent developmental phase, and it is when the adolescent attains sexual maturity (Craig, 1996:407; Gouws *et al.*, 2000:9). The timing of physical growth can have an impact on whether puberty is experienced as positive or negative. Adequate information, a positive self-identity and an atmosphere of family and peer support make it easier for adolescents to accept their physical changes.

The adolescent is acutely aware of the physical changes that are taking place in her body. It is important for her to integrate these changes into her existing identity in order to form a unified whole. Body image is linked to the adolescent's self-esteem, which is largely determined by her experience of how other people perceive her (Gouws *et al.*, 2000:22-24; Louw, 1991:387-388).

Furthermore, not only is the adolescent going through physical changes due to development, but her body changes rapidly once again when she becomes pregnant. The adolescent then does not have the opportunity to develop an adaptive understanding of her physical maturation and has to deal immediately with the pregnancy (Trad, 1999:225).

When adolescents become pregnant they experience two physical processes at once. On the one hand they experience the normal, intense physical changes that occur during the adolescent life phase, and on the other hand they experience the hormonal changes triggered by the pregnancy. Pregnancy disrupts the adolescent's ordinary process of physical growth and maturation.

### **2.2.1.2 Cognitive development**

During adolescence there is an expansion in the individual's capacity and style of thought. The adolescent becomes more rational and capable of more complex thinking, and shows a tendency to evaluate before arriving at a definite conclusion. Cognitive capacities such as greater awareness, imagination, judgement and insight are broadened, which allow the adolescent to rapidly accumulate knowledge about a broad range of issues and problems (Craig, 1996:424; Gouws *et al.*, 2000:38; Specht & Craig, 1982:190).

For adolescents, the main focus of cognitive development is the development of formal operational thought. During this time, abstract thought and egocentrism develop, and the concepts of the imaginary audience and personal fable begin to emerge (Newman & Newman, 1997:646).

Adolescents are egocentric in that they think other people are just as preoccupied with them as they are with themselves. They start to think more about themselves and think others feel just like them about certain matters (Gouws *et al.*, 2000:40; Louw & Louw, 2007:306). Egocentrism gives rise to two distorted images of the relationship between self and others, namely the imaginary audience and the personal fable.

The imaginary audience is the adolescent's belief that she is the focus of everyone else's attention. She believes that every eye is focused on her when she enters a room, and that people are preoccupied with her appearance and behaviour. The imaginary audience becomes a source of the adolescent's self-consciousness, and she feels constantly and painfully on display (Craig, 1996:428; Louw & Louw, 2007:306). Because she exaggerates the extent to which others view her, she becomes much more self-conscious than she was in previous developmental stages.

For an adolescent who is pregnant, feelings of shame, embarrassment and judgment are intensified as she considers the thoughts and opinions of others towards her. According to Germain and Gitterman (1996:110), this increases the amount of stress that she feels and makes it harder for her to adapt to the changes that she is experiencing.

The second egocentric distorted image of self is the personal fable. Newman and Newman (1997:647) refer to the personal fable as a deep investment in one's own thoughts and feelings and a belief that these are unique. The adolescent is convinced that only she can suffer so intensely and that no one else has experienced such agony. The personal fable is built on the

imaginary audience, as one becomes highly conscious of how one looks and acts, and this leads to the belief that there must be something unique and special about oneself (Louw & Louw, 2007:306; Wait *et al.*, 2005:154).

The pregnant adolescent experiences intense feelings of fear, anxiety, depression and anger. To her these feelings are unique and she believes that no one can understand how she is feeling. This leads to barriers concerning the adolescent's eagerness to receive and respond to support (Evangelisti, 2000:17).

### **2.2.1.3 Emotional development**

The third developmental task of adolescence is within the domain of emotional development. The period of adolescence is often described as being an emotionally unstable time, with frequent emotional outbursts and an inclination towards intense mood swings. It seems, according to Louw and Louw (2007:319), that these descriptions can be exaggerated, as not all adolescents experience such intense emotional fluctuations. These fluctuations are affected by changes in hormones. The emotional changes experienced by adolescents are largely due to their physical, sexual and social development.

Emotional changes can also be attributed largely to cognitive and environmental factors. Adolescents tend to move from one situation to the next, more so than children and adults. Their mood swings are often related to the situations in which they find themselves, and in this way the environment has an impact on their emotions. Because of their cognitive development, adolescents' tendency to focus on themselves could contribute to increased feelings of anxiety, guilt, shame and embarrassment. The demands of sexual relationships, peer-groups, and problems at school and in social institutions are significant contributors to feelings of inadequacy, stress, and heightened emotionality (Gouws *et al.*, 2000:96; Louw & Louw, 2007:319).

It has been found that adolescents experience fewer extremely positive emotions and more negative emotions than younger children (Newman & Newman, 1997:652-653). Negative emotions that are characteristic of this developmental phase include shame, anxiety, embarrassment, guilt, shyness, anger and depression. Furthermore, feelings of self-consciousness, embarrassment, awkwardness, loneliness, nervousness and being ignored are reported by adolescents more often than by pre-adolescents (Louw & Louw, 2007:319). In

addition, adolescent girls tend to experience an increase in feelings of anger, depression, shame and guilt (Louw & Louw, 2007:319; Newman & Newman, 1997:653).

The negative emotions that the adolescent experiences regularly during this phase become intensified when she is pregnant. This is due to increased hormonal changes, as well as incorporation of the negative emotions related to the pregnancy.

#### **2.2.1.4 Social development**

The final developmental task of adolescence is related to social development of which peer group and parental relationships are a specific focus. In general, the adolescent starts to form closer bonds with the peer group and tries to establish more individuality from her parents.

According to Gouws *et al.* (2000:73), adolescents start to show distinct signs of independence from their parents during this stage of life. Greater intimacy is experienced with friends than with parents. Nevertheless, adolescents still recognise that they need their parents for support, particularly emotional support. A lack of parental interest and support may have negative effects on the adolescent's schoolwork, self-esteem, and social adjustment, giving rise to problematic behaviour. The importance of a relationship with parents is not discarded by adolescents, even though the relationship is typically characterised by conflict and stress during this time.

During this life stage adolescents start to spend more time away from their home and parents, and being part of a peer group is of great importance. The significance of peer relations are sharpened due to heightened emotional intensity and a new sensitivity to peer approval. For adolescents it becomes very important to form bonds with their peers, and friendships become an increasingly important source of social support (Newman & Newman, 1997:658; Wait *et al.*, 2005:156).

Peer relationships are essential to the adolescent's development of social skills, and membership of a peer group is very important. Adolescents learn from their peers what behaviour is socially acceptable and what behaviour will be rewarded. Peer friendships provide an opportunity for emotional intimacy, support and understanding, as well as companionship and fun. In addition, adolescents look for peer group membership that will strengthen their sense of self-esteem by providing a clear definition of who they are.

These peer group friendships are based on a variety of aspects such as athletic ability, special talents, social class, scholastic achievement, religious or ethnic group affiliation, or involvement in deviant behaviour. Adolescents become part of a group with which they have, or wish to have, something in common (Wait *et al.*, 2005:156-157).

When an adolescent becomes pregnant, she no longer conforms or complies with the expectations of the peer group. The characteristics of the peer group that were held in common become jeopardised by the realisation that one of the members is an expectant mother. Pregnant adolescents consequently experience noticeable isolation from their peers (Wait *et al.*, 2005:160; Wiemann, Rickert, Berenson & Volk, 2005:352.e5).

Furthermore, the pregnant adolescent also relies heavily on her parents for financial support, and for making crucial decisions regarding the pregnancy. The adolescent and her parents once again enter into a dependent relationship, almost as if developmental regression has occurred (Trad, 1999:227). The pregnancy results in the adolescent having to adjust to a shift in peer and parental relationships.

### **2.2.2 Pregnancy as a developmental task**

As has already been established, developmental tasks are a set of life skills and abilities that function together in an individual. From conception to death, the human body and its organs change according to an orderly pattern. Developmental tasks define what healthy and normal development is at each stage in a particular society. Developmental tasks form a sequence; success in learning the tasks of one stage improves the individual's readiness for the next stage (Louw, 1991:6).

Pregnancy and parenthood are predominantly developmental tasks for those in the young adulthood stage. According to Wait *et al.* (2005:160), the decision to become a parent usually takes place within a marriage, and many couples make the decision to have a child once they are financially stable. Having a child brings a period of stress to the marriage, even if the relationship is one of love and companionship.

The initial adjustment to pregnancy and parenthood may be difficult, particularly if the expecting parents did not anticipate the pregnancy or the demands it would impose on their resources and relationship. Married couples in a secure relationship experience stress as they plan for the impending birth of their child. For the adolescent, who is less likely to be in a

stable relationship, and who will be facing likely conflict in the home and isolation from her peers, the adjustment and stress caused by pregnancy are manifold (Specht & Craig, 1982:242).

When the early adolescent falls pregnant she deviates from the expected path of development. An adolescent needs to make considerable physical, cognitive, emotional and social adjustments when she becomes pregnant. The implications of pregnancy are multiple, largely due to the fact that adolescents are still emotionally and socially immature.

Furthermore, adolescent pregnancy may cause a syndrome of failure in which the adolescent feels as if she has failed to remain at school, failed to establish a vocation and become self-supporting, and failed to meet the norms and expectations of her peers (Louw & Louw, 2007:295). In summary, when the early adolescent falls pregnant the natural development of a young woman to adulthood is prematurely halted as she becomes a mother whilst still a child herself (Holgate *et al.*, 2007:2).

### **2.3 ADOLESCENT SEXUALITY**

During adolescence, peer relationships are modified by new sexual interests and behaviour. The motivation for an increased interest in sexual relationships is derived from social expectations, sexual maturation and the related desire for romance and physical intimacy. Sexual relationships during early adolescence provide the initial context for sexual activity (Newman & Newman, 1997:661; Wait *et al.*, 2005:158). It is an important developmental task for adolescents to learn how to satisfy their sexual needs in a socially acceptable way so that it contributes to the development of their identity (Louw & Louw, 2007:288).

Louw and Louw (2007:290-291) claim that there is widespread evidence that adolescents are more sexually active, and also at a younger age, than previously. The reasons for sexual activity at a young age are early sexual maturation, peer-group pressure, changed values and attitudes, and the mass media.

In addition to early physical development, adolescents often become sexually active as a result of peer-group pressure and attitudes. Engaging in sexual behaviour allows adolescents to feel accepted by their peers. One of the greatest predictors of whether an adolescent engages in sexual activity is whether their peers are sexually active. When adolescents believe

that their peers are engaging in intercourse, they are more likely to do so themselves (Howes & Green, 1997:11; Kirby, 2002:480; Louw & Louw, 2007:290).

Further contributors to adolescents' early sexual activity are changing values, attitudes and sexual content in the mass media. The media communicate to adolescents that intercourse is romantic and exciting, and premarital intimacy is publicised. Adolescents' attitudes are malleable and the media gives adolescents a glimpse into the world of adult intimacy, whilst destroying the morals and boundaries that are expected around such behaviour (Hudson & Ineichen, 1991:18).

In the following section the risk factors for adolescents falling pregnant will be discussed. These risk factors range from individual and family levels to institutional and socio-economic issues. In addition, adolescents' use of contraceptives will be explored.

### **2.3.1 Adolescents at risk of becoming pregnant**

Sexual activity and pregnancy cut across all perceived boundaries, and all sexually active adolescents are at risk of becoming pregnant. It is not the case that only one group of adolescents, belonging to a specific cultural group who live in low-income communities, or only adolescents who do not excel at school, are those who are at risk of becoming pregnant. Nearly all youth experience pressure, either internally or externally, to have intercourse, and are at risk of becoming pregnant (Evangelisti, 2000:14; Kirby, 2002:475).

#### **2.3.1.1 Individual experiences and characteristics**

There are, however, some characteristics which make adolescents more likely to fall pregnant during this developmental stage. Holgate *et al.* (2007:2) state that unmarried adolescents seldom become pregnant for sound or emotionally healthy reasons. Low self-esteem plays an important role in some adolescents falling pregnant. These girls tend to find school and school work uninspiring. A pattern of worthlessness develops and they become passive receivers of almost anything easy that is offered to them outside of school. Looking to the future and the possible consequences of an enjoyable activity is a difficult concept (Hudson & Ineichen, 1991:41).

**(i) Academic aspirations**

The educational level and aspirations of the adolescent play a determining factor in early pregnancies. The relationship that adolescents have with school can influence their sexual behaviour. When adolescents feel a sense of attachment to the school and attain a sense of achievement from school work, they are less likely to fall pregnant. High aspirations, academic achievement and school attachment offer the adolescent incentives to avoid pregnancy. The opposite is also true, with the adolescent who strongly dislikes schooling, finds it laborious and has low aspirations of furthering her education, she is more likely to become pregnant (Holgate *et al.*, 2007:80; Panday, Makiwane, Ranchod & Letsoalo, 2009:21).

**(ii) Emotional vulnerability**

In addition to academic aspirations, vulnerable and exceptionally emotional adolescents are prone to engage in irresponsible sexual behaviour. When physical affection is absent in the home it can foster insecurity, and the adolescent in this situation can be vulnerable to sexual advances in an attempt to meet her needs for affection and security (Evangelisti, 2000:14). Hudson and Ineichen (1991:40) support this finding and claim that adolescent girls are not put off by the disharmony in their family, and that some adolescents set out to do better for themselves. They hope that by falling pregnant they will find happiness, and affection with their child and possibly with the child's father.

Furthermore, sexually active adolescents have often experienced physical, sexual and/or emotional abuse, and this can place them at greater risk of an early pregnancy (Evangelisti, 2000:14). In a study conducted by Francisco *et al.* (2008:237) it was found that there is a strong correlation between childhood sexual abuse and adolescent pregnancy. The study indicates that a large proportion of young mothers had reported a history of sexual or physical abuse.

There are a number of reasons that explain the link between prior abuse and increased risk of adolescent pregnancy. Adolescents with a history of childhood abuse have experienced a violation of their most intimate boundaries. This could lead to a sense of powerlessness in relationships and may influence their ability to negotiate contraceptive use and sexual boundaries (McCullough & Scherman, 1991:810; Panday *et al.*, 2009:34).

Traumatised adolescents also often turn to substance abuse, and even to prostitution or running away from home. This increases their risk of an early unplanned pregnancy (Panday *et al.*, 2009:36). The earlier an individual enters into sexual activity, for example during adolescence, the more likely the act is part of a profile of high-risk behaviour, including alcohol use, drug use and delinquent activity (Newman & Newman, 1997:663).

### **2.3.1.2 Contributing family factors**

Many facets of family life exert an influence on adolescents' sexual behaviour and place her at risk of becoming pregnant. Contributing factors include the family's socio-economic status, the family type, parental values and role modelling, parental style, monitoring and support, and parent-child communication (Panday *et al.*, 2009:34).

Family structural characteristics seem to play a vital role in adolescent sexual behaviour. Growing up in a single-parent household or without any parents places the adolescent at a higher risk of early pregnancy (Hockaday, Jasper Crase, Shelley & Stockdale, 2000:434). Corcoran (1999:610-611) offers two possible explanations for this. The first is that the adolescent in the single-parent household has more responsibility for younger children and therefore becomes socialised into a maternal role. The second possible reason is that adolescents need a father for guidance, discipline and control, and this lack of control places them at risk of engaging in promiscuous behaviour.

In addition, parental control, support and monitoring can have a positive effect on the adolescent's sexual behaviour. Parents who set and enforce rules, monitor behaviour and provide a supportive, nurturing environment can delay early sexual behaviour and limit the number of partners that the adolescent has (Corcoran, 1999:611; Kirby, 2002:479).

Family values and role-modelling also have an extensive impact on the adolescent's behaviour and values. Consistent values about sexuality help the adolescent to make decisions concerning sexual behaviour. Parents who are clear about their values concerning adolescent intercourse, delaying intercourse, or using contraceptives and protection, play a role in decreasing the risk of unintended pregnancies (Evangelisti, 2000:22; Panday *et al.*, 2009:35). However, sex education in the adolescent's home is rare, as many parents believe that educating their child will make her promiscuous, and hence discussions of sexual matters are taboo (Preston-Whyte, 1991:35).

Furthermore, family members serve as role-models for the adolescent. If parents or family members engage in sexual behaviour outside of marriage, have a child outside of marriage, or are cohabiting with a romantic or sexual partner, the adolescent is more likely to initiate sexual activity and experience an unplanned pregnancy (Hallman, 2004:24; Panday *et al.*, 2009:35).

In the light of the above it is clear that the family can have a significant impact on the sexual behaviour and attitude of the adolescent. Adolescents start to show independence from their parents, which was previously established as a developmental task of the adolescent's social development. However, parents and family members can still have an impact on the adolescent's sexual behaviour, primarily by teaching healthy values, enforcing constructive discipline and role-modelling healthy sexual relationships.

### **2.3.1.3 Institutional factors**

Further factors that place adolescents at risk of falling pregnant are institutional factors such as the services provided and the adolescents' knowledge of the services. Health care services, for example, which offer family planning, contraceptive and safe sex advice and material, are often inaccessible or not utilised by adolescents. Adolescents often lack knowledge about the services that are available (McCullough & Scherman, 1991:813). Poor awareness of the available services and support, the cost of the services and the operating hours of the places providing services act as deterrents for adolescents seeking help or advice.

The attitude of the staff at public health facilities serves as a significant barrier to adolescents trying to access contraceptives and advice on safe sex. For many, contraceptive use is associated with fear, shame and poor morality, rather than with responsible and healthy sexuality. Adolescents accessing contraceptives often choose not to return to health care facilities because of the judgement and scolding of the health care personnel (Panday *et al.*, 2009:37). Research by Farber (1991:703) highlighted the reprimanding and insensitive nature of the services rendered at the clinics where adolescents went for pregnancy tests and where they were unexpectedly shown horrific videos on abortion. Failure to utilise the opportunity of adolescents coming to obtain health care services to promote healthy sexual behaviour and to educate them about contraceptives represents a missed opportunity to prevent adolescent pregnancy, as well as the spread of sexually transmitted infections.

#### **2.3.1.4 Socio-economic status**

The socio-economic status of the adolescent and her family plays a significant role in adolescent pregnancy. A study conducted in South Africa found that economic disadvantage significantly increases the likelihood of unsafe sexual behaviours and experiences (Hallman, 2004:2). Adolescents who live in poorer communities with fewer advantages and opportunities, poor cohesion and more disorganisation are more likely to engage in sexual behaviour at an earlier age and are hence more likely to fall pregnant.

Socio-economic factors such as the educational level and occupation of the parents are key determining factors that place adolescents at risk of premature pregnancy (Corcoran, 1999:606-607). Household education has mainly protective effects on adolescents, and its influence is strong in reducing the adolescent's experience of forced or unprotected intercourse.

Residing in an area of poverty and low education reduces the adolescent's chance of accessing information about pregnancy and safe sexual behaviour, particularly media-based family planning information. Furthermore, economically disadvantaged communities are typically densely populated, informally structured, lack livelihood opportunities and recreational activities, and have high levels of crime and abuse. These factors contribute to the likelihood of the female adolescent engaging in risky sexual behaviour and falling pregnant (Hallman, 2004:25; Howes & Green, 1997:9).

#### **2.3.2 Adolescents' use of contraceptives**

Another factor that places adolescents at risk of having an unplanned pregnancy is the poor use of contraceptives. In a study conducted in South Africa by the Kaiser Family Foundation and the South African Broadcasting Corporation (2007:28), it was found that two thirds of young women who reported being pregnant identified failure to use contraceptives as their main reason for the pregnancy. This far outweighed other potential reasons for falling pregnant.

There are a variety of factors that influence an adolescent's use of contraceptives. These include religious beliefs, family attitudes and behavioural patterns, and peer norms (Newman & Newman, 1997:699). These factors, combined with confusion, ignorance and embarrassment about sexual matters and contraceptives, condemn most sexually active

adolescents to possible consequences, such as pregnancy, which could dramatically change their lives (Hudson & Ineichen, 1991:32; Preston-Whyte, 1991:21).

Although a lack of education and information is often cited as the main reason for the non-use of contraceptives, studies have shown that most young people are well informed about modern methods of contraception (Panday *et al.*, 2009:30). However, many adolescents are unaware of the connection between birth control, menstruation, intercourse, fertility and conception. Numerous adolescents believe they are too young to fall pregnant; that they have intercourse too irregularly to become pregnant; that they can fall pregnant only during menstruation; or that they will only fall pregnant when they want to have a baby (Louw & Louw, 2007:294).

In addition, many adolescents do not admit to themselves that they are sexually active. They experience feelings of guilt concerning their sexual activity and regard using contraceptives as a concrete reminder of their transgression (Evangelisti, 2000:15; Wait *et al.*, 2005:159). Consequently, approximately one third of adolescents use no contraceptives the first time they have intercourse, and delay the use of contraceptives until several months after they become sexually active (Andersen & Taylor, 2006:353).

Another main reason for the non-use of contraceptives is that sexual intercourse is not planned and that it “just happens”. Adolescents hence do not have contraceptives available at the time or choose not to make use of them for fear of taking away the romance and spontaneity of the moment. Hallman (2004:17) reports that, in some instances where adolescents do have contraceptives and try to negotiate the use of them, the response from their partner is violence. Such encounters discourage the adolescent from negotiating contraceptive use in the future and increase her chances of falling pregnant.

Studies have shown that when there is a positive perception about condom or contraceptive use among peers, adolescents are more likely to use contraceptives (Panday *et al.*, 2009:36). Sex education programmes in schools are also effective methods of spreading information about contraceptives and teaching adolescents how to use them correctly (Hudson & Ineichen, 1991:28; Panday *et al.*, 2009:44). Research has shown that adolescents who attend sex education programmes are more likely to make use of contraceptives (Craig, 1996:423).

In the light of the above it can be assumed that there are many factors that hinder adolescents from accessing contraceptives. However, these barriers could easily be overcome by parents teaching values, effective peer education programmes and institutional interventions.

### **2.3.3 Multiple contributing factors**

Based on the above findings it is clear that there are multiple factors that contribute to the early adolescent's risk of becoming pregnant. As the number of risk factors increase, the probability of engaging in unprotected intercourse and becoming pregnant increases. The varying spheres of influence on health behaviour are comprised of the individual, interpersonal, institutional, structural and public policy spheres (Hockaday *et al.*, 2000:423; Panday *et al.*, 2009:29). Individual factors include sexual behaviour, contraceptive use, substance use and childhood abuse, as well as knowledge, attitudes, beliefs and personality traits. The interpersonal level considers groups such as the family, friends, peers and the role that they play in social support, identity formation and role definition. The institutional level incorporates schools and health care services, whilst the structural level encompasses the cultural context of the society, the residential area and poverty. Public policy factors that influence adolescent health behaviour include the local and national laws that regulate family planning services and access to education (Panday & Mabunda, 2009:18).

An example of how the varying spheres of influence impact on the adolescent's health behaviour can be applied to an adolescent who delays using contraceptives. For example, on the individual level she may have limited knowledge about contraceptives and how to use them. At the interpersonal level her partner may refuse to use contraceptives, and her peers may not believe that it is important to use contraceptives. At the institutional level, access to contraceptives may be difficult at clinics because of the judgemental attitude of the staff. At a structural level, the culture might not condone the use of contraceptives, coming from a poor community her only opportunity for upward mobility could be through a relationship. At the policy level, lack of policy on youth-responsive services may affect her ability to access contraceptives (Panday *et al.*, 2009:29).

All these factors contribute to the poor use of contraceptives by adolescents. Hence it is more effective to look at all the factors than to try to intervene on one level. This is a principle of the ecological perspective, in which all the levels of society must be considered when

working with an individual (Germain & Gitterman, 1996:8). The ecological perspective will be discussed in more detail in chapter three.

## **2.4 IMPACT AND CONSEQUENCES OF ADOLESCENT PREGNANCY**

The issue of adolescent pregnancy is a problem for the individual as well as for society at large. Adolescent pregnancy has far-reaching effects on the education, relationships and emotional development of the adolescent, as well as an impact on society, as a cycle of disadvantage is perpetuated (Holgate *et al.*, 2007:1; Hudson & Ineichen, 1991:158).

### **2.4.1 Emotional response to pregnancy**

When the adolescent finds out that she is pregnant she experiences a range of emotions. Some of these emotions are lasting, whilst some of them come and go as the pregnancy progresses. Numerous authors (Philkill & Walsh, 2002:530-56; Swart, 1993:25-27; Trad, 1999:225-230) have identified emotions that many adolescents experience during the course, and particularly at the discovery, of their pregnancy. Commonly experienced emotional reactions include anxiety, fear, denial, anger, guilt, worthlessness, depression and detachment.

For most adolescents finding out that they are pregnant is a crisis, as they have not planned for the pregnancy and it represents a threat to their emotional and physical well-being. It is natural, then, that the adolescent experiences strong feelings of anxiety during her pregnancy. She may experience anxiety as a result of the decisions she needs to make, as well as the pressures that others are exerting on her. The adolescent often experiences anxiety and worry about disclosing the pregnancy to her family and close relations (Hudson & Ineichen, 1991:74-79).

Coupled with this anxiety is a feeling of fear. The adolescent often does not realise her fear and does not admit to experiencing it. Feelings of fear are related to factors such as how she will support the child, how a baby will change her life, how her boyfriend will react to the news, as well as fear that the truth of her sexual activities will be revealed. Further, the fear of physical pain can overwhelm the expectant mother and immobilise her in seeking antenatal services (Hudson & Ineichen, 1991:74-79; Motjelebe, 2009:10).

Denial often follows fear and anxiety as the adolescent battles to believe that she is pregnant. Research (Farber, 1991:701-702) indicates that there can be a long period of denial before the adolescent acknowledges her pregnancy. Although adolescents often strongly suspect that their symptoms indicate a possible pregnancy, they delay receiving a diagnosis until they can no longer deny the possibility of a pregnancy.

Furthermore, feelings of anger can crowd the adolescent's thought process and this makes it difficult for her to think rationally about the decisions that need to be made. The adolescent may feel angry at herself, at her boyfriend or even her parents. Her feelings of anger are related to failed expectations of herself as well as of her parents and her future career (Motjelebe, 2009:10).

The adolescent may also experience feelings of guilt. Guilt is experienced because the adolescent has been caught engaging in risky behaviour that she knows is wrong in terms of societal and family values. She experiences guilt for not using birth control, and for possibly lying about her sexual behaviour in the first place. Further feelings of guilt arise from the realisation that she is not in the position to care for her child and that her parents will have to assist her in order to be able to support the child (Evangelisti, 2000:18).

In addition, Philkill and Walsh (2002:56) suggest that worthlessness can be felt strongly by the pregnant adolescent. She may feel worthless and like a failure due to the pregnancy. Feelings of failure are exacerbated as she considers how she has failed the expectations her family, friends and boyfriend. Feelings of helplessness begin to permeate all aspects of her life as she becomes overwhelmed by her emotions, pressures and responsibilities. These feelings of worthlessness and failure all contribute to a loss of self-esteem for the adolescent when she is pregnant.

The adolescent is also prone to depression during this time. When the adolescent accepts her pregnancy she accepts the reality and responsibility that come with it. It is easy for her to become overwhelmed with feelings of hopelessness and despair, and to become preoccupied with negative emotions. During this time the adolescent is ambivalent about how to proceed with the pregnancy and struggles to think positively (Swart, 1993:26).

As a result of these accumulating negative emotions and responses, the adolescent may become detached. Detachment from a situation is characterised by a lack of emotional and intellectual involvement (Philkill & Walsh, 2002:55). The adolescent may perceive her

situation as so threatening and desperate that she shuts off her feelings and refuses to think about the situation. This affects the adolescent's ability to make an informed decision about keeping the baby or choosing an abortion.

When the adolescent falls pregnant she is faced with a situation that cannot be ignored. She is forced to make a decision about the pregnancy amidst intense emotions and difficult reactions from loved ones. The pregnant adolescent struggles to plan for the future, as it provokes anxiety, whilst the reality of the present cannot be avoided (Evangelisti, 2000:18; Hudson & Ineichen, 1991:159).

#### **2.4.2 Impact on the family**

When the adolescent finds out that she is pregnant she has the difficult task of disclosing her pregnancy to her family. A study conducted by Wiemann *et al.* (2005:352.e3-e5) indicates that adolescents are afraid to tell their parents about their pregnancy because they fear that their parents will think they have made a big mistake by falling pregnant and want nothing to do with them.

For a pregnant adolescent the most significant person in her life is her mother, and it is therefore natural that she is most concerned about how her mother will react to the news of her pregnancy. Despite her fears of telling her mother, the mother copes well with the pregnancy in most cases and helps the adolescent to make decisions once she has dealt with the initial shock of the news (Hudson & Ineichen, 1991:74-75). Fathers, on the other hand, are usually less accepting of their daughter's pregnancy and are more upset than other family members. The initial anger usually wears off, but occasionally the relationship between the father and daughter is severed as the father cannot accept the pregnancy and does not talk with his daughter.

Most parents, regardless of race or ethnic background, are disappointed by the unplanned pregnancy of their adolescent daughter. Parents experience anger and embarrassment at the news of the pregnancy (Motjelebe, 2009:11). They are set back by the news that their daughter is sexually active, and the fact that she is pregnant is an even greater bewilderment. The reality also sets in for the parents that the new child will be their responsibility to care for, and in particular to support financially.

However, once the initial shock and disappointment have been resolved, most families find a way to cope by dealing with the problem rationally and sensitively. The family learns to accept and even welcome the birth of the unplanned child, but this reaction is an adjustment, not a preference (Farber, 1991:703; Hudson & Ineichen, 1991:74).

### **2.4.3 Education**

The Western Cape Education Department states that it is imperative that schools ensure that “...the rights and development of female learners are not curtailed and that special measures are taken in respect of pregnant schoolgirls” (Department of Education, 2003:1). However, despite education policies that encourage pregnant adolescents to continue their education or return after the birth of their child, approximately only a third re-enter the schooling system (Panday *et al.*, 2009:27).

The literature states repeatedly that the majority of pregnant adolescents leave school before completing their education and do not return. As a result they have limited opportunities for further education and successful careers (Gouws *et al.*, 2000:170; Hudson & Ineichen, 1991:158; Wait *et al.*, 2005:159). One of the first things an adolescent thinks about when she finds out that she is pregnant is the difficulty she will have to remain in school (Furstenberg, 1976:127).

Low educational abilities and a lack of ambition aside, some adolescents wish to stay in school. However, their pregnancy does not allow them to. Difficulties with morning sickness and fatigue make it challenging for the adolescent to give her school work her full attention. There may be times when she could miss school due to health problems or clinic visits. On top of this, it becomes hard for her to concentrate and to keep up with the pace of work that is required of her (Hudson & Ineichen, 1991:119).

Studies indicate that, in terms of training, education and employment opportunities, pregnant adolescents or adolescent mothers are not considered worthy of equal opportunity. The broad assumption is made that adolescents who leave school do not require further training, as they have chosen the full-time occupation of being a mother (Hudson & Ineichen, 1991:158-159). Pregnancy causes a disruption in the education and occupational outcomes and opportunities for young mothers, and this maintains and exacerbates poverty (Daniels & Nel, 2009:62; Panday *et al.*, 2009:27)

#### **2.4.4 Economic and financial impact**

Limited education and training opportunities for pregnant adolescents means that they cannot easily become economically independent. This results in dependence on others, primarily their parents, to support them. Daniels and Nel's (2009:68) study supports the fact that pregnant adolescents rely largely on their parents for economic and material support. There appears to be no long-term support from the father of the child, who seems to prefer giving sporadic material items.

In a study conducted by Trad (1999:223) it was found that pregnant adolescents and young mothers earn approximately half as much as their peers who are not adolescent mothers. It is undeniable that, in most instances, adolescent pregnancy has a negative impact on economic progress and achievement later in life. Adolescent pregnancy may not inevitably lead to poverty, but it can worsen the economic situation of the adolescent during her pregnancy and thereafter. According to Panday *et al.* (2009:27), the pregnant adolescent is more likely to rely on state welfare for a longer period than her peers as a result of her lower earning capacity.

#### **2.4.5 Social consequences**

The age old practice of sending pregnant adolescents away to live with relatives has been replaced with pregnant girls remaining in their homes. They are therefore more highly visible to their community, school and family. Increased visibility in the community also means increased stigma. Because of the relationship between pregnancy, contraceptive use, HIV and sexually transmitted infections, adolescent pregnancy is bound with morality and stigma (Howes & Green, 1997:9; Panday *et al.*, 2009:27; Wiemann *et al.*, 2005:352.e1).

Many adolescents view pregnancy as unfavourable and have a negative view of their peers who fall pregnant. Pregnant adolescents experience stigma and isolation from their peers (Holgate *et al.*, 2007:2-4). Expectant mothers become isolated from their peers, particularly when they drop out of school, and this has a significant impact on their social activities. Remaining in school leads to experiences of criticism, chastisement and ridicule from both peers and teachers (Wiemann *et al.*, 2005:352.e4-e5).

Another complicated aspect of adolescent pregnancy is the pressure to marry or stay in a relationship with the father of the baby. In many cases the girl is abandoned by the father of the child; however, if he chooses to be involved or resides close by he is also personally and

emotionally involved in the situation. Should the couple decide to marry, marriage satisfaction is generally lower than in planned adult marriages, and divorce rates are considerably high (Louw & Louw 2007:296; Panday *et al.*, 2009:27). The freedom for the adolescent to become involved in romantic relationships is significantly reduced due to her changing physical and emotional state, as well as her peers' perceptions of her pregnancy.

The pregnant adolescent can no longer live the carefree life associated with adolescence. Her rapidly changing physical state and weight gain make it difficult for her to engage in social activities with her peers. Along with her altering physical condition, she also has new responsibilities to herself and to her growing foetus. This further limits her relationships with her peers and the possibility of romantic relationships, and leads to increased social isolation (Trad, 1999:225-228).

## **2.5 CONCLUSION**

This chapter gave an overview of the early adolescent life phase by exploring the developmental tasks that adolescents go through at this time. The chapter then described adolescent sexuality and what behaviour puts them at risk for having an unplanned pregnancy. Finally, the chapter looked at the impact and consequences of an unplanned pregnancy at multiple levels.

From the above it can be deduced that pregnancy is a time of dramatic change and transition. For the adolescent, this transition is magnified as she has to cope with her developmental and emotional changes. Adolescent pregnancy not only burdens the adolescent and her family, but its effects are widespread, as the community, society and the state feel the repercussions of the adolescent's behaviour.

Multiple factors play a role in the risk factors for adolescent pregnancy, and naturally the pregnancy has an effect at multiple levels. In understanding the issue of adolescent pregnancy and developing ways in which to support adolescents during their pregnancy it is important to have a thorough understanding of all the spheres of influence in the adolescent's life.

These spheres of influence will be explored in more detail in the following chapter through a discussion of the ecological perspective.

## **CHAPTER 3**

### **THE ECOLOGICAL PERSPECTIVE**

#### **3.1 INTRODUCTION**

There are a variety of factors that contribute to the occurrence of adolescent pregnancy, and there are manifold consequences for the individual, her family and the community. Adolescent pregnancy is not an isolated event within the individual, but is the outcome of multiple interactions and inputs from the environment. The adolescent's behaviour hence occurs within a context of relational and environmental factors.

The interactions and relationships that impact on adolescent behaviour, coping ability and support must be understood in order to comprehend and address the adolescent's support needs during her pregnancy. The systems and ecological perspectives provide a framework for understanding the numerous levels of influence and support in the adolescent's life (Goldenberg & Goldenberg, 2002:24-25; Trad, 1999:222-224).

The systems perspective focuses on individuals as part of systems that interact with each other in complex ways. Systems are interrelated and interconnected parts that form an identifiable whole. Systems theory provides a way to understand how individuals interact with other people in their family, the community and in the wider social environment (Payne, 2005:142).

Building on the systems perspective is the ecological perspective. This perspective considers the various ways in which a client system adapts to a changing environment in order to cope and survive within a particular economic and political context. The perspective emphasises the person within their environment and the importance of this interdependence (Sheafor *et al.*, 2000:91).

This chapter will address the second objective of the study, which is to discuss the systems and ecological perspectives and explore the relevance of the theories to adolescent pregnancy. In order to meet this aim the chapter will first give an overview of general systems theory. Then the chapter will explore the primary authors who contributed to the ecological perspective. The theory will be applied to the issue of unplanned adolescent pregnancy and will touch on how the ecological perspective guides the work of social workers.

## **3.2 GENERAL SYSTEMS THEORY**

General systems theory explores the interrelated nature of systems and how intervention in one part may affect the whole. Complex living systems can be organised in hierarchical levels. On each of these levels the systems consist of subsystems, and form part of a suprasystem. These multiple levels of the system are related and interact with one another. Interactions between the levels of a system and the changes in them affect the system as a whole, thus change in one part of the system causes change in all parts of the system (Oak, 2009:164; Visser, 2007:22-25).

Systems theory adopts concepts such as causality, homeostasis, feedback and open or closed systems to describe the interchange between the different systems and how balance can be maintained. These concepts will be discussed below and provide a foundation for understanding the ecological perspective.

### **3.2.1 Causality**

The systems and ecological perspectives provide a new outlook on problems experienced by the individual or other systems, by adopting the approach of circular causality as opposed to linear causality. In linear causality, events take place in a sequence in which one object has an impact on another object, hence A causes B, which causes C to occur. This manner of thinking places the responsibility of a problem on one person and views the individual as causing the problematic behaviour (Preston-Shoot & Agass, 1990:50; Worden, 1994:5-6). For example, the adolescent's pregnancy causes financial difficulties in the household, which causes tension in the family relationships. In this scenario, the adolescent is blamed for the family's problems. This generally results in interventions focussing primarily on the problematic individual and not with the system as a whole.

Circular causality, on the other hand, places individual behaviour within a network of circular feedback loops. It emphasises that events do not move in one direction, but that they instead become part of a casual chain, each influencing and being influenced by other events. Circular causality focuses on the reciprocity of behaviour between people, hence A affects B and C, as much as B and C affect A. This causality eliminates the issue of blame falling on one person. Rather, each family member is mutually and reciprocally shaping the behaviour of others, and what emerges are patterns that are either functional or dysfunctional (Goldenberg & Goldenberg, 2002:25; Worden, 1994:6).

In this way, adolescent pregnancy is viewed in the light of family, peer and environmental interactions. The adolescent's behaviour has as much to do with the interactional context in which it occurs as with the inner mental processes or emotional problems of all who are involved in the interactions.

### **3.2.2 Maintaining homeostasis**

According to the systems perspective, systems tend to seek homeostasis or equilibrium. Homeostasis can be used to describe a system that is in constant interchange with its environment, which results in a dynamic balance, not a static equilibrium. For systems to achieve this stable state they must constantly be changing in order to maintain stability in a constantly changing environment (Chetkow-Yanoov, 1997:40).

Homeostasis is achieved by means of feedback information. Feedback can be understood as a method of controlling a system by reintroducing into it the results of its past behaviours. Information about how a system is functioning is fed back from the output to the input. Feedback is thus a circular mechanism that reinserts information into a system in order to alter, correct or control the system's functioning (Goldenberg & Goldenberg, 2002:27). Feedback increases the system's awareness of its functioning, and allows the system to adapt if it is not functioning ideally.

There are two types of feedback loops, namely negative and positive feedback. Feedback is considered negative when it results in restoring the balance of the system. If the system is receiving information as a result of deviant behaviour, the system will try to reintroduce self-correcting information in order to maintain homeostasis and return to a steady state (Visser, 2007:26). For example, if a parent has a discussion with his or her daughter about sexual values and safe sexual practices, and the result is that the daughter makes use of contraceptives and engages in less risky sexual behaviour, the feedback will be regarded as negative.

Positive feedback is when the feedback facilitates change in a system in the same direction as it is already taking place. Positive feedback causes further change by augmenting or accelerating the initial deviation. Such feedback may become threatening and force the system beyond its limits to the point of chaos (Goldenberg & Goldenberg, 2002:28). For example, if the parent's discussion with the adolescent concerning safe sexual behaviour results in the

adolescent rebelling and engaging in even more risky sexual behaviour, the feedback in this instance is regarded as positive because it causes a further escalation in rebellious behaviour.

### **3.2.3 Open and closed systems**

Maintaining homeostasis through feedback means that systems are constantly receiving new information from the environment. All systems are selective in their availability to new information and their willingness to incorporate such information. Systems are said to be open or closed depending on the extent to which they are organised to interact with the outside environment (Goldenberg & Goldenberg, 2002:30).

Open systems are open to, and interact with, their environment. Open systems exchange materials, energies or information with the environment. They are characterised by continuous activity, where their parts act purposefully and their structures are adjusted to achieve goals. The open system has permeable boundaries, which permit input and output exchanges with the environment (Dale, Smith, Norlin & Chess, 2006:31; Preston-Shoot & Agass, 1990:46). Openness is important, as it allows for growth and change within the system; the less interaction there is between systems, the greater the degree of deterioration and disintegration of the system as a whole.

Closed systems have impermeable boundaries and are not open to interactions with the environment. The closed system does not exchange energy and resources with the environment or with other systems. Such systems develop rigid and unchanging patterns of behaviour, which limit their exchanges with other systems. Closed systems tend toward entropy, a gradual regression, as they become disorganised as a result of insufficient input. Systems are rarely completely isolated from the outside world, particularly systems involving human beings. Since most human beings interact within smaller systems and with larger systems in their environment, a completely closed system is unlikely. However, a relatively closed system is limited in the information and resources it exchanges with the environment, and this can have a negative impact on the individual's and family's homeostasis (Chetkoy-Yanoov, 1997:40; Goldenberg & Goldenberg, 2002:31).

The adolescent needs to strike a balance between openness and closeness within the context of the systems around her. In doing this she is able to have discipline and structure, as well as healthy opportunities for exchange with the environment.

In conclusion, causality, homeostasis, and open and closed systems all put emphasis on the relationships and behaviour within a system. Within this system all the levels interact and contribute to the behaviour of the individual and the system as a whole. These concepts form a foundation for understanding the ecological perspective.

### **3.3 ECOLOGICAL PERSPECTIVE**

The systems perspective provides insight for social workers to assess their clients within the context of their environment. More specifically, it highlights that there are multiple factors that lead to maladaptive behaviour or family problems. The ecological perspective developed from the systems perspective and gives further insight into how the person and environment interact with each other (Payne, 2005:142).

The ecological perspective links life to its natural habitat, namely its environment. Ecology focuses on the relationship between organisms and their biological and physical environments (Dale *et al.*, 2006:35). There is a strong focus on the interdependence and interrelatedness that characterise everything that shares the same habitat. The ecological perspective offers a means to examine the effects of the environment on social organisation and social change.

In addition, the ecological perspective emphasises that people shape their environment and are shaped by it. The problems that are experienced in social functioning are the result of people-environment exchanges, rather than being the result of only personality characteristics or environmental factors (Sheafor *et al.*, 2000:92)

There are several authors who have contributed to the development of the concept of the ecological perspective, including Lewin, Bronfenbrenner, and Germain and Gitterman. Their key contributions and their main concepts of the ecological perspective will be discussed below.

### **3.3.1 LEWIN'S FIELD THEORY**

The field theory was one of the earliest psychological contributions to the belief that human behaviour can only be usefully studied by viewing the individual in an environmental context. Lewin believed that a theory could be developed that would apply to the study of the community, organisation, group, family, as well as the individual (Dale *et al.*, 2006:192).

Field theory highlights the importance of the interplay between the person and the environment. This can be expressed symbolically by Lewin's famous equation  $B = f(PE)$ , meaning that behaviour is the function of the person and the environment. There are many forces that shape behaviour and they must all be considered when working with people (Bronfenbrenner, 1979:16; Lewin, 1952:25).

According to Lewin (1952:25-31), field theory in physics states that, as a particle travels through space, it is influenced by many vectors, or forces, and their interactions. Attempting to describe this behaviour accurately without knowing the dynamics of all the vectors would fail. Similarly, humans travel through a life space and have many experiences. Their behaviour is influenced by many vectors, just as the particle passing through space is; in addition, humans are also influenced by conscious experiences and perceptions (Scileppi, Teed & Torres, 2000:28). Hence, in order to understand human behaviour one must consider the internal and external factors that influence the individual.

Field theory highlights that, in order to change behaviour, it is necessary to change the abilities of the individual and the characteristics of the environment. When all the factors in a system line up with each other, a synergy is said to result. When such a situation is created, the effects of all the factors working together is greater than the sum of each force working separately. This, according to Visser (2007:23), is a central concept in systems theory, which holds that the whole system is greater than the sum of its parts. The approach of field theory aims to ensure that all the vectors in the individual's life are moving towards the same goal, as this creates synergy and a good person-environment fit (Scileppi *et al.*, 2000:28).

### **3.3.2 BRONFENBRENNER'S ECOLOGICAL THEORY OF HUMAN DEVELOPMENT**

Bronfenbrenner's work agrees with the principles of Lewin's work, which emphasises that a person's behaviour must be considered within the context of the environment. Bronfenbrenner used Lewin's concepts to present a model of development within the context of multiple systems (Higham, 2006:159). Bronfenbrenner noted that theories on human development treat the person as an individual entity without sufficient concern for the context in which the human develops. Instead, he developed a perspective that views the developing person within the environment, with emphasis on the evolving interaction between the two (Scileppi *et al.*, 2000:45).

According to Bronfenbrenner (1979:9) the ecological environment is visualised as extending beyond the immediate situation that directly affects the developing person. The connections between other persons present in the setting, the nature of these links and their influence on the developing person are all of equal importance. Considering all these interrelated systems, development can be understood as the person's evolving conception of the environment, their relation to it, as well as the person's growing capacity to discover, sustain or alter the environments' properties. This reflects the influence of Lewin's emphasis of the close interconnections between the structure of the person and of the situation (Ungar, 2002:482).

Bronfenbrenner's ecological environment is composed of four interrelated systems, namely the micro-, meso-, exo- and macrosystems. The principle of interconnectedness applies to the systems, as well as to the linkages between the systems, both in which the developing person participates and in which events occur that affect the person's immediate environment (Bronfenbrenner, 1979:7). These interrelated systems will be discussed below.

#### **3.3.2.1 Microsystem**

The microsystem is the smallest and most direct system that the person experiences. These are objects to which the person responds or people with whom the person interacts on a face-to-face basis. Other persons in the setting, the nature of these links, and their direct or indirect influence on the developing person are of the same importance. Relationships within the microsystem include interactions with family, friends, teachers, peers and extra-mural affiliates (Bronfenbrenner, 1979:7; Wait *et al.*, 2005:156). In early adolescence, the most significant relationships in this system are family relationships and friendships.

### **3.3.2.2 Mesosystem**

The set of links between microsystems is defined as the mesosystem. The stronger and more diverse the links between the microsystems, the greater positive influence the mesosystem has on the developing person (Nash, Munford & O' Donoghue, 2005:37). For example, if the same values regarding sexual behaviour are taught at home and at school, it is highly likely that adolescents will internalise the values. If home, school and friends support healthy sexual behaviour and the use of contraceptives it is more likely that adolescents will make careful decisions about sexual activity. However, when values do not correspond, adolescents may become confused and this will jeopardise their ability to make discerning decisions about sexual behaviour.

### **3.3.2.3 Exosystem**

The exosystem consists of the interconnections between the micro- and mesosystems, and the settings or systems with which the individual does not necessarily have direct contact, but which may affect their experience of these two systems. This is the community environment in which individuals, families and organisations become components of a larger collectivity. The community level can be described as a system of systems, as it has multiple components that influence the micro- and mesosystems. The exosystem includes medical, educational and recreational resources (Chetkow-Yanoov, 1997:11; Visser, 2007:25). For the pregnant adolescent, important resources in this system include the medical system and community support systems. The adolescent needs to gain access to clinics, doctors, pregnancy classes, support groups, counselling and various other resources in order for her to cope optimally with the pregnancy.

### **3.3.2.4 Macrosystem**

The macrosystem is the most global level of analysis, and it includes large-scale societal factors such as culture, racism, discrimination, and economic and political conditions. It can be defined further as the wider system of ideology and organisation of social institutions common to a specific social class, ethnic group or culture. The macrosystem includes gender roles, social class, cultural values, as well as the attitudes and values of people and policies that govern behaviour. Changes in these processes affect the lives of all people in society (Scileppi *et al.*, 2000:47; Visser, 2007:25). The pregnant adolescent is influenced by a variety of factors in the macrosystem. Political rulings on contraceptive use and availability; access to abortion and health care services; the Department of Education's decisions on attendance of school by pregnant learners; as well as cultural values concerning premarital sexual behaviour and the sacredness of unborn life play a significant role in the adolescent's sexual attitudes and behaviour.

### **3.3.3 GERMAIN AND GITTERMAN'S LIFE MODEL**

Bronfenbrenner's paradigm was adopted by the social work field as an ecological approach to practice (Higham, 2006:159). The life model was developed from the application of the ecological perspective. The life model is based on the principle that people are interdependent with each other and the environment; they are people in the environment. The model aims to improve the fit between people's perceived needs, capacities and aspirations, and their environmental supports and resources (Nash *et al.*, 2005:35). Germain and Gitterman are the primary contributors to the life model. Their key ideas and concepts will be discussed below.

#### **3.3.3.1 Person-environment**

Ecological theory focuses on the reciprocity of person-environment exchanges. These exchanges influence and shape each other over time. Person-environment exchanges can be positive, negative or neutral.

When there is a good fit between the person and the environment, a condition of adaptedness is said to exist. This is when the environment provides resources and experiences that assure the person's optimal biological, cognitive, emotional and social development and functioning (Germain & Gitterman, 1996:8). For example, if an environment provides sufficient resources

for pregnant adolescents that are sensitive to the experience of the adolescent, the adolescent is more likely to utilise these resources. This would ultimately result in greater biological, cognitive, emotional and social functioning of and adaptation by the pregnant adolescent.

However, when there is a poor fit between the person and the environment, development and functioning may be impaired and the environment may be damaged. The person may respond positively by changing the self or the environment; alternatively, the poor fit could lead to disintegration. Germain (1996:390) describes this by explaining how some people mobilise inner strength and resilience to protect themselves against the environment. Others internalise the oppression and turn it into self-destructive behaviour, or externalise it into crime or violence.

It is evident that, at times, the individual will have to take action that will lead towards adaptedness, and this is called adaptation. Adaptation is based on actions that achieve personal change, environmental change, or both, in order to improve the person-environment fit. Adaptations are needed when the environment is changing. Hence, adaptation is a never-ending process, as people must constantly adapt to the changes they or the environment have made (Germain & Gitterman, 1996:9). Adaptation allows the person and the environment to cope in an action- and change-oriented manner when problems arise.

### **3.3.3.2 Habitat**

Habitat is an ecological concept that is important to consider when assessing the person-environment relationship. Habitat refers to the physical and social setting of the individual within a particular cultural context. People tend to thrive in habitats that are rich in the resources that are required for growth and development. Habitats that do not support growth and social functioning are likely to lead to isolation, disorientation and helplessness. Thus, habitat can interfere with the basic functions of family and community life (Germain & Gitterman, 1996:9).

### 3.3.3.3 Life transitions

As people move through their life course they experience life stressors. These are transitions, events or issues that disturb the person's fit with the environment. The intense stress caused by life transitions is related to the dimension of the stressor and its implications for the individual. There are a variety of factors that indicate how distressing the life stressor will be for the person (Payne, 2005:150-152).

One factor that affects the impact of the stressor on the individual's functioning and coping is whether a stressor is chronic or acute (Germain & Gitterman, 1996:11). For the adolescent, negative feelings associated with adolescent pregnancy are largely a result of the realisation that pregnancy is a long-term transition that could lead to lasting problematic consequences.

When a person feels ambivalent about the stressor and its resolution, it may complicate the difficulty of coping (Germain & Gitterman, 1996:11). For example, the adolescent may feel stressed because she is having an unplanned pregnancy and this has many negative repercussions, but yet she feels ambivalent about the birth of the baby, as it could be an exciting experience and an introduction to a new phase of her life. This confusion and uncertainty makes coping more complicated.

Whether a critical event is anticipated or expected affects the amount of time that a person has to prepare for the life change. Unpredictable life changes are more difficult to cope with than predictable ones (Germain & Gitterman, 1996:11). When adolescents engage in sexual behaviour they do not foresee the possibility of pregnancy, even though it is an obvious outcome of engaging in unprotected intercourse. For the adolescent, the pregnancy is unexpected, and clearly unplanned. Neither the adolescent, nor her family, have time to prepare themselves for the pregnancy and the impact it will have on them. In addition, the timing of a stressor has a significant impact on the degree of stress that is experienced. Most people anticipate that certain events will take place according to certain social or biological expectations, for example falling pregnant during early adulthood (Wait *et al.*, 2005:160). Pregnancy during early adolescence is not part of the expected life path and, as the adolescent is limited in her skills to deal with this unexpected event, this contributes to the amount of stress that she experiences.

In addition, when people experience a life stressor they move through a stage of appraisal. During this time they judge how serious the stressor is, and whether it will lead to harm or be a challenge. Secondly, they look at what resources they have to help them. Among the

resources that people have to cope successfully are feelings of relatedness, competence, self-direction and self-esteem. In contrast, a stressor can be accompanied by a sense of jeopardy, and this interferes with the individual's problem-solving ability. As a result, levels of self-esteem, competence, relatedness and self-direction start to drop (Payne, 2005:151).

These coping resources are in relation to the individual's capacity to cope, although personal responses are significantly affected by the experience of a person's family and community (Payne, 2005:151). Coping expresses a person-environment relationship as both personal and environmental resources are required for the person to cope successfully. Personal resources for coping include problem solving, motivation, relationship skills, healthy levels of self-esteem and self-direction, a hopeful outlook, and the ability to identify and use information and resources from the environment. Flexibility, a positive attitude and hope are important in coping with life stressors, as they reflect the recognition of positives despite the presence of a stressor (Germain & Gitterman, 1996:13). Should the pregnant adolescent possess these coping resources, the negative impact of an unplanned pregnancy would be reduced substantially.

Environmental resources that can be drawn upon for coping include formal and informal networks. Formal networks include public and private agencies. Their availability depends on the society's and the community's social provision, hours of service and transportation facilities. Informal networks include relatives, friends, neighbours and co-workers. Informal and formal support networks act as buffers against stress, and even the perception of their availability can make it easier to cope with life stressors. However, some support systems may be unresponsive and cease to be supportive and thus do not contribute to the physical and emotional well-being of the person going through the life transition (Germain, 1996:391; Germain & Gitterman, 1996:13).

When coping efforts are ineffective and support networks are insufficient, stress is likely to become intensified and may lead to physical, emotional or social dysfunction. The stress caused in one area may cause other stressors, so that multiple stressors become involved (Germain & Gitterman, 1996:13). For example, the adolescent experiences stress because she has found out that she is pregnant. She needs to disclose this to her family, which is a stressful experience in itself. Should the family respond negatively she needs to deal with the stress of family conflict and disapproval, as well as with the personal adjustment of realising that she is

pregnant. Impending stresses concerning how she will remain in school and how her relationships with her friends will be influenced contribute to her overall level of stress.

#### **3.3.3.4 Relatedness, competence, self-esteem and self-direction**

It is clear that a person going through a life transition requires resources in order to cope and to appraise the stressor as a challenge that can be mastered. Relatedness, competence, self-esteem and self-direction refer to the positive coping outcomes of the adaptive person-environment relationships. All these attributes are interdependent and each is critical for the development of the others. The social worker must act in ways that support, restore or increase these attributes (Germain & Gitterman, 1996:15).

Relatedness refers to the individual's capacity to form attachments. Attachments are made to people who are key influences in the individual's life (Payne, 2005:151). The need for closeness to those people is strong, and loss of this closeness can be overwhelmingly devastating. Relatedness also incorporates ideas about isolation, loneliness and a lack of supportive networks. Friendships reflect a growing capacity for relatedness and, as the individual grows, the circle of friends grows. In adolescence, the network of affiliates includes friends, relatives, neighbours and extramural affiliates. These social networks are important buffers against stress. The power of these informal systems comes from their communication to their members that they are valued, esteemed and loved. Networks can also be a negative influence or be emotionally destructive, for example an adolescent with friends who are all engaging in risky sexual behaviour (Germain & Gitterman, 1996:15). The attachments that a person forms can play a significant role in buffering against stressful life transitions, or can contribute to the negative experience.

Another individual resource is competence. This refers to a person's sense that they have relevant skills or that they can get help from others. Competence is the ability to take action to have an effect on the community, as well as to seek and accept help on one's own terms when needed (Payne, 2005:151). Accumulated experience of competent action, together with the ability to seek and accept help, leads to a sense of competence over the course of life. When the pregnant adolescent accesses resources in her community, for example a clinic, but does not do so successfully because the health practitioners are judgemental and unhelpful, this will lead to her experiencing a decreased sense of competence. A sense of failure and lowered

competence will lead to the adolescent no longer accessing resources or practising the skills that she needs to cope with the unplanned pregnancy.

This sense of competence is connected to one's self-esteem. Self-esteem is the extent to which a person feels that she is significant and worthy. This is the most important dimension of self-concept, which is the person's overall view of herself. High self-esteem reflects self-respect and feelings of self-worth, and is inherently satisfying. Low self-esteem reflects a lack of self-respect, and feelings of inadequacy and inferiority. Levels of self-esteem shift from time to time. Positive self-esteem is important in the person's belief that she is able to affect her environment, cope with stressors and overcome barriers (Germain & Gitterman, 1996:17-18).

Another positive coping outcome described by Germain and Gitterman (1996:15) is self-direction. Self-direction refers to the sense of having control over one's life, and feeling able to take responsibility for one's decisions and actions whilst respecting the rights of others. Age-appropriate opportunities for making decisions and taking action foster self-direction and sustain self-esteem and the sense of competence. According to Farber (1991:714), adolescents are influenced more by other people's input and expectations than by their own desires when making decisions about their pregnancy. This, according to Motjelebe (2009:11), suggests that adolescents make decisions based on family values and beliefs, and hence allow other people to make decisions for them during pregnancy.

In addition, when people's life circumstances narrow their options and they have no control over life events, their self-direction, self-esteem and sense of self competence may be threatened (Germain & Gitterman, 1996:17-18). For example, when the adolescent can no longer conceal that she is pregnant and is forced to leave school, her choices become narrowed. This has an impact on her self-esteem and particularly on her self-direction, as her choices for the future are now limited.

In summary, for the individual to cope successfully with stressful life transitions she must possess relatedness, competence, self-esteem and self-direction. These reflect positive coping outcomes and an adaptive person-environment relationship, in which the individual is able to access and influence the resources available to her in the environment.

### **3.3.3.5 Ecological view of life course**

Life courses or life stages form an important part of the ecological model. Life course refers to the unique pathways of development that each person takes. The ecological view of non-uniform pathways of development within diverse environments is incorporated into the life course concept. Life course incorporates concepts of human and environmental diversity, and emphasises the self-regulating and self-directing nature of human beings (Germain & Gitterman, 1996:21).

The life course concept can be organised around matters of life stressors, stress and coping that are caused by difficult life transitions. Life transitions are seen as on-going psychosocial processes, occurring and reoccurring at any point in the life course. The resolution of these processes leads to growth, while lack of resolution can lead to the physical, emotional or social dysfunction and disorganisation of the individual, family, group or community. In adapting to life experiences over time, individuals change themselves and their environment, either positively or negatively. To understand these changes it is necessary to understand the interplay of personal, environmental, and cultural factors that produce change (Germain & Gitterman, 1996:23).

In conclusion, the life model provides a framework for viewing the individual in the context of person-environment exchanges. The way in which the environment meets the individual's needs and the ability of the individual to negotiate for resources will determine how the individual copes when a stressful life event occurs. This helps the social worker to understand how multiple factors contribute to a person's appraisal of a stressor and coping abilities when faced with life transitions.

### **3.4 IMPLICATIONS FOR SOCIAL WORKERS**

Using a systems and ecological framework provides the social worker with a perspective that views problems holistically, and hence the assessment and interventions are also conducted holistically. The helping professional is encouraged to promote responsive environments that support growth, health and social functioning, whilst helping people to develop the resources they require to cope with stressful events (Germain & Gitterman, 1996:5).

The social worker should focus on customising interventions to specific people, their environment, and the interaction between the two. Such a focus allows for the facilitation of the restoration of the balance between the person and the environment by reducing stress, enhancing coping mechanisms and establishing stability (Nash *et al.*, 2005:34).

#### **3.4.1 Assessment tools**

The ecomap is one of the visual tools used most commonly by social workers to plot information related to the person and the environment. It is an illustration of where the client locates herself in relation to surrounding systems. By making use of different symbols, the nature of the relationships between the systems can be symbolised. Drawing the ecomap is a useful way for the practitioner and the client to gain an appreciation of the main stressors and supports that exist in the client's life (Nash *et al.*, 2005:34). The ecomap helps to highlight unidentified patterns of relationships and behaviour. It allows the social worker and client to delineate the complexity of people's relationships and their transactions with the environment (Germain & Gitterman, 1996:118).

Looking at the pregnant adolescent, for example, the ecomap would be a useful tool for the social worker and the client to assess interactions that support or stress the adolescent. In doing so, both parties become aware of which relationships need to be strengthened in order to improve support for the adolescent during her pregnancy. It also becomes clear which relationships are protective and can be drawn upon by the adolescent to grow in her feelings of relatedness, competence, self-esteem and self-direction.

### **3.5 CONCLUSION**

This chapter gave an overview of general systems theory by exploring the notion that the individual is in a process of exchange with the environment and that balance, or homeostasis, needs to be maintained. The chapter then described the three main works that contributed to the ecological perspective, with a specific focus on the different levels of society described by Bronfenbrenner (1979). Finally, the life model was explained and more insight was gained into the person-environment relationship, as well as how life transitions and life stressors can impact on the client.

According to the above discussion it is clear that the ecological model is useful when working with pregnant adolescents. The perspective provides insight into the different aspects that impact on the individual's behaviour and emotions. It is evident that a supportive environment with sufficient resources will promote the well-being of the individual, whilst the opposite could lead to disintegration and maladaptive behaviour. Social support networks are essential buffers against life stressors and the stress they generate. The ecological perspective provides insight into the relevance of social networks and how these can be used to buffer the adolescent from the negative effects of an unplanned pregnancy.

In the next chapter, support for pregnant adolescents will be explored in terms of the different ecological levels. The support networks available to pregnant adolescents will be explored in relation to how they can assist adolescents in dealing with their unplanned pregnancy.

## **CHAPTER 4**

### **PROVIDING SUPPORT FROM AN ECOLOGICAL PERSPECTIVE**

#### **4.1 INTRODUCTION**

The ecological perspective emphasises the study of the individual as embedded in a diversity of social contexts. The properties of the person, the environment, and the processes taking place within and between them must be viewed as interdependent and analysed in the light of each other (Bronfenbrenner, 1979:21; Nath, Borkowski, Whitman & Schellenbach, 1991:411). Hence, when assessing how support can best be provided for adolescents it is important to consider all aspects of support within the whole environment. Nath *et al.* (1991:413) support this statement by identifying a need for research that compares and distinguishes the effects of various types of support in order to further the understanding of the ways in which support functions in the lives of pregnant adolescents.

Support can be understood as interactions with family members, peers and professionals that communicate information, understanding, esteem and aid. Support can be both formal and informal. Informal sources of support include relatives, friends and neighbours. Formal support, on the other hand, consists of institutions, agencies or programmes outside the family. Informal and formal support systems provide material, psychological and emotional support. Effective support can result in improved coping, moderation of the impact of stressors and enhanced health (Cruse, Hockaday & McCarville, 2007:506; Letourneau *et al.*, 2004:515).

Multiple sources of literature and research (Devereux, Weigel, Ballard-Reisch, Leigh & Cahoon, 2009; Howes & Green, 1997:31; Hudson & Ineichen, 1991; Nath *et al.*, 1991) stress the importance of support for pregnant adolescents, and recognise how support can benefit adolescents in adjusting and functioning more positively during pregnancy. Furthermore, Samuels, Stockdale and Cruse (1994:428) confirm that adolescent pregnancy is an event in which the individual's well-being could be influenced positively by social support. The presence of a network of support is one of the best predictors of the prenatal and postnatal attachment of the adolescent to her infant. When adolescents perceive that they are receiving support from certain types of people, such as their boyfriend, mother or friend, it may contribute to higher self-esteem and greater overall well-being.

Support networks are of great significance to the pregnant adolescent because, in addition to the pregnancy, she is undergoing the unique life phase of early adolescence and the developmental tasks that come with it. Many of the adolescent's cognitive skills are still developing and the adolescent's ability to assess problems realistically and to cope with various stressors may be limited. Consequently, the pregnant adolescent may need to rely more heavily on her support networks to help her cope with the problems of pregnancy and impending parenthood. It therefore is important to ensure that social networks are adequate and know how to respond to the multiple needs of the adolescent during her pregnancy (Panzarine, 1986:153).

From the above there appears to be a clear indication that adolescents would benefit from a network of support. There is a need for agencies to link up and work in partnership to help pregnant adolescents have a positive start to their pregnancy and experience of motherhood (Hudson & Ineichen, 1991:215; Samuels *et al.*, 1994:440). In doing so the well-being of the mother and of the coming child are protected (Letourneau *et al.*, 2004:515).

The following chapter will meet the third objective of the study, which is to describe from an ecological perspective how support can be provided for pregnant adolescents. Support can be provided to adolescents by means of prevention, policy and practice. Within the practice setting, the tasks of social workers are related specifically to assessment and intervention as a means to offer support to the adolescent and to identify areas that require improved support. The following chapter will discuss what the adolescent's support needs are within the individual, micro-, meso-, exo- and macrosystems, as described by the ecological perspective (Bronfenbrenner, 1979:7).

## **4.2 THE INDIVIDUAL**

As has been established previously, self-esteem can be understood most basically as feelings and attitudes towards the self. Self-esteem is essential to the individual's coping abilities and feelings of competence to access resources and to negotiate for her rights. The literature appears to present conflicting information on the relationship between pregnancy and self-esteem. Some findings (Medora & Goldstein, 1994:582) indicate that there is a relationship between low self-esteem and adolescent pregnancy, as well as between decreased self-esteem during and after pregnancy. While other literature has found that there is no relationship between self-esteem and pregnancy (Samuels *et al.*, 1994:429). However, it is agreed upon

that there is a positive relationship between social support and self-esteem, where receiving support has contributed to higher self-esteem (Samuels *et al.*, 1994:430; Stevenson, Maton & Teti, 1999:110).

Self-esteem has two components, namely the evaluative and affective component. The evaluative component addresses the issue of how competent or successful the individual thinks she is. The affective component addresses the issue of acceptance and how the individual feels about herself. These aspects of self-esteem are related, and are largely associated with the way in which significant others respond to and support the individual (Crockenberg & Soby, 1989:128). This implies that self-esteem is related to social interactions and the support that the individual receives from these interactions.

An aspect of importance is that, according to Letourneau *et al.* (2004:509), pregnant adolescents exhibit more identity confusion and coping difficulties, less autonomy and lower self-esteem than non-pregnant adolescents. All these factors may interfere with the adolescent's ability to cope with the pregnancy, and ultimately affect her parenting ability.

The ecological perspective provides a clear framework for understanding how the social context of the individual interacts with their personal characteristics. In the same way, the social context of the pregnant adolescent interacts with her personal characteristics to influence her coping ability and personal development, and subsequently her child's development. As a result, the adolescent's self-esteem, competence and coping abilities are challenged if her social support is limited (Letourneau *et al.*, 2004:509).

It is clear from the above that social relationships and interactions have an impact on self-esteem and life satisfaction. Stevenson *et al.* (1991:112) found that adolescents who have high-quality relationships report higher levels of self-esteem and less depression. By building supportive networks around the adolescent, relationships are strengthened, self-esteem is increased and the overall well-being of the mother and baby are improved.

### **4.3 MICROSYSTEM**

For pregnant adolescents, support on the microsystem level comes primarily from family, friends and partners. According to Letourneau *et al.* (2004:516), typical sources of support for adolescents are mainly informal support networks and, to a lesser extent, professional support. It is important to help adolescents adequately utilise sources of support on the microsystem level because these are people with whom the adolescent has regular interaction. If these interactions are positive and foster the well-being of the pregnant adolescent, then it is more likely that she will have higher self-esteem, improved physical health and will be more likely to access other resources in the community (Letourneau *et al.*, 2004:515).

In a study conducted by Devereux *et al.* (2009:442-444), it was found that providing social support to pregnant adolescents is directly related to reducing the stress caused by the pregnancy. Therefore, building support networks around adolescents is a good way to prevent stress and the deleterious effects of the unplanned pregnancy. Further research revealed that the adolescent's most value the support that they received from their family, and particularly their mothers (Cruse *et al.*, 2007:510-511).

These findings are supported by a study conducted by Koniak-Griffin, Lominska and Brecht, (1993:51), who found that, amongst a variety of sources of support, families were ranked as the highest form of support. Friends were ranked as the second highest form of support and partners as the third best source of support. However, in the same study (Koniak - Griffin *et al.*, 1993:44), it was found that, in some groups, peer support is completely absent. This could be due to the fact that peers do not understand what the pregnant adolescent is going through and do not have the skills to support her. Instead, it would be more effective to have peer support or education from adolescents who are going through, or have had, a similar experience as the pregnant adolescent. This will be discussed in further detail when the mesosystem is explored.

#### **4.3.1 Family**

From the above it can be agreed upon that the family is the most important source of support for the pregnant adolescent. As a result, efforts to involve family members and specifically mothers in the lives of the pregnant adolescent would be beneficial. Mothers are seen as the most significant person of support, and are the major source of emotional and material support to the adolescent. In a study conducted by Cruse *et al.* (2007:508) it was found that

mothers were ranked amongst the highest sources of support for the adolescent for a number of different types of support. The five types of support that were considered were money, giving advice, positive encouragement, physical assistance, and sharing private feelings, in other words concrete, social and emotional support.

Furthermore, Hudson and Ineichen (1991:126) found that family support was related to a higher likeliness of adolescents continuing with school work, improving their employment prospects and planning for the future. Unfortunately, however, many pregnant adolescents do not receive this support from their families. Parents often offer unreliable and inconsistent support, and can be hostile and rejecting. Nevertheless, it is clear that family support will increase the likelihood of the adolescent coping successfully with the pregnancy.

In the light of this, interventions with adolescents should focus on improving the quality of the relationship between pregnant adolescents and their families. Social workers should assess the level of support that the family is offering the adolescent and, during the intervention should encourage family members to be involved in the adolescent's pregnancy. Research (Letourneau *et al.*, 2004:516; Stevenson *et al.*, 1999:110) has indicated that family support has a positive relationship with life satisfaction and reduces psychological distress for pregnant adolescents. Interventions should focus on promoting positive interactions between parents and adolescents, as well as encouraging the opportunity for the adolescent to make decisions and contribute to the household.

#### **4.3.2 Partners**

In the study mentioned above that was conducted by Crase *et al.* (2007:508-509), in which support from mothers was explored, the support of the partner, the alleged father of the child, was also included. Of the five types of support that were measured, boyfriends nearly always ranked as the highest form of support. In an earlier study, partners were ranked as the third most important source of support (Koniak-Griffin *et al.*, 1993:51). Regardless of these different rankings it is clear that the partner is a significant source of support and that the adolescent relies on her partner to support her during the pregnancy.

Partner support has been correlated with greater maternal satisfaction, and enhanced adjustment to pregnancy and psychosocial well-being. Little support from the partner has been associated with anger, poor coping skills and lower quality of parent-child relationships

(Letourneau *et al.*, 2004:517). It was further found that partner support leads to an increased likelihood of the adolescent regularly accessing health care facilities.

The positive effects of partner support were also found by Stevenson *et al.* (1999:110-114), who found that pregnant adolescents with partner support showed decreased psychological distress and depression, and increased self-esteem and life satisfaction. Adolescents who reported a high-quality relationship with their partner showed a trend towards higher mastery and life satisfaction than adolescents who had a low-quality relationship with their partner. Relationship quality was measured by means of determining the overall happiness experienced by the adolescent, as well as the ability to talk to and confide in their partner.

High-quality relationships between the pregnant adolescent and her partner indicate many benefits for the adolescent's psychosocial well-being. Unfortunately, according to Letourneau *et al.* (2004:517), the relationship between the pregnant adolescent and her partner is often short lived, meaning that the relationship with the boyfriend often ends soon after the adolescent finds out that she is pregnant, as the partner realises the overwhelming responsibility of fatherhood. However, other research findings (Smith, 2006:157) seem to suggest that young fathers are prepared to assume responsibility for their child and remain involved with their adolescent partners.

When the adolescent does remain in a relationship with her partner there is consensus that the partner is too demanding and is not considerate of the physical strain the pregnancy places on the adolescent, or the time needed to care for the baby. In addition, a common concern is that young couples have difficulties discussing problems and fight frequently (Panzarine, 1986:156).

According to Nath *et al.* (1991:412), pregnant adolescents frequently lack support from an intimate relationship with a male partner, even less so with the father of their child. Where studies have indicated that partners are a significant source of support (Cruse *et al.*, 2007:508-509; Koniak-Griffin *et al.*, 1993:51), this is dependent on the quality of the relationship, which is more often than not poor (Stevenson *et al.*, 1999:110-114). Unmarried pregnant adolescents hence find themselves having to turn to their families, friends or community agencies for support and assistance.

Social support services for adolescent fathers and for the adolescents as a couple are minimal. In order for services to be effective and beneficial to the pregnant adolescent, the partner must

also be involved. Interventions in the practice setting should focus on building communication skills, conflict management, and managing responsibilities between the adolescent and her partner. This would facilitate increased involvement of the partner, and promote a higher quality of relationship between the couple (Smith, 2006:188-190).

### **4.3.3 Reciprocal support**

Support is clearly valuable in helping the adolescent adjust to the pregnancy and to function more positively. Research suggests that adolescents will benefit most from support if they are also active providers of support, rather than mere passive recipients of support (Stevenson *et al.*, 1999:111). Reciprocal exchange of support between adolescents and their parents, for example, has been correlated with increased life satisfaction and decreased anxiety and depression.

Rook (1987:145) also found that receiving social support is most beneficial when it is offered within a relationship and environment that is characterised by equitable patterns of resource and support exchange reciprocity. This means that adolescents would benefit most from their networks and sources of support if a relationship existed that allowed them to reciprocate support, instead of only receiving it. Rook (1987:145) suggests that reciprocal support, or bidirectional support, contributes to well-being, specifically with psychological benefits. Feelings of self-worth, significance and awareness that one is an important contributor to the network are created through bidirectional support relationships.

Reciprocal support can be understood within the ecological perspective where the nature of fit between the person and her environment is essential. Each system is related to every other one and they have an influence on each other (Bronfenbrenner, 1979:7; Visser, 2007:22-25). It is possible that interdependent, balanced relationships are associated with improved well-being, while unequal relationships are associated with decreased well-being among pregnant adolescents (Stevenson *et al.*, 1999:118).

It hence is important that the reciprocal exchange of support is not ignored by those who work and intervene with pregnant adolescents. Interventions should encourage the bidirectional exchange of support, particularly with the adolescent's parents and direct family (Stevenson *et al.*, 1999:118). Adolescents often need to be assisted in identifying and utilising sources of support, but they also need to be encouraged to participate in reciprocal support, which fosters a constructive home environment and has positive benefits for their health.

#### **4.4 MESOSYSTEM**

The linkages between the microsystems are explored within the mesosystem. As has been established previously the mesosystem can have a great influence on the individual, particularly if the same values are taught across all systems (Nash *et al.*, 2005:37). One of the most effective ways to teach adolescents values is through education programmes in schools. This is supported by Panday *et al.* (2009:45), who state that the most effective curriculum-based programmes are based on designing activities that are consistent with community values. Education programmes can be even more effective when they are presented by peers, as it makes it easier for the adolescents to relate to what is being taught. Likewise, peer support groups are also effective ways of providing support and education to adolescents who are facing similar stressors (Nath *et al.*, 1991:412).

##### **4.4.1 Peer education**

Peers have been identified as important determinants in adolescent sexuality and risk-taking behaviours. This applies not only to the negative, as peer education and role modelling can have a positive effect on the adolescent's attitude towards intercourse and sexual behaviour, and on how adolescents cope once they find out that they are pregnant. Young people in peer programmes serve as role models, and as sources of skills development and information (Kidger, 2006:112-117; Panday *et al.*, 2009:47).

While the emphasis in most peer programmes is on prevention, there are still many benefits for pregnant adolescents to participate in such programmes. Positive outcomes associated with peer programmes include increased knowledge, contraceptive and condom use, and a decline in the number of sexual partners and risky sexual experiences (Panday *et al.*, 2009:47). These positive outcomes are also beneficial for the pregnant adolescent, as she has the opportunity to learn how to protect herself in the future and how to make different decisions about her sexual behaviour.

In England a study was conducted across four different projects that had young mothers as peer educators in school-based sexual education programmes. One of the primary reasons that the projects proved to be effective was that the educators were young people who had participated in sexual activity and were now mothers. This meant that the pupils regarded the educators as peers and were more open to learning from them (Kidger, 2006:112-117). Such a project is effective in teaching adolescents how to negotiate for safer sexual experiences and

to make rational decisions about sex. This is also beneficial for pregnant adolescents, as it not only provides them with information, but also with evidence that a pregnancy does not have to end one's school career and life ambitions.

In South Africa, peer programmes are limited and evidence of their effectiveness has not been measured accurately (Panday *et al.*, 2009:47). However, it is important that the youth should be provided with consistent, accurate messages about reproductive health that promote decisions to protect their well-being. This can be done effectively through peer education programmes as well as through social support, primarily from support groups (Speizer, Magnani & Colvin, 2003:345).

#### **4.4.2 Support groups**

Nath *et al.* (1991:412) suggest that the most beneficial source of support for pregnant adolescents may be from individuals who are facing similar stressors. Such support is highly effective in helping adolescents learn new skills, adjust to the pregnancy and prepare for the birth of the baby. Hence, pregnant adolescents would benefit from participating in self-help or support groups for pregnant adolescents.

Another benefit of being part of a self-help group is that it allows adolescents to practise reciprocal support, in which they receive support but are also able to offer support to other members of the group. Stevenson *et al.* (1999:111) found that members of support groups reported higher levels of well-being than those who were not in such groups.

In addition to reciprocal support, support groups have many other benefits for adolescents. Research claims that it is reasonable to assume that pregnant adolescents who are involved in supportive services, particularly in support groups, may be better prepared to become parents (Nath *et al.*, 1991:416). Support groups help adolescents to learn how to cope with the deleterious effects of an unplanned pregnancy and to share their feelings openly. In addition, they are able to receive information concerning child development and parenting practices, that prepares them for the future (McCullough & Scherman, 1991:812).

Research has shown that adolescents who are part of support groups have higher levels of social support, are more likely to access health care services, and are less likely to have repeat pregnancies (Letourneau *et al.*, 2004:518). One of the most frequent benefits mentioned by adolescents who participate in a support group is role modelling. Support groups are

beneficial to adolescents and help them to deal with their hopelessness and despair by providing them with positive role models (Nath *et al.*, 1991:416).

Panday *et al.* (2009:49) indicate that adolescent friendly services are limited in South Africa, and this includes support groups. Adolescents appear to have a limited knowledge of what support groups are and how they could be of benefit (McCullough & Scherman, 1991:813). A further barrier to adolescents accessing support groups is the issue of confidentiality, in cases where the adolescents do not want their personal stories disclosed. However, this problem would be reduced with peer-based support groups and education programmes.

#### **4.5 EXOSYSTEM**

Adolescents are inexperienced and lack knowledge in arranging their own health care and seeking support services. They are at the mercy of local service providers to receive contraceptives, support, advice and information. As legislation in relation to the very young remains unclear, and embarrassment is a real barrier to the accessibility of services, the younger adolescent who is most in need of help is least likely to receive it (Hudson & Ineichen, 1991:184-190).

However, the pregnant adolescent is in great need of social and health services. When help and support cannot be found in the family, which is often the case, the adolescent must seek support from another source. These alternative sources of support include the social welfare services, non-governmental organisations (NGOs) and health care professions (Hudson & Ineichen, 1991:190).

Despite the fact that social workers, counsellors and health professionals are available to adolescents, low influence has been attributed to these sources of support by adolescents in a number of cultural groups. Multiple studies have indicated that health care and social service providers are the lowest source of support utilised by and impacting on adolescents during pregnancy (Koniak-Griffin *et al.*, 1993:50-51).

Health care services and social welfare service providers are professionally trained to help people who are experiencing personal or health problems, but adolescents are often treated with judgement and stigma (Wiemann *et al.*, 2005:352.e4). Although these services are not frequently used by adolescents and appear to pose problems for the adolescent as a service

user, they do have merit and could serve as a valuable source of social support to the pregnant adolescent.

#### **4.5.1 Health care services**

According to Hudson and Ineichen (1991:63), adolescent pregnancy is marked by poor use of medical services. Adolescents often present late to clinics and, on the whole, are poor clinic attendees. This is supported by Atuyambe, Mirembe, Annika, Kirumira, and Faxelid (2009:783), who found that adolescents book antenatal care late and that many attend only once. This limits the potential impact of the quality of care on the overall well-being of the adolescent.

Adolescents access health services late due to a variety of reasons, the first being that they often do not know that they are pregnant, or choose to deny their pregnancy until a later stage. This was the primary reason given in a study conducted by Hudson and Ineichen (1991:63) for why clinic and antenatal services had not been accessed. Another main reason why adolescents do not consult health services is because of fear or embarrassment. It was found that adolescents do not want to tell their parents about their pregnancy, and that they fear that the health staff would disclose the pregnancy. Adolescents also fear that they would be pressured into having an abortion at the clinic. Finally, adolescents expressed that they felt out of place amongst older women, and this hindered them from going to the clinic.

In addition, many adolescents have negative experiences at antenatal services and clinics. The adolescent is nervous and lacks confidence when she visits the clinic, she is anxious and reacts defensively to people's responses and attitudes toward her. Often the adolescent is young, terrified and confused about the situation, and because she lacks the skills to communicate what she needs, she certainly is not likely to know what questions to ask. In combination, the uncertainty and fear of the adolescent, and the busy, insensitive nature of the clinic staff, contribute to a poor experience of clinic and antenatal services (Hudson & Ineichen, 1991:65).

Adolescents experience health care staff to be harsh, scolding and unwilling to acknowledge adolescents as contraceptive users or as being sexually active. Wood and Jewkes (2006:114-115) found that, in South Africa, some adolescents have had such an unpleasant experience at clinics that they refused to return ever again. When the adolescent experiences stigma and condemnation whilst trying to access contraceptives at a clinic, it is not likely that she will

return to the clinic once she is pregnant. According to multiple sources (Atuyambe *et al.*, 2009:783; Wood & Jewkes, 2006:115), high quality of care in clinics and antenatal services leads to continued use of contraceptives and improved utilisation of health services.

Furthermore, factors such as perceived health needs, knowledge of the role of antenatal services, nurse-patient relationships, economics and transport all influence adolescents' attendance of clinics and antenatal care (Atuyambe *et al.*, 2009:783). In a study conducted in South Africa (Myer & Harrison, 2003:268) it was found that women did not perceive pregnancy as a time of potential health risks and hence viewed antenatal services as unnecessary. Women perceive labour and delivery as a time of significant health threats and they want to give birth in a health facility; this is their primary reason for seeking antenatal services. Seeking antenatal care allows women to receive an antenatal attendance card, which is required for delivery at a health facility.

When the adolescent goes to a clinic it offers an opportunity for the staff to educate her and support her. Adolescents feel stigmatised by their pregnancy and are at increased risk of social isolation and abuse (Wiemann *et al.*, 2005:352.e2). It is important that these young women receive special attention during their pregnancy so that they can develop strategies to care for themselves, complete their education, avoid depression, and promote the overall well-being of themselves and their baby.

Very few clinics provide adolescent focussed antenatal care (Wiemann *et al.*, 2005:352.e4). Preston-Whyte (1991:47) supports the view that adolescent centred services should be established that can offer confidential and appropriate support for adolescents seeking services. In situations where clinic care has focused on adolescents and attempted to meet their needs appropriately, there have been positive effects on behaviour. These positive effects include increased condom or contraceptive use, and more frequent visits to health facilities during and after the pregnancy (Tonelli, 2004:69). Furthermore personnel behaviour and statements that chastise adolescents should be eliminated, as they can lead to increased feelings of social isolation and stigmatisation, and decreased use of health care services. Finally it is essential that, when providing services to adolescents, their unique phase of life and developmental tasks should be considered. In doing so, the staff would be able to have greater understanding and empathy for the adolescent, and would be able to offer services that are relevant and that will have a lasting impact on health behaviour.

### **4.5.2 Social service providers**

From the above it is clear that the attitude and approach of the service provider has a great influence on the adolescent's use of health services. Previous research (Koniak-Griffin, *et al.*, 1993:50; Panzarine, 1986:160) indicates that, although counsellors and health professionals are available, low influence is attributed to these sources of support by adolescents. In fact, professionals were reported as the lowest source of cognitive support and information by pregnant adolescents.

Social service providers, for example social workers, play a key role in assisting adolescents to cope with their pregnancy and to access resources, and this is done primarily through a counselling relationship. If a relationship of trust is not established between the social service providers and adolescents throughout the community, the adolescents will regrettably miss out on many valuable services. The social service provider is usually the one who has to help the adolescent cope with the crisis of an unplanned pregnancy, consider all the options of abortion and child care, and assist the adolescent to identify and access support networks in her environment.

According to Marecek (1987:90), there are several goals of pregnancy counselling. The first goal is to mobilise the adolescent's coping skills. Should the adolescent perceive the pregnancy as a crisis, the social service provider must utilise crisis intervention skills to help the adolescent restore balance in order to be able to activate her coping skills.

Secondly, the social service provider needs to provide the information, referrals and emotional support needed for the adolescent to make an informed decision about the pregnancy. The adolescent is faced with a number of choices when she finds out that she is pregnant and needs to reach a point of pregnancy resolution, where she can make a clear decision about the future of her pregnancy and her child. She must decide whether she will carry her pregnancy to term or terminate the pregnancy. If she carries the child to term she must decide whether she will raise the child, most likely as a single parent, or place the child up for adoption (Plotnick, 1993:324).

It is very important for the adolescent to understand the processes and consequences of the above-mentioned options. If her choices are explained to her, the adolescent is able to make a rational and informed decision about how to proceed with the pregnancy. If all the choices and possibilities available to the adolescent are explained to her, it is easier for her to make a final decision with the least amount of regret. This, according to Marecek (1987:90), is the

third goal of pregnancy counselling. However, based on the low level of support attributed to the social service professions, it can be assumed that many adolescents are not receiving sufficient information from service providers.

Finally, counselling should aim to aid the adolescent in using the crisis of the unplanned pregnancy as an opportunity for personal growth. It is important to help the adolescent to develop a greater sense of personal responsibility and control over her sexual behaviour (Marecek, 1987:90).

In order for the adolescent to function more healthily, to be able to think clearly and to make the best decisions for herself and her baby, she needs to first deal with the crisis of the unplanned pregnancy. Crisis intervention provides the opportunity and mechanisms for change to those who are experiencing disequilibrium (Payne, 2005:97). This is a process by which the counsellor assesses the individual in crisis and intervenes to restore the balance and reduce the negative effects of the crisis in her life.

#### **4.5.2.2 Crisis intervention**

Crisis intervention can be used within the context of the ecological model. While the social service provider appreciates that the individual exists within a larger environment that impacts on her as a whole (Germain & Gitterman, 1996:8), it also needs to be considered that, when the individual is in a crisis it first needs to be resolved in order for the individual to function more effectively and to access resources in the environment. It hence is important for social workers to first assess whether the adolescent is in a crisis before continuing with intervention. Crisis intervention provides a model for social service providers to utilise when they encounter the adolescent who views her pregnancy as a crisis (Kanel, 1999:23).

Crisis intervention assumes that the individual is living in a steady state, or equilibrium, and is able to cope with the changes in her life. A crisis disrupts this steady state and, if the equilibrium is not restored, the individual's capacity to cope and manage life will deteriorate (Payne, 2005:97). As has been established previously, pregnancy during adolescence is perceived as a crisis. When an event such as an unplanned pregnancy is viewed as threatening and all the usual coping strategies have been exhausted, the event may push the individual towards disequilibrium or a state of crisis (Evangelisti, 2000:37-38).

According to Cannon Poindexter (1997:125-126), the crisis presents an opportunity for heightened potential, maturity and growth, or for deterioration and greater vulnerability. It is important for the crisis to be resolved in order for the individual to achieve equilibrium once again. If the person fails to resolve the crisis, they will become overwhelmed by stress and function less well in the future. Crisis intervention is crucial in helping the individual establish new coping mechanisms, process feelings associated with the event, mobilise resources for support, reduce continuing negative effects, emotions and stress, and to integrate the crisis event into her personal life narrative. It is essential that the crisis of the unplanned pregnancy be resolved so that the adolescent can adjust to the changes that the pregnancy will bring about, and feel competent to access resources and sources of support.

According to Philkill and Walsh (2002:58) there are six essential steps to crisis intervention counselling, namely making contact, reducing anxiety, focussing on the issue, evaluating resources, encouraging action, and following up. In the light an unexpected pregnancy and the stress that the adolescent is experiencing, it is important that crisis intervention is implemented correctly. This will increase the likelihood of the adolescent coping successfully with the crisis and learning sufficient skills to make decisions that affect her, the baby and her family (Evangelisti, 2000:48). These six steps will be explored briefly in order to gain an understanding of what the adolescent needs in order to deal with the crisis, and how social service providers or counsellors can meet these needs.

### **(i) Step 1: Making contact**

The pregnant adolescent needs to know that someone cares about her situation, that she is not being judged and that her opinion will be respected. When making contact it is essential that the counsellor communicates concern and empathy towards the client. Empathy is of particular importance, as the adolescent is in a position where she feels that others do not understand her circumstances and that she is being judged. Further feelings that the adolescent is experiencing at this time are shock, fear and numbness (Philkill & Walsh, 2002:58). The counsellor needs to develop and maintain rapport, which is a state of understanding and comfort. As the adolescent begins to feel this rapport, trust and openness are likely to follow, allowing the interview to proceed (Kanel, 1999:55).

**(ii) Step 2: Reducing anxiety**

In order to reduce anxiety the counsellor needs to let the client know what can be expected during the counselling session. Finding out what the adolescent hopes will happen will help the counsellor gain a clearer understanding of what the client wants from the counselling session (Compton & Galaway, 2005:141). During this time the prominent feelings that the adolescent experiences are denial and anxiety. The counsellor should alleviate tension and bear in mind that the adolescent is most likely ambivalent about the pregnancy and the possibility of abortion (Evangelisti, 2000:49).

**(iii) Step 3: Focussing on the issue**

Once rapport has been developed and anxiety has been reduced, the counsellor needs to focus on the adolescent's presenting problem, which is the unplanned pregnancy. During this time the counsellor needs to enable the adolescent to define her feelings associated with the crisis, and assess the impact the crisis has had on her life. It is likely that the adolescent will be feeling guilty, angry, resentful and worthless. The counsellor can help resolve these feelings by exploring the meanings, perceptions and cognitions of the unplanned pregnancy (Kanel, 1999:62).

Counsellors must recognise that, during this time, the adolescent may not process the information given to her about her options to carry out or terminate the pregnancy, because she might still be in denial or shock. She should be provided with concrete information and aided to think through all the implications of her decision concerning the pregnancy (Franz & Reardon, 1992:170).

**(iv) Step 4: Evaluating resources**

The counsellor should assist the client to assess all the resources available to her, such as family, friends and community resources, as well as her own interpersonal skills and strengths (Philkill & Walsh, 2002:58). This can be done by means of an ecomap, which has been identified as a useful assessment tool in identifying resources in the client's environment (3.4.1 Assessment tools). By adopting an ecological perspective, the counsellor will be able to enable the adolescent to identify sources of support within the environment that can assist her to cope successfully with the pregnancy. The counsellor needs to further support the

adolescent in dealing with feelings of detachment and depression by discussing options and future goals.

**(v) Step 5: Encouraging action**

Once the problem and available resources have been identified, the counsellor needs to encourage the client to determine a plan of action that includes concrete goals (Philkill & Walsh, 2002:58). The counsellor should encourage the client by exploring previous successful attempts at coping and discuss how new coping behaviours can be developed. The adolescent is more likely to follow a plan of action that she has developed, rather than one suggested by the counsellor. The counsellor should facilitate the process and aid the adolescent in utilising her problem-solving abilities (Kanel, 1999:78).

**(vi) Step 6: Following up**

The final step in crisis intervention counselling, according to Philkill and Walsh (2002:58), is following up. The counsellor should follow up with the adolescent on the decision she has taken to determine whether she has implemented her decision. It is important that the counsellor builds up a relationship with the client by building rapport, as discussed earlier. Having a relationship of trust and empathy will make it easier for the adolescent to return to the counsellor to discuss her decisions, or any further difficulties that she is experiencing. Follow up is also necessary as the adolescent may leave the counsellor having decided on what to do, but then be placed under pressure by her family, friends or partner to change her mind. The counsellor will need to reassure the adolescent and help the adolescent to negotiate within these relationships so that they are more supportive of her.

#### **4.6 MACROSYSTEM**

Within the macrosystem, one of the most significant spheres of influence on the adolescent is the Government. Government policies and procedures impact on the sexual behaviour and attitude of the adolescent, as well as on the options that she has concerning pregnancy resolution. According to Plotnick (1993:325), social policies are important elements of the environment within which adolescents engage in sexual behaviours and that may have long-term consequences for their emotional, social and financial well-being.

Through understanding these policies and how they affect the pregnant adolescent, social service providers and NGOs can better serve adolescents in two complementary ways. On the micro-level the service provider can refer and direct the adolescent to services that are effective and appropriate for adolescents. Secondly, on the macro-level, the social service provider can promote and advocate for policies and programmes that contribute to the desired social outcomes for pregnant adolescents (Plotnick, 1993:325).

Government policies have the power to influence the course of adolescent pregnancy. Policy decisions can determine the availability of resources that provide services and implement programmes. According to Jewkes and Christofides (2008:10), the slight decline in adolescent pregnancy, as discussed previously, occurred in parallel with the establishment of a supportive policy environment for adolescents. These policies include the increased availability of contraceptives and termination of pregnancy services in terms of the National Health Act (Act no 61 of 2003) and the Choice of Termination of Pregnancy Act (Act no 92 of 1996). Consequently, the evidence suggests that adolescents are terminating their pregnancies safely. Furthermore, policies on life-skills education in school and government media campaigns have served to raise awareness and empower adolescents to safely negotiate their sexual relationships (Jewkes & Christofides, 2008:10).

According to the Department of Health (2001), research indicates that young people in particular lack knowledge of their reproductive rights. Adolescents do not have knowledge of the different types of contraceptive services, or other policies, for example the Children's Act (Act no 38 of 2005), which apply to their reproductive health.

There are several policies that have an impact on the adolescent during her pregnancy. These include the National Contraception Policy Guidelines (Department of Health, 2001), the Choice of Termination of Pregnancy Act (Act no 92 of 1996), the Children's Act (Act no 38

of 2005), as well as policies put in place by the Department of Education (2003). These policies will be explored briefly.

#### **4.6.1 Access to contraceptives**

South Africa has instituted free health care, including contraceptives, to all pregnant women (National Health Act, Act no 61 of 2003, Section 3[a]). This means that adolescents should be accessing antenatal and other health care services earlier and more frequently during their pregnancy. However, issues such as the negative and judgemental attitudes of the staff are major barriers to adolescents utilising health care services.

The National Contraception Policy Guideline (Department of Health, 2001) makes strong recommendations for the promotion and availability of contraceptives. The policy aims at removing barriers that restrict access to contraceptive services. Furthermore, the policy seeks to increase public knowledge of contraceptive rights, methods and services. Adolescents are identified as a key disadvantaged group that needs to be paid special attention in accessing health care services.

Adolescents, according to the Children's Act (Act no 38 of 2005, Section 134), may not be refused access to condoms or contraceptives if they are twelve years of age. Hence it is the adolescent's right to use contraceptives and she should not be discouraged from this by stigmatisation in health care facilities. Access to contraceptives will not only prevent the adolescent from falling pregnant, but it will protect her from sexually transmitted infections, HIV and from having repeat pregnancies in the future.

#### **4.6.2 Termination of pregnancy**

The social service provider should be able to educate the adolescent about all her choices concerning her pregnancy, which include abortion, adoption and options with regard to social security. The adolescent has the right to know about the Choice of Termination of Pregnancy Act (Act no 92 of 1996). This is important because if an adolescent knows how to access termination of pregnancy facilities she is less likely to go for an illegal abortion. It also helps her to understand that once the foetus reaches a particular gestational age, namely older than 12 weeks, she can no longer have an abortion without consulting a medical practitioner (Choice of Termination of Pregnancy Act, Act no 92 of 1996, Section 2[1a]).

The double stigma of an early pregnancy and seeking termination services, however, serve as deterrents for young women seeking services at health care facilities. Research has indicated that adolescents have little knowledge about termination of pregnancy. It hence is important for social service providers to educate the adolescent concerning the termination and to inform her of her rights (Panday *et al.*, 2009:25).

#### **4.6.3 Adoption**

When considering the various alternatives for pregnant adolescents it is also necessary to look at adoption and social security as feasible options for the adolescent. These options could significantly impact how the adolescent deals with the pregnancy and if she carries the pregnancy to term (Evangelisti, 2000:57).

According to the Children's Act (Act no 38 of 2005, Section 230 [1a]), a child may be adopted if it is in the best interests of the child. Hence, should the adolescent feel that she cannot provide financially or emotionally for her child, she may allow the child to be adopted. Knowing that this option is available is more likely to result in the adolescent carrying her baby to term. It is important for the adolescent to know that she needs the father of the child to give his consent for the child to be adopted, regardless of whether they are married or not, as stipulated in the Children's Act (Act no 38 of 2005, Section 233 [1a]).

#### **4.6.4 Social security**

Should the adolescent decide to keep her child it would be beneficial if she knew about social security, particularly the Child Support Grant, and how this can assist her in caring for her child. Research suggests that there is no significant relationship between the Child Support Grant and adolescent fertility trends (Mokoma, 2008:26), therefore one must assume that the Child Support Grant is not an incentive for having a child, but rather that it can be used to support mothers who have children in low-income communities.

According to the South African Social Security Agency (SASSA) (2010), the Child Support Grant is R250. Both the applicant and the child must reside in South Africa, and the grant is available for children under the age of 15 years. To apply for the grant, the individual must go to the nearest SASSA, office where a SASSA officer will aid the individual to complete the application form. This is information that the pregnant adolescent should have access to.

#### **4.6.5 School policies**

The Department of Education (2007) introduced guidelines for the prevention and management of learner pregnancy. The guidelines recognise the responsibility of the education system within the community to prevent and manage adolescent pregnancy. This goal is promoted through sex education programmes and peer education. This progressive approach allows the adolescent to remain at school and to return to school after the pregnancy, which will hopefully lead to a decrease in the negative educational and economic consequences of unplanned pregnancy. A further benefit of allowing adolescents to return to school is that rapid childbearing after the first birth is prevented (Panday *et al.*, 2009:40).

In summary, adolescents need to be informed about their rights to access educational facilities and health care services. Social service providers and NGOs play a key role in educating adolescents about these rights. According to Panday *et al.* (2009:40), the strongest determinant of sexual behaviour is the adolescent's knowledge, attitudes and confidence in skills. It is important then that adolescents should have full knowledge of the policies that impact on them during their pregnancy.

#### **4.7 CONCLUSION**

This chapter provided an overview of the social support networks that are valuable in aiding the adolescent to cope successfully with her unplanned pregnancy. By adopting an ecological approach, the different aspects of support could be understood in the context in which they impact on the adolescent. The chapter also discussed the importance of different systems of support around the adolescent, as well as how social service providers should be equipped to help the adolescent in accessing appropriate support services.

It is critical to examine social support during pregnancy. This forms a basis for identifying potential problems and can help in mitigating the deleterious effects of an unplanned early pregnancy (Koniak-Griffin *et al.*, 1993:45). Someone in the adolescent's family should offer support, although this may require more psychological and personal resources than the family members possess. Peer educators, support groups, health care professionals, NGOs and social service providers should provide support to the adolescents and to their families.

The threat imposed by unplanned adolescent pregnancy may be buffered by a supportive environment. Social support is a coping resource that may be called upon to foster resilience. Pregnancy during adolescence presents a significant life change for the individual. A responsive environment, with sufficient support networks, could help the adolescent to cope with the adjustment and provide the opportunity for greater functioning, heightened potential and growth (Devereux *et al.*, 2009:444; Letourneau *et al.*, 2004:509).

## CHAPTER 5

### AN EXPLORATION OF SUPPORT FOR PREGNANT ADOLESCENTS

#### 5.1 INTRODUCTION

The previous chapters explored the adolescent life phase, the ecological perspective and the provision of support from multiple levels. This literature study formed a foundation of knowledge to understand adolescents' experiences during pregnancy and how support could benefit the adolescent during this time.

It is clear that adolescence is a unique time in which the individual goes through many personal and social changes. When the adolescent also has to deal with an unplanned pregnancy, new challenges and difficulties are introduced into a time that is already challenging (Specht & Craig, 1982:242; Trad, 1999:221).

Furthermore, when considering the challenges presented by an unplanned pregnancy it is necessary to consider that the adolescent's behaviour and experiences take place within a relational and environmental context. Exploring the ecological levels helps to create an understanding of how each level has an impact on the adolescent, and how each level can provide support (Goldenberg & Goldenberg, 2002:24-25).

Research confirms that support during pregnancy could significantly reduce the negative impact of an unplanned pregnancy on an adolescent (Cruse *et al.*, 2007:506; Holgate *et al.*, 2007:1; Letourneau *et al.*, 2004:515). When the support is provided from multiple levels, it has a greater impact on the individual during a time of stress.

In the light of the above-mentioned facts, the literature review provided a basis for the empirical study. The findings of the empirical study can be verified against the literature review and hence be explored in terms of its validity and applicability to the support needs of pregnant adolescents.

In this chapter the results of the empirical study will be presented and discussed. Where relevant, the data will be presented in tabular, figure or narrative form in order to best capture the findings of the study. The aim of this chapter is to verify the findings of the literature review and to explore what levels of support are meeting the adolescent's needs during pregnancy.

## **5.2 DELIMITATION OF THE INVESTIGATION**

The participants for the study came from three communities, namely Lwandle, Chris Nissen Park and Broadlands, all within the Helderberg basin, which is a metropolitan area. These communities were identified because they all have access to basic resources in the area, such as health providers, schools and social service providers. The participants were identified by groups or organisations that work in the communities. Hospitals and clinics were not approached, as the services and attendance of health care facilities were factors that were being explored in the empirical study.

The population consisted of adolescents from these communities who had had a baby within the last year. The sample consisted of 32 participants who were selected by means of a purposive sampling method (De Vos *et al.*, 2005:201). This ensured that participants were selected who met the criteria for inclusion and hence could fulfil the purpose of the study.

## **5.3 THE EMPIRICAL STUDY**

The investigation can be classified as descriptive and exploratory research, as described by De Vos *et al.* (2005:106) and Mouton (2001:53). Descriptive and exploratory research was conducted as a result of a noticeable gap in South African research pertaining to support for adolescents during pregnancy. As a result, the research aims to explore the support available to pregnant adolescents and to describe how this impacts on the adolescents.

Data was collected by means of a semi-structured questionnaire, which consisted of both open and closed questions. This ensured that the data that was collected was both measurable and rich in description (Bless *et al.*, 2006:184). The questionnaire was administered by the researcher individually with each participant by means of an interview. In doing so, the researcher could ensure that the participants understood all the questions and terminology in the research instrument. Furthermore, the participants' confidentiality was respected and they were allowed the opportunity to debrief after the interview.

The data which was collected by means of the questionnaire was then coded and represented by means of graphs and figures. This allowed the researcher to identify consistent and relevant patterns within the data.

## **5.4 RESULTS OF THE EMPIRICAL INVESTIGATION**

The findings of the empirical study and the interpretation of the data in comparison to the literature review will be presented below.

### **5.4.1 Identifying details**

The participants were asked to give details about their age, race, living arrangements and the nature of the pregnancy. These identifying details, along with the criteria of inclusion allow for a profile of the participants to be created. The identifying details are summarised in Table 5.1. Each aspect will then be discussed separately.

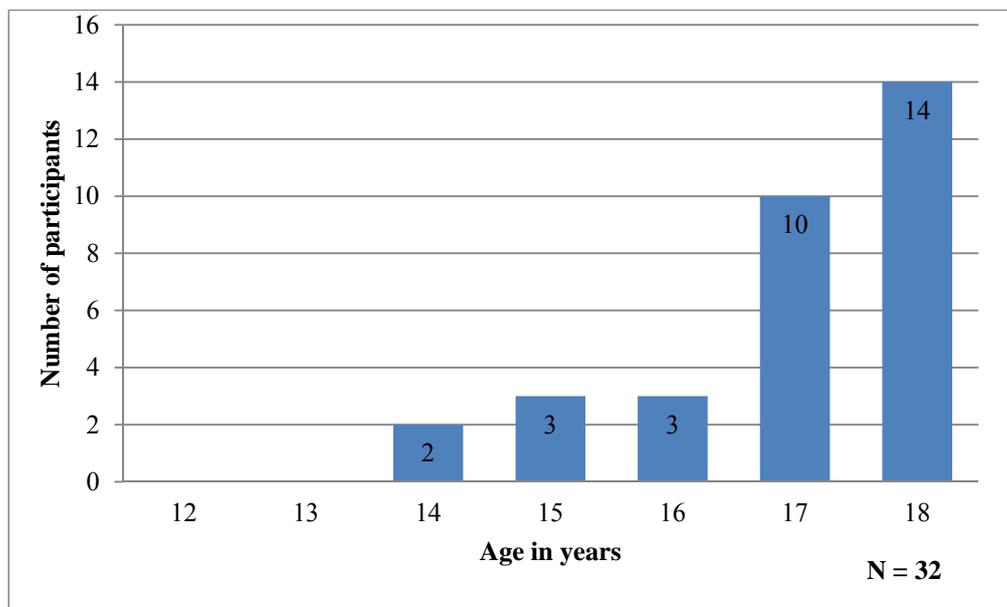
**Table 5.1 Identifying details of participants**

	<b>Age</b>	<b>Race</b>	<b>Living arrangements</b>	<b>Nature of pregnancy</b>
1	18	Black	Mother, no father	Unplanned
2	18	Black	Both parents	Unplanned
3	18	Black	Both parents	Unplanned
4	17	Black	Mother, no father	Unplanned
5	18	Mixed race	Both parents	Unplanned
6	17	Black	Both parents	Unplanned
7	16	Mixed race	Mother	Unplanned
8	15	Black	Both parents	Unplanned
9	18	Black	Mother, no father	Unplanned
10	18	Black	Both parents	Unplanned
11	14	Mixed race	Both parents	Unplanned
12	16	Black	Mother, no father	Unplanned
13	18	Black	Reconstructed	Unplanned
14	17	Black	Both parents	Unplanned
15	18	Black	Both parents	Unplanned
16	14	Mixed race	Mother, no father	Unplanned
17	15	Black	Reconstructed	Unplanned
18	18	Black	Both parents	Unplanned
19	18	Black	Mother	Unplanned
20	17	Black	Mother	Unplanned
21	17	Mixed race	Both parents	Unplanned
22	18	Black	Both parents	Unplanned
23	15	Black	Both parents	Unplanned
24	16	Mixed race	Mother, no father	Unplanned
25	17	Black	Mother	Unplanned
26	18	Mixed race	Both parents	Unplanned
27	17	Black	Mother	Unplanned
28	18	Black	Mother, no father	Unplanned
29	17	Mixed race	Both parents	Unplanned
30	18	Black	Mother	Unplanned
31	17	Black	Mother	Unplanned
32	17	Black	Mother	Unplanned

**N= 32**

### 5.4.1.1 Age

The participants were asked to indicate their age. This had to be determined in order to ensure that they qualified to take part in the study, as the study focuses on adolescents between the ages of 12 and 18 years.



**Figure 5.1 Age of participants**

Figure 5.1 indicates that all 32 (100%) of the participants were between 12 and 18 years old and therefore qualified for the study. Two (6%) of the participants were 14 years old and three (9%) were 15 years old. Three (9%) of the adolescents were 16 years old, ten (32%) were 17 years old and 14 (44%) were 18 years old. The participants can all be categorised into the early adolescent life phase. This stage is defined by Wait *et al.* (2005:19) as the sixth life stage, when the individual is between the ages of 12 and 18 years.

The findings show that the majority of the participants (24 or 75%) were towards the end of the early adolescent life phase, within the age bracket of 17 to 18 years. This indicates that adolescent pregnancy is more predominant amongst older adolescents than those who are at the beginning of this life stage. This correlates with South Africa statistics that reveal that adolescent pregnancy is more prevalent amongst adolescents between the ages of 15 and 19 (Department of Health, 2003).

#### **5.4.1.2 Race**

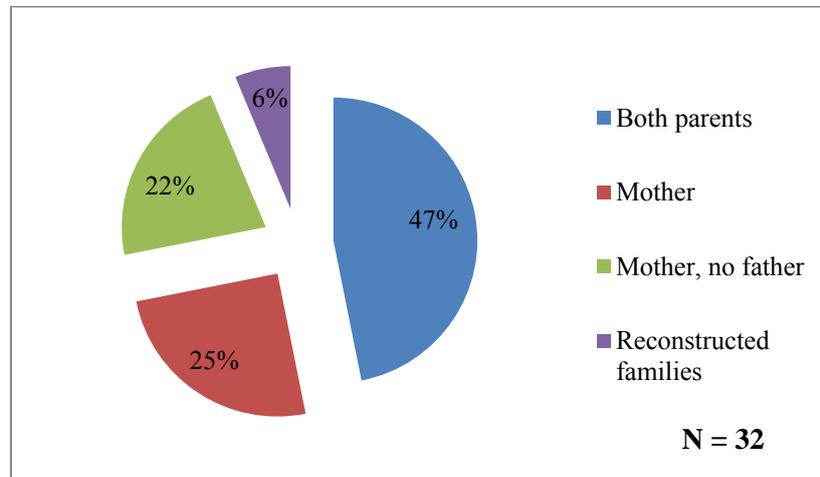
The participants (N = 32) were asked to indicate what community and race group they came from. Twenty-four (75 %) of the participants came from a low-income Xhosa speaking community. The other eight (25%) came from a low-income coloured or mixed race community. None of the participants (0%) came from a middle- or higher-income community, and none of the participants were white. Hence all the participants came from low-income communities.

According to Hallman (2004:2), economic disadvantage significantly increases the likelihood of unsafe sexual behaviours and experiences. Such communities, as were sampled in this study, are densely populated and informally structured, lack livelihood and recreational opportunities, and have high levels of crime. These factors contribute to the adolescent's chances of having unplanned pregnancies. The findings of the study correspond with the literature, in that unplanned adolescent pregnancy was prevalent amongst low-income communities with low socio-economic status.

Having participants from two particular race groups and one income-group allows for the research to be generalised into two types of communities and adolescents, instead of being limited to only a specific group of adolescents. This can be done as there were no noticeable differences between the participants from the different race and cultural groups.

### 5.4.1.3 Living arrangements

The participants were asked to indicate who they currently were living with. This gives an indication of their family structure.



**Figure 5.2 Respondents living arrangements**

As indicated by Figure 5.2 above, 15 (47%) of the participants, just less than half, lived with their mother and father. Eight (25%) of the participants indicated that they come from single-parent households, and all of these indicated that the mother was the parent who was present. Seven (22%) of the participants lived with their mother and had no contact with their father, and two (6%) of the participants live in reconstructed households.

Hockaday *et al.* (2000:434) suggest that family structure plays a vital role in adolescent sexual behaviour. Growing up in single-parent households, or without any parents, places the adolescent at higher risk of an early unplanned pregnancy. Fifteen (47%) of the respondents lived with both their parents. This means that, excluding the two participants who lived in reconstructed families, 15 (47%) either lived in a single-parent household or without their parents.

Corcoran (1999:610-611) offers two explanations for how growing up with a single parent or with no parents can lead to engaging in risky sexual behaviour. The first explanation is that, in a single-parent household, the adolescent has more responsibility for younger children and hence becomes socialised into a maternal role. A second possible reason for risky sexual behaviour is that adolescents need their parents, particularly their fathers, to discipline and

control them. The lack of control and guidance places them at risk for engaging in risky sexual behaviour.

The findings illustrated in Figure 5.2 hence correlate with the above mentioned literature. Nearly half (15 or 47%) of the participants did not live with both their parents and this could be a contributing factor to their unplanned pregnancies.

#### **5.4.1.4 Nature of the pregnancy**

All (32 or 100%) of the participants indicated that their pregnancy was unplanned. Having an unplanned pregnancy was one of the criteria for inclusion in the study. Determining that all the participants' pregnancies were unplanned ensured that they qualified to participate in the study.

Marecek (1987:89) states that most adolescent pregnancies are unintended and unplanned, and this gives rise to a personal crisis. Furthermore, the adolescent is propelled into a state for which she is unready and unprepared to assume (Daniels & Nel, 2009:62). Hence the adolescent who has an unplanned pregnancy has a significantly different experience of support and stressors compared to an individual who has planned her pregnancy.

#### **5.4.2 The adolescent**

The following section explores the individual characteristics and behaviour of adolescents. Ecological concepts, as described by Germain and Gitterman (1996:15), such as relatedness, competence, self-direction and self-esteem, will be discussed. Furthermore, individual characteristics that place the adolescent at risk of an unplanned pregnancy, such as sexual activity and the use of contraceptives, will be examined. Furthermore, the emotional response to the pregnancy, as well as the social and educational aspects of pregnancy, will also be explored.

### 5.4.2.1 Self esteem

The adolescent's self-esteem before and during the pregnancy was explored. The participants were asked to indicate if their level of self-esteem had changed as a result of their pregnancy, and to explain why they felt it had changed. The results are summarised in Table 5.2 below.

**Table 5.2 Change in self-esteem as a result of the pregnancy**

<b>THEME: CHANGE IN SELF-ESTEEM AS A RESULT OF PREGNANCY</b>		
<b>Subtheme – self-esteem before the pregnancy (N = 32)</b>	<b>Narratives</b>	<b>f (%)</b>
High self-esteem before pregnancy	<p><i>“Before I was preg I loved myself, I was happy.”</i></p> <p><i>“I was confident and proud about myself before my pregnancy.”</i></p>	27 (84%)
Low self-esteem before pregnancy	<p><i>“I always felt bad about myself, I didn't like who I was.”</i></p> <p><i>“I had low self-esteem before my pregnancy.”</i></p>	5 (16%)
<b>Subtheme – self-esteem during the pregnancy (N = 32)</b>		
High self-esteem during pregnancy	<i>“I felt more mature when preg, like I now knew what life was about.”</i>	1 (3%)
Low self-esteem during pregnancy	<p><i>“I hated myself when I looked in the mirror.”</i></p> <p><i>“I had low body image, I didn't like myself anymore.”</i></p> <p><i>“I was so disappointed in myself, I became introverted and less confident.”</i></p>	31 (97%)

**N = 32**

#### (i) Self-esteem before the pregnancy

According to Table 5.2 twenty-seven (84%) of the participants said that they had high self-esteem before their pregnancy. This was determined by the participants expressing confidence in their body image (*“...I loved myself...”*), belief in their personal abilities and a general happiness about themselves (*“I was confident and proud...”*). Five (16%) of the participants said that they had poor self-esteem before their pregnancy. These participants expressed that

they felt bad about themselves and had low self-esteem (*"I always felt bad about myself, I didn't like who I was"*).

According to Holgate *et al.* (2007:2), low self-esteem plays an important role in adolescents falling pregnant. A pattern of worthlessness develops and they become passive receivers of anything easy that is offered to them. Looking to the future and the possible consequences of an enjoyable activity is a difficult concept. Holgate *et al.* (2007:2) hence suggest that low self-esteem is a significant contributing factor to adolescent pregnancy. This contradicts the findings in Table 5.2 as majority (27 or 84%) said that they had high self-esteem before they fell pregnant, and hence this cannot be considered a contributing factor to adolescent pregnancy.

#### **(ii) Self-esteem during the pregnancy**

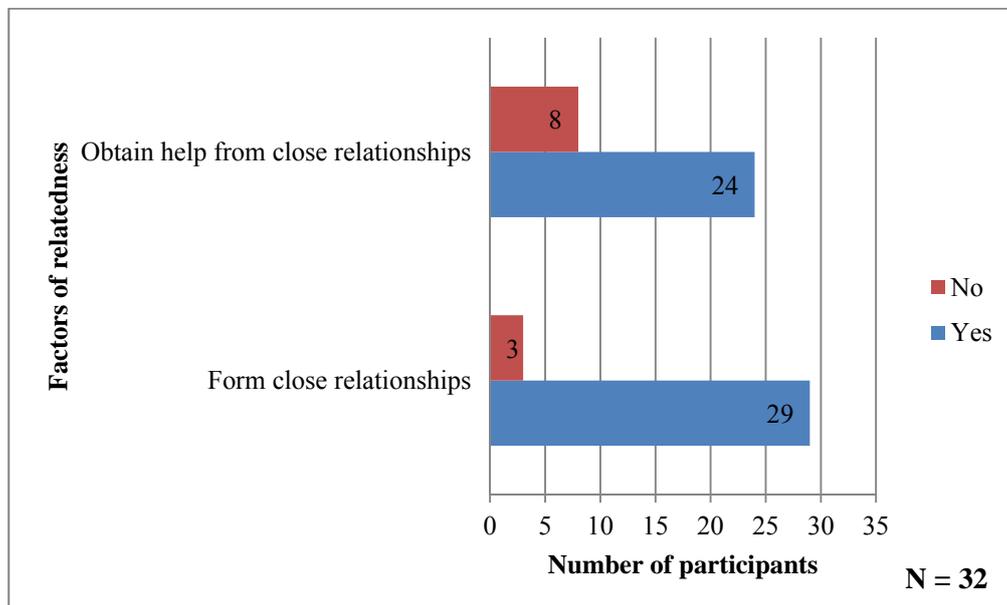
However, for many of the adolescents their feelings of self-esteem changed once they were pregnant. After the pregnancy only one (3%) participant expressed that she had higher self-esteem than before her pregnancy. Her higher self-esteem was attributed to increased confidence in herself and feelings of maturity (*"I felt more mature when preg, like I now knew what life was about"*).

The majority of the participants said that they had lower self-esteem during their pregnancy than before. This was indicated by 31 (97%) of the participants. Lowered self-esteem was reported due to a lowered body image (*"I hated myself when I looked in the mirror"*), loss of confidence, and loss of respect for oneself (*"I was so disappointed in myself, I became introverted and less confident"*).

According to Philkill and Walsh (2002:56), the adolescent often feels like a failure due to the pregnancy, and these feelings are exacerbated when she considers how she has failed her family's, friend's and boyfriend's expectations, as well as lost the possibility of a successful future. These feelings permeate all aspects of her life and she becomes overwhelmed by her emotions. All these negative emotions related to the pregnancy lead to a loss in self-esteem for the adolescent. This literature is supported by the findings presented in Table 5.2 as the majority (31 or 97%) of the participants expressed a lowered self-esteem as a result of their pregnancy.

### 5.4.2.2 Relatedness

Relatedness refers to an individual's capacity to form attachments (Payne, 2005:151). The participants were asked to indicate whether they were able to form attachments and use these attachments as part of a supportive network. The results are indicated in Figure 5.3.



**Figure 5.3 Relatedness**

According to the above Figure 29 (91%) of the participants felt that they could form close relationships with their friends and family. Three (9%) of the participants felt that they could not form close relationships with their families. In addition, 24 (75%) participants felt that they could go to their friends and family to help them cope with stressful experiences or problems. Eight (25%) felt that they could not go to their family or friends to help them cope.

Payne (2005:151) states that attachments are made to people who are key influences in the individual's life, for example friends and family. Relatedness incorporates ideas about isolation and the lack of supportive networks. Adequate social networks are important buffers against stress (Germain & Gitterman, 1996:15). For the adolescent who is able to form good attachments and use these attachments to buffer stress, she is more likely to cope successfully with the unplanned pregnancy.

The concept of relatedness was clearly reflected by two of the participants who had opposite experiences of close attachments with people as a buffer against stress. One participant was raped at a young age, but was able to talk about this and about her unplanned pregnancy with people who were close to her. This helped her significantly in dealing with both these issues, as expressed in her statement below:

*“Talking about my rape has made it easier for me to deal with it. It doesn’t hurt any more when I talk about it. I can talk to my boyfriend and family about anything, so I know I can deal with every problem.”*

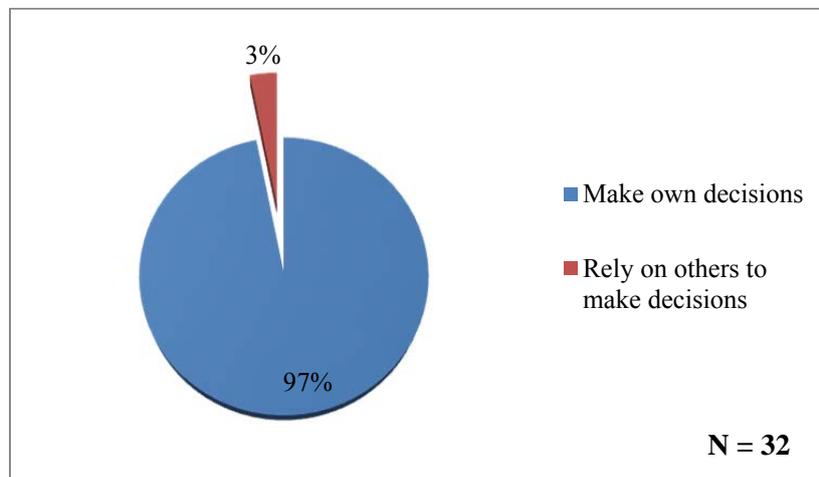
The other participant had not spoken to anyone about her negative emotions concerning her unplanned pregnancy and, as a result, finds it difficult to accept her baby and to be positive about her life. She stated:

*“I haven’t spoken to anyone about my pregnancy. I have held it in all this time, which is very hard. I still feel angry and hurt about the pregnancy, I suppose I should try to deal with these emotions. It just makes it hard for me to accept my boy and to feel happy about life.”*

Figure 5.3 indicates that the majority of the participants were able to form close relationships with their family and friends (29 or 91%), as well as obtain help from these relationships when problems arose (24 or 75%). From the statements above, the findings shown in Figure 5.3 correlate with those in the literature, as the adolescents who had close relationships experienced these to be buffers against stress.

### 5.4.2.3 Competence and self-direction

Competence and self-direction refer to the individual's ability to take action and control over her life (Payne, 2005:151). The participants were asked to evaluate this in terms of how they make their decisions. Their answers are summarised in Figure 5.4.



**Figure 5.4 Decision making**

Thirty-one (97%) of the respondents indicated that they made their own decisions. One (3%) participant indicated that she wanted other people to make her decisions for her. Farber (1991:714) and Motjelebe (2009:11) are in agreement that most adolescents rely on other people to make decisions for them during their pregnancy. The adolescent makes decisions based primarily on what her family and friends advise her to do, and not based on her intrinsic motivation.

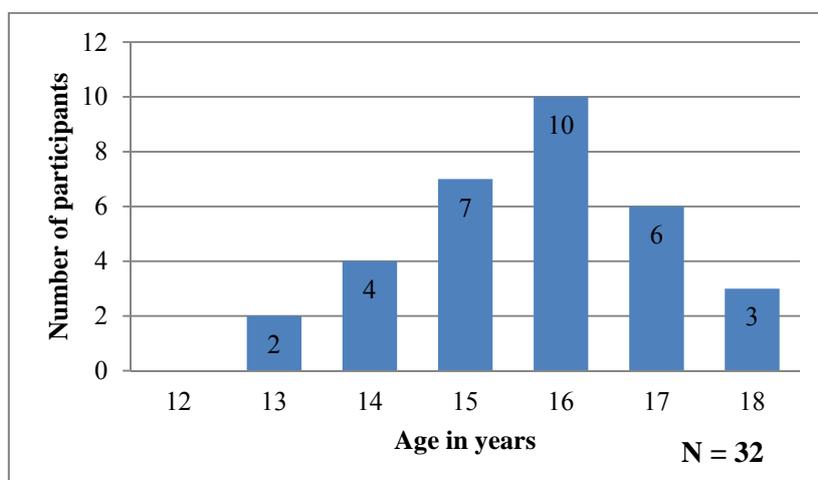
The findings of the literature appears to contradict the findings of the study, as presented in Figure 5.4, as most of the adolescents (97%) made their own decisions regarding their life decisions, sexuality and pregnancy.

#### 5.4.2.4 Sexual activity

The participants were asked questions pertaining to their sexual activity. Age at first sexual experience, reasons for engaging in sex, and history of abuse were explored. All these factors can contribute to the adolescent having an unplanned pregnancy.

##### (i) Age at first sexual experience

The participants were asked to indicate their age at their first sexual experience. The findings are indicated in Figure 5.5.



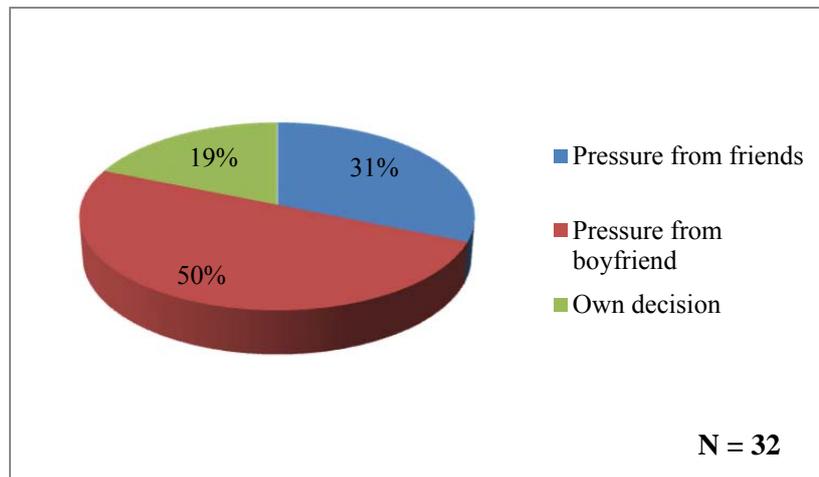
**Figure 5.5 Age at first sexual experience**

According to Figure 5.5, two (6%) participants indicated that their first sexual experience was at the age of 13. Four (13%) had sex for the first time when they were 14. Seven of the participants indicated that their age at their first sexual experience was when they were 15 (22%), ten (31%) said that they were 16, six (19%) were 17 and three (9%) were 18 years old.

Statistics suggest that the majority of women have their first sexual experience at the age of 18 (Department of Health, 2003). The findings of this study contradict the statistics, as the majority of the participants had their first sexual experience at the age of 16 (31%), with the second most at the age of 15 (22%).

### (ii) Reason for engaging in sexual activity

The participants were asked to give their primary reason for engaging in sexual relationships. They were asked whether it was pressure from their friends, pressure from their boyfriend, or their own decision to engage in sexual activity. There was also the option for them to state other reasons for engaging in intercourse, should the given categories not have applied.



**Figure 5.6 Reason for engaging in sexual activity**

Ten (31%) of the participants indicated that their main reason for engaging in sexual activity was due to pressure from friends. Sixteen (50%) participants indicated that pressure from their boyfriends was their main reason for engaging in sexual activity, whilst six (19%) said that it was their own decision to engage in sexual activity. None (0%) of the participants indicated any other primary reasons for engaging in sexual activity. From the above it can be assumed that pressure from the adolescents' boyfriends is the main reason for adolescents engaging in sexual activity.

Kirby (2002:480) found that the primary reason for adolescents engaging in sexual behaviour was pressure from the adolescent's friends or romantic partner. Engaging in sexual behaviour increases feelings of being accepted by the adolescent's friends or boyfriend, as the adolescent conforms to their norms and expectations of behaviour.

In addition, Louw and Louw (2007:290) state that, if adolescents believe that their peers are engaging in sexual behaviour, then they are more likely to do so themselves. Adolescents feel pressure to behave in the same way as their friends, and a noticeable emphasis is placed on

the pressure from peer relationships. This was emphasised by one of the participant's comments:

*“I had sex because my friends were having sex. They all talk about it; it's embarrassing being a virgin.”*

These findings in the literature correlate with the findings of this study as represented in Figure 5.6, which shows that a majority (26 or 81%) of the adolescents engaged in sex as a result of pressure from their friends or boyfriend. There is pressure for the adolescent to conform to a norm of expected behaviour, and as a result she engages in sexual activities.

### **(iii) Abuse**

The participants (N = 32) were asked whether they had ever been sexually, emotionally or physically abused. Twenty-nine (91%) of the participants said that they had never been sexually, emotionally or physically abused. Three (9%) participants indicated that they had experienced some form of abuse.

Francisco *et al.* (2008:237) found that there was a strong correlation between abuse and adolescent pregnancy. Their study indicated that a large proportion of young mothers reported a history of physical, sexual or emotional abuse. One of the predominant reasons why adolescent who have been abused are at risk of unplanned pregnancy is that they have experienced a violation of their most intimate boundaries. This leads to a decreased ability to negotiate contraceptive use and sexual boundaries (McCullough & Scherman, 1991:810; Panday *et al.*, 2009:34). This was made clear when one participant spoke about how she had been raped at a younger age, and she said that this was one of her main reasons for falling pregnant, as she *“needed something”* for herself.

The findings of this study related to abuse indicate that abuse had not been a significant contributing factor to unplanned adolescent pregnancy amongst the selected participants, as the majority (29 or 91%) of the adolescents had never been abused. However, for the one participant who was willing to talk about her experience, the abuse was linked to her pregnancy.

### 5.4.2.5 Use of contraceptives

The participants were asked several questions concerning their use of contraceptives. Poor contraceptive use can be a risk factor for adolescent pregnancy (Hudson & Ineichen, 1991:32).

#### (i) Use of contraceptives before pregnancy

The participants were asked to indicate whether or not they used contraceptives before they fell pregnant.

**Table 5.3 Use of contraceptives before pregnancy**

<b>BEHAVIOUR</b>	<b>YES: f (%)</b>	<b>NO: f (%)</b>
Use of contraceptives before pregnancy	9 (28%)	23 (72%)

**N = 32**

Table 5.3 shows that nine (28%) participants had made use of contraceptives before they fell pregnant, while 23 (72%) had not used contraceptives before they fell pregnant. This means that 72% of the participants failed to use contraceptives before they fell pregnant.

The participants who had used contraceptives used condoms as their main method of contraception. Several of the participants expressed fear of the injection and said that it was too sore to get it. Many of the participants said that the pill was not readily available at their local clinics and hence they could only use condoms or the injection.

In a South African study by the Kaiser Family Foundation and the South African Broadcasting Corporation (2007:28) it was found that two thirds of young women who reported pregnancy identified that they had failed to use contraceptives before their pregnancy.

These findings support the findings of this study as represented in Table 5.3, as 23 (72%) of the participants had not used contraceptives before their pregnancy. The reasons for not using contraceptives will be explored below (5.4.2.5 - (iii) Reasons for not using contraceptives).

**(ii) Use of contraceptives from first sexual experience**

The nine respondents who indicated yes in the previous question were then asked if they had used contraceptives from their first sexual experience.

**Table 5.4 Use of contraceptives from first sexual experience**

BEHAVIOUR	YES: f (%)	NO: f (%)
Use of contraceptives from first sexual experience	7 (78%)	2 (22%)

**N = 9**

From Table 5.4 it can be deduced that only seven of the participants used contraceptives from their first sexual experience. Two (22%) had failed to use contraceptives from their first sexual experience. This indicates an irregular use of contraceptives and therefore a higher risk of falling pregnant.

According to Andersen and Taylor (2006:353), approximately one third of adolescents use no contraceptives from the first time that they have intercourse. Adolescents tend to delay the use of contraceptives until several months after they become sexually active.

For one adolescent, not using contraceptives from her first sexual experience had a significant impact on her. She fell pregnant the first time that she engaged in sexual activity. She said:

*“I didn’t use a condom, it was the first time I was having sex. I had sex once with my boyfriend and I fell pregnant.”*

Possible reasons for not using contraceptives from their first sexual experience are often related to the fact that adolescents do not admit that they are sexually active, they experience guilt concerning their sexual activity, or experience contraceptives as being a concrete reminder of their behaviour (Evangelisti, 2000:15; Wait *et al.*, 2005:159).

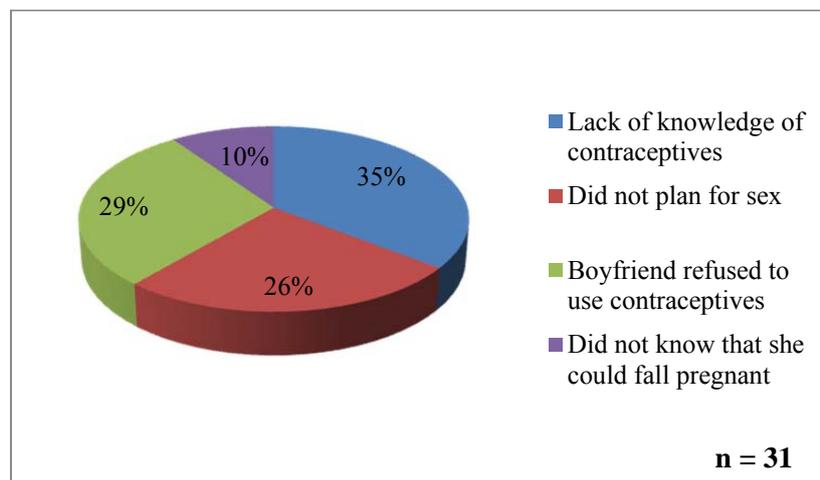
Table 5.4 indicates that only seven (78%) participants made use of contraceptives from their first sexual experience (n = 9). If the total sample of 32 participants is considered, this means that 25 (78%) of the adolescents did not use contraceptives from their first sexual experience, if at all, during sexual activity. The findings indicated in Table 5.4 support the findings suggested by the literature, as the majority (25 or 78%) of the participants (N = 32) failed to use contraceptives from their first sexual experience.

Based on the above it is clear that some of the participants had used contraceptives before their pregnancy, and even from the first time that they engaged in sexual activity. This then

raises the question why they did not use contraceptives, as it resulted in them falling pregnant. Many of the adolescents said that they had not planned to have sex at the time or that it just happened, as indicated in section iii below (5.4.2.5 - (iii) Reasons for not using contraceptives).

### (iii) Reasons for not using contraceptives

On the basis of the above findings, the participants were asked to indicate their primary reason for not using contraceptives. The participants who did use contraceptives from their first sexual experience were also asked to respond as to why they had not used protection, thus falling pregnant. One of the participants said that she had used a condom, but that it had broken, hence the sample size is 31 ( $n = 31$ ).



**Figure 5.7 Reasons for not using contraceptives**

Figure 5.7 indicates that 11 (35%) of the adolescents had not used contraceptives because they did not have knowledge of them. Eight (26%) indicated that they did not plan to have sex and hence did not have any contraceptives available at the time. Furthermore, nine participants (29%) said that they had not used contraceptives because their boyfriend refused to use them, and three (10%) said that they did not know that they could fall pregnant. From Figure 5.7 it can be deduced that there are many reasons why adolescents do not use contraceptives.

According to Louw and Louw (2007:294), numerous adolescents believe that they are too young to fall pregnant, that they have intercourse too irregularly to fall pregnant, or that they can only fall pregnant during menstruation. Some adolescents are unclear about the connection between birth control, menstruation, intercourse, fertility and conception. It was clear in this study that some of the girls did not have knowledge of their bodily functioning and pregnancy. Below are some of their statements:

*“I thought I was too young to be pregnant, so I didn’t worry about condoms.”*

*“I didn’t know that I could fall pregnant.”*

*“I only had sex a few times, I didn’t think I would get pregnant.”*

*“I did not think that my body was ready to be pregnant, it is only for older women.”*

These statements clearly indicate ignorance about sexuality, fertility, contraceptives and how one falls pregnant. Figure 5.7 indicates that 11 (35%) participants did not have knowledge of contraceptives, and three (10%) of the participants did not know that they could fall pregnant. These findings therefore correlate with the findings of Louw and Louw (2007).

One of the main reasons for failing to use contraceptives, according to the literature, is that sexual intercourse is not planned and that it “just happens”, and adolescents therefore do not have contraceptives available at the time (Evangelisti, 2000:15; Louw & Louw, 2007:294). This was indicated by eight (26%) of the participants in the study, who had not planned to have sex.

Furthermore, Hallman (2004:17) reports that, when adolescents try to negotiate the use of contraceptives, their partners usually respond with violence. This discourages adolescents from negotiating contraceptive use in the future. Adolescents also choose not to make use of contraceptives for fear of taking away the romance or the spontaneity of the moment, because their partners do not want to use condoms. The boyfriend refusing to use contraceptives was indicated by nine (29%) of the participants in this study.

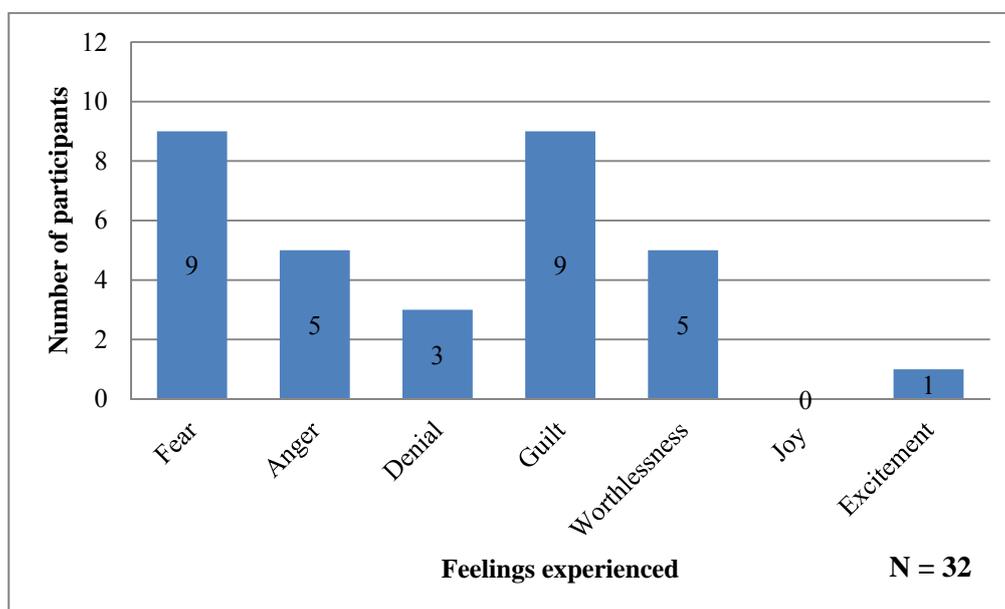
The findings as shown in Figure 5.7 hence support the findings of the literature, and highlight the four primary reasons for adolescents not using contraceptives during intercourse.

### 5.4.2.6 Emotional response

The participants were asked questions about their emotional response to the pregnancy, whether they viewed the pregnancy as a crisis, and how they felt about disclosing the pregnancy to their parents and partner.

#### (i) Emotional response to pregnancy

The participants were asked to indicate what their emotional response was when they found out that they were pregnant.



**Figure 5.8 Participants' emotional responses to pregnancy**

As shown in Figure 5.8, most of the adolescents experienced fear (9 or 28%) or guilt (9 or 28%) when they discovered that they were pregnant. Five (16%) participants indicated that they felt anger, and three (9%) experienced denial when they found out that they were pregnant. Furthermore, five (16%) indicated that they felt worthless when they found out about their pregnancy. None (0%) of the participants indicated that they felt joy, and only one (3%) said that she felt excitement when she found out about her pregnancy.

When the adolescent finds out that she is pregnant she experiences a range of emotions. According to numerous authors (Philkill & Walsh, 2002:53-56; Swart, 1993:25-27; Trad, 1999:225-230), the most commonly experienced emotions are fear, anger, denial, guilt and

worthlessness. One also has to allow for the possibility that the adolescent could experience a positive emotion in reaction to her pregnancy, as indicated by the participant's statement below:

*“When I found out that I was pregnant I didn't panic. I just thought about it and realised that I had to make the best of it because I couldn't get rid of my baby. Once I realised this I was excited that I was going to be a mom.”*

However, not many adolescents experienced excitement when they find out that they are having an unplanned pregnancy, and the most common emotions are negative ones. Feelings of fear are often related to the fact that the adolescent does not know how she will support the child, how people will react to the news, and fear that the truth of her sexual activities will be revealed (Hudson & Ineichen, 1991:74-79). Nine (28%) of the participants indicated that they experienced fear when they found out that they were pregnant.

The adolescent may also experience anger when she finds out about her pregnancy, and this anger can be directed at herself, her boyfriend, or even her parents for not educating her about sex and contraceptives (Motjelebe, 2009:10). An emotional response of anger was indicated by five (16%) of the participants.

Nine (28%) of the participants said that they experienced guilt when they found out that they were pregnant. Guilt is experienced because the adolescent is caught engaging in risky sexual behaviour. Furthermore, she feels guilty for possibly lying about her sexual behaviour and for not practising safe sex (Evangelisti, 2000:18). In addition, the adolescent may experience worthlessness because she feels like a failure due to her pregnancy (Philkill & Walsh, 2002:56). Five (16%) of the participants indicated that they experienced feelings of worthlessness when they found out that they were pregnant.

Finally, the adolescent also experiences denial. Three (9%) of the participants said that they were in denial when they found out that they were pregnant. Farber (1991:701-702) found that adolescents often strongly suspect that they are pregnant, but delay receiving a diagnosis until they no longer can deny the possibility of the pregnancy.

The findings shown in Figure 5.8 support the findings of the literature in identifying feelings of fear, anger, denial, guilt and worthlessness as the main emotional responses of adolescents when they find out that they are pregnant.

### (ii) Experiencing the pregnancy as a crisis

The participants were asked to indicate whether they experienced the pregnancy as a crisis or not, and were then asked to explain why they perceived the pregnancy to be a crisis.

Almost all (28 or 88%) of the participants said that the pregnancy was a crisis for them. Main reasons for experiencing the pregnancy as a crisis were related to fear of how the family would respond, worry about their school and ambitions, as well as anxiety over limited resources. These aspects are summarised in Table 5.5. Only four (12%) of the participants said that they did not view the pregnancy as a crisis, hence the size of the sample was 28 (n = 28).

**Table 5.5 Reasons for perceiving the pregnancy as a crisis**

<b>THEME: REASONS FOR PERCEIVING THE PREGNANCY AS A CRISIS</b>			
<b>Subtheme</b>	<b>Category</b>	<b>Narratives</b>	<b>f (%)</b>
<b>Personal resources</b>	Lack of personal coping abilities	<p><i>“It was like a catastrophe! I didn’t know how I would cope.”</i></p> <p><i>“My life was going to change, I was going to have to think about someone else now.”</i></p>	10 (36%)
	Concern about completing school	<p><i>“I was still at school, I didn’t know if I could finish.”</i></p> <p><i>“I just worried about staying in school.”</i></p>	2 (7%)
<b>Subtotal</b>			<b>12 (43%)</b>
<b>Disclosing to parents</b>	Fear that parents would kick them out	<p><i>“I thought they would be so cross they would kick me out the house.”</i></p> <p><i>“Didn’t want to tell my mom, I was scared she would kick me out.”</i></p>	2 (7%)
	Fear that parents would be very angry	<i>“My family looked up to me. I did something that would disappoint them, I knew my parents would be angry.”</i>	12 (43%)
<b>Subtotal</b>			<b>14 (50%)</b>
<b>Stigma within the community</b>	Fear that the community would be judgemental	<p><i>“I was scared about what the community would think.”</i></p> <p><i>“I was afraid of the community.”</i></p>	2 (7%)
<b>Subtotal</b>			<b>2 (7%)</b>

**n = 28**

The adolescent life phase is described as a state of crisis for adolescents because of the many personal and social changes that they go through. When the adolescent has an unplanned pregnancy it adds to the stress of the developmental phase and can be considered as a personal crisis (Marecek, 1987:89; Trad, 1999:221).

It is clear that, during this time, the adolescent needs to learn coping skills in order to adjust to the pregnancy and to successfully disclose the news to the relevant people. The counsellor in this situation needs to help the adolescent restore balance and activate coping skills (Marecek, 1987:90).

The participants' reasons for experiencing the pregnancy as a crisis were related to concerns regarding personal resources, disclosing to their parents, and stigma within the community. These will be discussed in more detail below.

#### **(a) Personal resources**

One of the primary reasons that the adolescents experienced the pregnancy as a crisis was that they were anxious about the decisions that they had to make about their future, as well as the future of their child ("*...I was going to have to think about someone else now*"). For the participants, this caused stress and anxiety, as they had to appraise which resources were available to help them cope with the pregnancy ("*It was like a catastrophe! I didn't know how I would cope*"). The lack of personal coping resources was indicated by ten (36%) of the participants as their main reason for perceiving the pregnancy as a crisis.

In addition, two (7%) of the participants were concerned that they would not be able to attend school or complete their education ("*I was still at school, I didn't know if I could finish*"). For these participants the pregnancy was a crisis because they wanted to remain in school but did not know if they could cope personally or if they had the financial resources to remain in school.

According to Payne (2005:151) when people experience a life stressor they move through a stage of appraisal. During this time they judge how serious the stressor is. They also look at what resources they have to help them. Appraising the stressor as harmful and having limited resources causes the individual to feel a sense of jeopardy and crisis. This is supported by the findings in Table 5.5 as twelve (43%) of the participants indicated the lack of personal resources as their main reason for perceiving the pregnancy as a crisis.

**(b) Disclosing to parents**

Table 5.5 also indicates that the adolescents' main reason for assessing their pregnancy as a crisis was fear of how other people, namely their parents and family, would respond to the news of the pregnancy. This reason was indicated by 14 (50%) of the participants.

The participants said that they were scared to tell their parents about the pregnancy because they (2 or 7%) feared that their parents would kick them out of the house (*"Didn't want to tell my mom, I was scared she would kick me out"*) or because they (12 or 43%) were scared that their parents would be angry (*"... I did something that would disappoint them, I knew my parents would be angry"*).

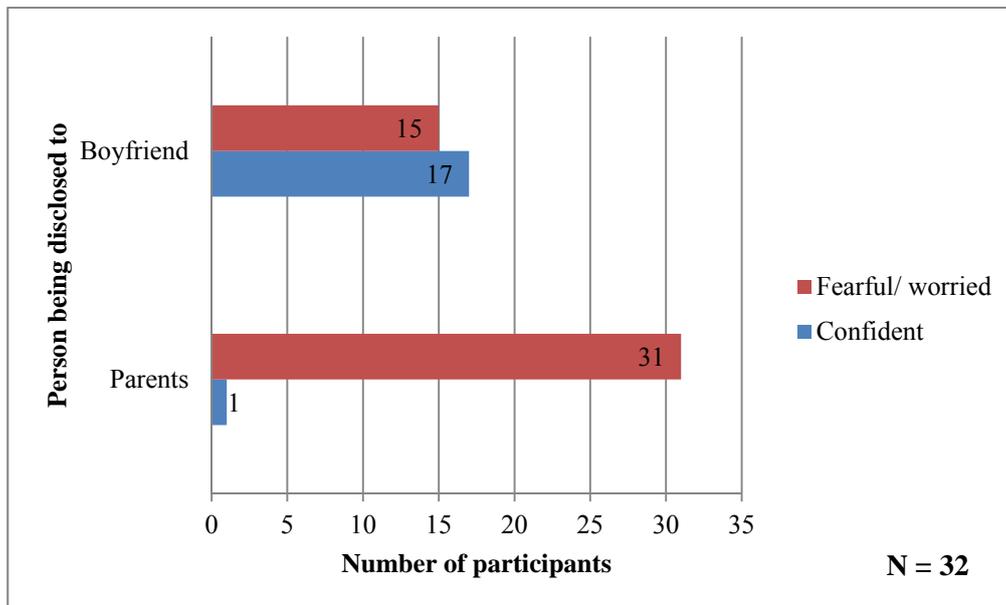
**(c) Stigma within the community**

Two (7%) of the participants expressed that they were anxious about how the community would judge them because they were pregnant (*"I was scared about what the community would think"*). The participants expressed that they did not want to be seen in their community and they were scared of how people would treat them (*"I was afraid of the community"*).

According to Hudson and Ineichen (1991:74-79), adolescents feel anxious and fearful of how their family and parents will respond to the pregnancy, as well as what people in the community will think and say about them. This literature correlates with the findings depicted in Table 5.5 as pregnancy was viewed as a crisis for the majority (28 or 88%) of the adolescents.

### (iii) Disclosing the pregnancy

The adolescents were asked how they felt about telling their parents and boyfriend about the pregnancy. For many adolescents, disclosing a pregnancy is a stressful experience and this can contribute to the adolescent appraising the pregnancy as a crisis (Wiemann *et al.*, 2005:352.e3).



**Figure 5.9 Feelings regarding disclosing the pregnancy to parents and boyfriend**

The findings in Figure 5.9 show that 31 (97%) of the adolescents participating in the study were fearful about telling their parents about their pregnancy. One (3%) said that she was not scared to tell her parents about the unplanned pregnancy. The adolescents' reasons for fearing disclosure relate closely to the reasons for perceiving the pregnancy as a crisis, as discussed in section ii above (5.4.2.6-(ii) Experiencing the pregnancy as a crisis). These reasons include fear that their parents would kick them out of their home, that their parents would be very angry, or that their parents would not talk to them. This is supported by the literature, as Wiemann *et al.* (2005:352.e3-e5) state that adolescents are afraid to tell their parents about their pregnancy because they fear that their parents will think they have made a big mistake and want nothing to do with them.

Furthermore, Figure 5.9 indicates that 15 (47%) of the adolescents were worried about telling their boyfriend about their pregnancy, whilst 17 (53%) said that they were confident to tell him. Some adolescents claimed that they were worried about telling their boyfriend for fear of

him ending the relationship. Most said that they felt confident to tell him because they knew that they could not avoid it and had to face the truth.

In summary, the majority (31 or 97%) of the participants were scared to disclose the pregnancy to their parents. Nearly half (15 or 47%) of the participants expressed that they were fearful about telling their boyfriend about the pregnancy. This clearly indicates that adolescents are more concerned about disclosing the pregnancy to their parents, and that they feel more confident about disclosing the pregnancy to their partners.

#### 5.4.2.7 Education

The participants were asked questions about how their pregnancy affected their schooling.

##### (i) Remaining in school after discovery of pregnancy

All of the participants were in school when they found out that they were pregnant. They were asked to indicate whether or not they remained in school while they were pregnant.

**Table 5.6 Remaining in school after discovery of pregnancy**

	<b>YES: f (%)</b>	<b>NO: f (%)</b>
Participant remained in school when pregnant	24 (75%)	8 (25%)
Pregnancy made schooling more challenging	22 (69%)	0
Pregnancy was the main reason for dropping out of school	8 (25%)	0
Pregnancy had no negative effect on schooling	2 (6%)	0

**N = 32**

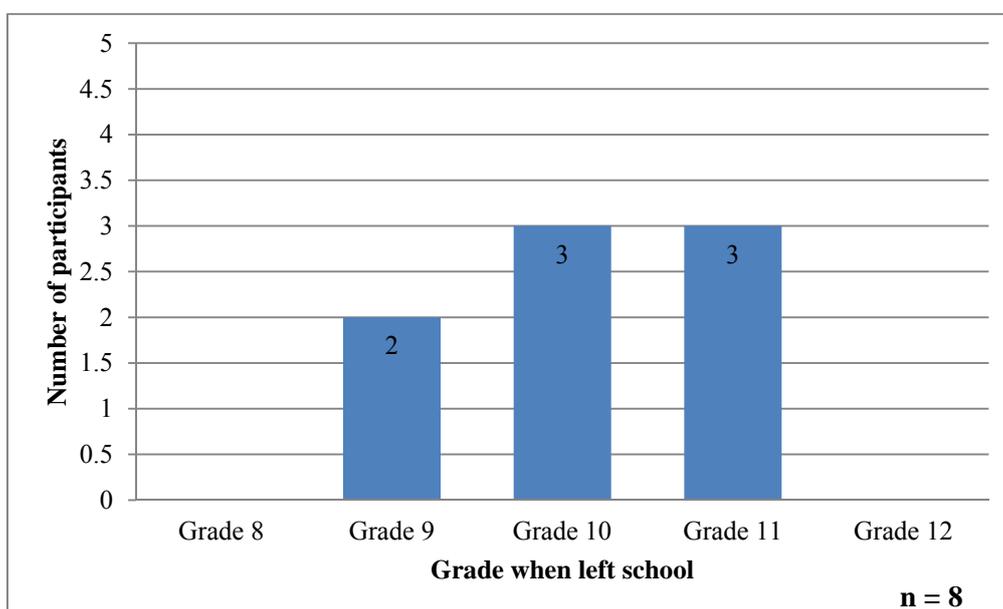
Three quarters (24 or 75%) of the participants said that they had remained in school while they were pregnant, while a quarter (8 or 25%) said that they left school when they were pregnant.

All of the participants who left school (8 or 25%) indicated that pregnancy was their main reason for dropping out of school. Of the participants who remained in school, 22 (69%) said that being pregnant in school made schooling more challenging. The reasons that these participants felt that they could stay in school were largely due to having a supportive family who encouraged them to continue with school and who were committed to help care for the baby once it arrived so that the adolescent could continue with her schooling career. Only two (6%) participants said that the pregnancy had no negative effect on their schooling.

Panday *et al.* (2009:27) suggest that, despite educational policies that encourage pregnant adolescents to continue their education or return after the birth of their child, approximately only a third re-enter the schooling system. This contradicts the findings of the current study, as it is clear from Table 5.6 that the majority (24 or 75%) of the participants remained in school when they were pregnant and returned to school after the birth of their baby.

**(ii) The grade the participant was in when she left school**

The eight participants who did not remain in school were asked to indicate which grade they were in when they left school.

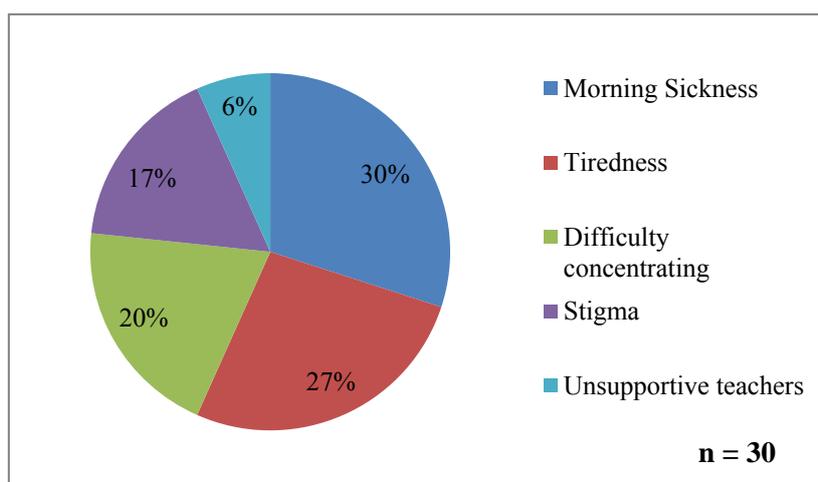


**Figure 5.10 Grade the participant was in when she left school**

According to Figure 5.10, two (25%) of the participants were in grade nine when they left school. Three (37.5%) were in grade ten and three (37.5%) were in grade eleven when they left school. According to the literature, the majority of pregnant adolescents leave school before completing their education and do not return (Gouws *et al.*, 2000:170; Hudson & Ineichen, 1991:158; Wait *et al.*, 2005:159). For these participants, pregnancy was their main reason for dropping out of school and not returning, hence they never completed their education.

### (iii) Aspects making it difficult to remain in school

The participants who indicated that they found schooling more challenging or that they dropped out of school were asked to indicate what made it difficult for them to remain in school. Two of the participants said that their pregnancy had no negative effect on their schooling and they therefore did not answer the following question, hence the size of the sample is 30 participants ( $n = 30$ ).



**Figure 5.11 Aspects making it difficult to remain in school**

According to Figure 5.11, nine (30%) of the adolescents struggled with morning sickness and this made it hard for them to stay in school. Eight (27%) said that tiredness was an issue that made it hard for them to stay in school, and six (20%) said that they had difficulty concentrating. Five (17%) of the adolescents indicated stigma, and two (6%) indicated unsupportive teachers as the main aspect that had made it difficult to remain in school. None (0%) of the participants identified any other aspects that made it hard for them to remain in school.

According to Hudson and Ineichen (1991:119), difficulties with morning sickness and fatigue make it challenging for the adolescent to give her school work her full attention. It becomes hard for her to concentrate and to keep up with the pace of the work. Furthermore remaining in school often leads to experiences of criticism, chastisement and ridicule from peers and unsupportive teachers (Wiemann *et al.*, 2005:352.e4-e5). Some of the participants in the study experienced stigma and tried to cover up their pregnancy:

*“I wore big jackets to school so that no one could see my stomach. I was embarrassed and people gossiped about me.”*

The findings of the study as presented in Figure 5.11 hence support the literature in identifying the main aspects that made it hard for the pregnant adolescents to remain in school. The most significant of these aspects were morning sickness (9 or 30%) and tiredness (8 or 27%), which were indicated by the majority of the participants.

### **5.4.3 Microsystem**

The following section explores the microsystem of the pregnant adolescent. The main systems, for example parents, partner and friends, are considered in terms of how they offer supportive relationships before and during the pregnancy, as well as how they responded to the news of the unplanned pregnancy.

#### **5.4.3.1 Type of support**

The participants were asked to indicate which people had been the most supportive during their pregnancy. Support was divided into five main categories and the participants had to indicate who their main source of support was within each category.

**Table 5.7 Types of support received from different people**

Person	Money/ Financial	Giving advice	Positive encourage- ment	Physical assistance	Sharing private feelings	Rank of support
Mother	20 (62%)	20 (62%)	17 (53%)	25 (78 %)	12 (37%)	1
Father	6 (19%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	5
Boyfriend	4 (13%)	2 (6%)	3 (9%)	4 (13%)	6 (19%)	3
Friends	2 (6%)	5 (16%)	5 (16%)	0 (0%)	6 (19%)	4
Other	0 (0%)	5 (16%)	7 (22%)	3 (9%)	8 (25%)	2

**N = 32**

### **(i) Mother**

According to Table 5.7, mothers ranked as the highest form of support with regards to all the areas that were examined. Twenty (62%) of the participants said that their mother gave them the most financial support and advice during the pregnancy. Seventeen (53%) said their mothers were the highest source of positive encouragement, 25 (78%) of the participants mothers gave the most physical assistance, and 12 (37%) of the participants could share their private feelings with their mother.

This indicates that adolescents' mothers offer both practical concrete support as well as emotional support during the pregnancy. In all the categories the mother rated as the person who gave the most support during the pregnancy.

### **(ii) Other**

Several of the participants indicated that there were other people who offered a higher level of support than those listed in the given categories. These people were family members, particularly older sisters and aunts. Significantly, six of the participants indicated themselves as their greatest form of support within different categories. This was indicated for two different reasons. The first was that the participants generally kept their feelings and needs to themselves and found it hard to trust other people. The second reason was that the participants felt that they had no one to talk to and they were scared about how people would react to their pregnancy.

Other people ranked highest in areas of emotional support such as giving advice (5 or 16%), positive encouragement (7 or 22%), and sharing private feelings (8 or 25%).

**(iii) Boyfriend**

Boyfriends ranked as the third highest person who provided overall support during the pregnancy. However, the support attributed to them is significantly low compared to the support that mothers offer their pregnant daughters. Four (13%) of the adolescents said that their boyfriend helped financially during the pregnancy. Two (6%) participants said that their boyfriend was their primary source of advice, and three (9%) said that their boyfriend supported them by giving positive encouragement. Furthermore, four (13%) said their partners gave them physical support and six (19%) said that they could talk to their partner about their private feelings. The most significant form of support that the participants received from their boyfriend during the pregnancy was being able to talk to them about their personal feelings, as indicated by six (19%) of the participants.

**(iv) Friends**

Friends ranked fourth as the person to give the adolescent the most support during the pregnancy. Friends ranked low in daily needs, such as financial help (2 or 6%) and physical assistance (0%). However, on the emotional level friends were valuable in offering advice (5 or 16%) and encouraging the adolescent (5 or 16%), and the adolescent was able to talk to her friends about her private feelings (6 or 19%).

**(v) Father**

Finally, overall fathers ranked as the lowest source of support for the pregnant adolescents. The participants identified their fathers as supportive with regard to financial support. Six (19%) said that their fathers supported them financially. In all the other areas of support that were investigated, such as advice giving, positive encouragement, physical assistance and sharing of personal feelings, none of the adolescents (0%) identified their fathers as a significant source of support.

In a study conducted by Crase *et al.* (2007:508-509) various people were ranked according to the amount of support they gave the adolescent during pregnancy. They were also ranked according to certain categories, including financial support, giving advice, positive encouragement, physical assistance, and sharing private feelings. Within the study by Crase *et al.* (2007) the person who gave the highest support was nearly always attributed to the partner. The mother and friends came second as a significant person for support during adolescent pregnancy.

Koniak-Griffin *et al.* (1993:51) also explored a variety of sources of support. They found that families, and particularly mothers, were considered to be the highest and most significant form of support during adolescent pregnancy.

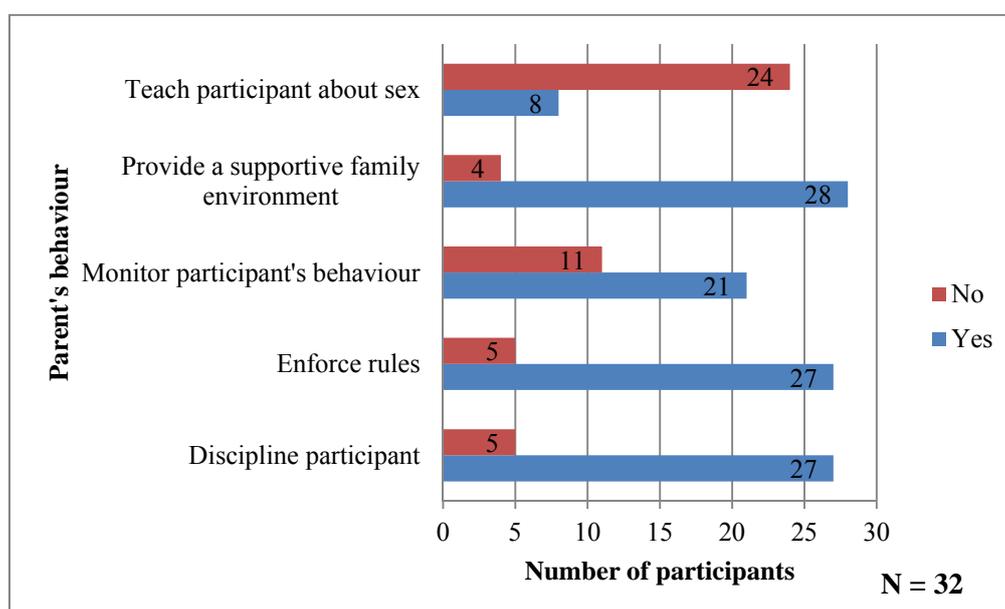
The findings of the empirical study shown in Table 5.7 support the literature in identifying the mother as a significant source of support, but suggest that it is mothers, and not boyfriends, that offer the adolescent the most support during her pregnancy. This study hence contradicts the findings of Crase *et al.* (2007:508-509). In fact, the boyfriend ranked significantly lower than the mother in all categories, and often support was attributed to others, such as siblings or extended family, before being attributed to the boyfriend. The findings in Table 5.7 also highlight the father as the person who offered the adolescent the least support in the various categories during the pregnancy.

### 5.4.3.2 Family

The participants were asked questions about their family life, specifically with regard to rules and discipline. The participants were also asked to discuss how their parents responded to the news of the pregnancy.

#### (i) Family life

The adolescents were asked to indicate certain factors related to their parents' parenting style. These factors are considered significant contributors to adolescent pregnancy.



**Figure 5.12 Parenting style**

#### (a) Discipline and support

The majority (27 or 84%) of the adolescents said that their parents disciplined them at home. With reference to enforcing rules, 27 (84%) of the participants said that their parents enforced rules in their house, and this was illustrated by 21 (66%) of the participants saying that their parents monitored their behaviour. In addition, 28 (88%) of the participants said that they felt that their parents provided a supportive environment. Four (12%) of the participants therefore felt that they did not have a supportive family environment.

Kirby (2002:479) suggests that parental control, support and monitoring can have a positive effect on the adolescent's sexual behaviour. Corcoran (1999:611) further states that parents

who set and enforce rules, monitor behaviour and provide a supportive environment can delay early sexual behaviour and limit the number of partners the adolescent has.

The findings in Figure 5.12 contradict the literature. The majority of the participants indicated that their parents disciplined them (27 or 84%), enforced rules (27 or 84%) and monitored their behaviour (21 or 66%). Most (28 or 88%) indicated that they had a supportive family environment. Hence it is clear that even though these protective factors were in place, they apparently had no significant impact on reducing the adolescent's risky sexual behaviour, as all the participants had an early unplanned pregnancy.

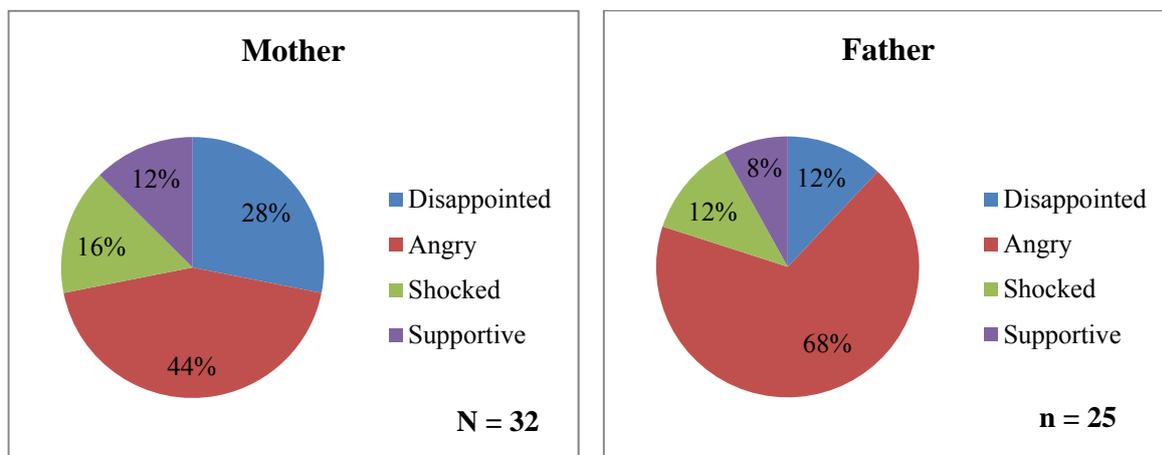
#### **(b) Teach children about sex**

Furthermore, 24 (75%), the majority of the participants, said that their parents did not teach them about sex. A low number of participants (8 or 25%) said that their parents did teach them about sex and talked to them openly about it. The literature (Evangelisti, 2000:22; Panday *et al.*, 2009:35) clearly supports that if parents teach their children about sex and sexual values they can have a significantly protective impact on the adolescent's sexual behaviour. Parents who are clear about their values against intercourse and about using contraceptives play a role in decreasing the risk of unintended pregnancy. However, Preston-Whyte (1991:35) states that, in most homes, parents do not teach their children about sex, and such discussions are considered taboo.

The findings in Figure 5.12 appear to agree with the literature, as most of the adolescents had not been educated by their parents about sex and contraceptives. As all of the adolescents who participated in the study had an unplanned pregnancy, the fact that their parents did not educate them on sexuality or protection can be considered as a contributing factor to adolescent pregnancy.

### (ii) Parents' responses to pregnancy

The adolescents were asked to indicate their parents' responses to their pregnancy.



**Figure 5.13** Parents' responses to pregnancy

The findings show that nine (28%) of the mothers and three (12%) of the fathers expressed disappointment when the pregnancy was disclosed. Fourteen (44%) mothers and 17 (68%) fathers expressed anger at the news of their daughter's pregnancy. The adolescents further reported that five (16%) mothers and three (12%) fathers were shocked when they found out about the pregnancy. Four (12%) of the mothers and two (8%) of the fathers showed their daughter support when she disclosed the news of the early unplanned pregnancy.

According to the literature (Farber, 1991:703; Hudson & Ineichen, 1991:74-75; Motjelebe, 2009:11), the most common reactions of parents when they find out that their adolescent daughter is pregnant are anger, shock and disappointment. Parents are typically shaken that their daughters are sexually active and that they are to have an unplanned pregnancy. This is supported by the findings in Figure 5.13, which show that 28 (88%) mothers and 23 (92%) fathers had a negative response to the adolescent's unplanned pregnancy.

Only two (8%) of the adolescents' fathers responded in a supportive manner, and four (12%) of their mothers responded supportively. Hudson and Ineichen (1991:74-75) suggest that the mother is more likely to respond in a supportive manner and copes well with the pregnancy. She is able to help the adolescent in making decisions and planning for the baby, once she has dealt with the initial shock of the news. Furthermore, Hudson and Ineichen (1991:74-75) state that fathers tend to be less accepting of their daughter's pregnancy. Occasionally the

relationship between the father and daughter is severed, as the father cannot accept the pregnancy and does not talk with his daughter.

This was the case for several of the participants, even for one who had a good relationship with her father:

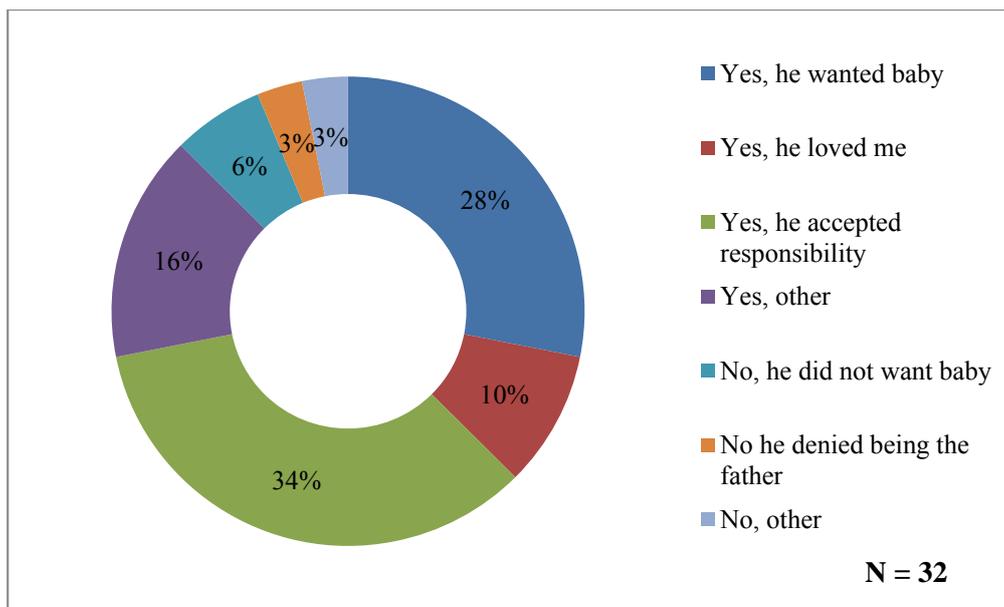
*“My dad and I are close, we talk about stuff. He is respected in the community and supposed to know how to deal with difficult things. But when he found out about me being pregnant he was so upset. He didn’t talk to me for months, only just before the baby came were we able to fix it.”*

The news of the unplanned pregnancy was difficult for this participant and her father to deal with, even though they had a good relationship based on open communication. However, this is not the case for most of the adolescents, and the relationship with the father remains strained.

#### **5.4.3.3 Partner**

##### **(i) Status of relationship with partner after disclosure of pregnancy**

The adolescents were asked to indicate whether or not they stayed in the relationship with their partner when they found out about the pregnancy (N = 32). Most (28 or 88%) of the participants said that they stayed in the relationship with their partner. The other four (12%) participants did not stay in the relationship with their partner. Their main responses are summarised in Figure 5.14.



**Figure 5.14 Status of relationship with partner after disclosure of pregnancy**

Figure 5.14 indicates that 28 (88%) of the participants stayed in the relationship with their partner when they were pregnant. Four (12%) of the couples ended the relationship when they found out about the pregnancy.

Of the adolescents who said that they had stayed in the relationship with their partner, three (10%) said that their main reason for staying together was because they loved each other, and because he loved her she did not leave. Nine (28%) said that they stayed in the relationship because their partner wanted the baby, and 11 (34%) indicated that their partners accepted responsibility as the baby's father and agreed to make the situation work. Five (16%) of the participants indicated other reasons for staying in relationships with their partner. One participant said that she stayed with her partner because she did not want to get sexually transmitted infections (she indicated the option of 'other'). The four remaining participants who indicated the option of 'other' said that they stayed in the relationship, but that the partner was angry and that their relationship became more distant.

In addition, four (12%) of the adolescents did not stay in the relationship with their partner when they found out about the pregnancy. Two (6%) said that the partner did not want the baby and that was the main reason why the relationship ended. One (3%) of the partners denied being the father and ended the relationship, and one (3%) participant indicated other

reasons for ending the relationship, which was that she did not like her partner at the time so she wanted to break up when she found out that she was pregnant.

The literature has presented conflicting views of adolescent fathers. Letourneau *et al.* (2004:517) are of the opinion that the relationship between the adolescent and her partner is short lived, whilst Smith (2006:157) states that young fathers are staying in relationships with their partners and plan on remaining involved when their child is born. The findings depicted in Figure 5.14 support the findings of Smith (2006), as the majority (28 or 88%) of the participants indicated that they had stayed in the relationship with their partners when they were pregnant.

### (ii) Partner support during pregnancy

The participants were asked to indicate two aspects of partner support during their pregnancy. These aspects included partner support and encouragement to seek health care services, as well as partner support and consideration of the physical strain of the pregnancy.

**Table 5.8 Partner support during pregnancy**

<b>PARTNER'S BEHAVIOUR</b>	<b>YES: f (%)</b>	<b>NO: f (%)</b>	<b>N</b>
Partner encouraged participant to access health care facilities during her pregnancy	24 (75%)	8 (25%)	32
Partner was considerate of the physical strain of the pregnancy	26 (81%)	6 (19%)	32

Three quarters (24 or 75%) of the adolescents indicated that their partners encouraged them to go to health care providers during their pregnancy, and the majority of the participants said that their partners often accompanied them when they went to the clinic or doctor. Partner support has been correlated with greater maternal satisfaction, enhanced well-being and better adjustment to the pregnancy. Furthermore, partner support leads to an increased likelihood of the pregnant adolescent accessing health care facilities (Letourneau *et al.*, 2004:517). The findings of this study, as presented in Table 5.8, support the literature, as it is clear that where partners have shown support and interest in health care services, the adolescent is more likely to seek health care. This is indicated by one of the participant's statements:

*“My boyfriend told me to go to the clinic. I didn’t want to go. He said we should go have a pregnancy test, and later for check-ups on the baby. It was because of him that I wasn’t so scared to go to the clinic.”*

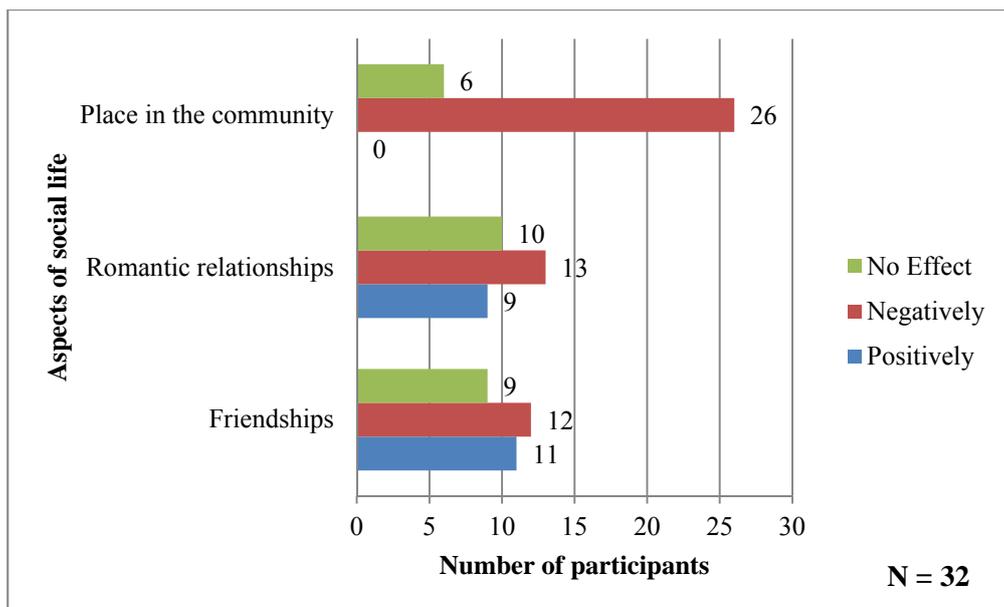
In addition to partner support is the partner’s consideration of the physical strain of the pregnancy. Twenty-six (81%) of the participants said that their partners were considerate of the physical strain of the pregnancy. The other six (19%) said that their partners were not considerate. Panzarine (1986:156) found that partners often were not considerate of the physical strain that the pregnancy places on the adolescent. The findings in Table 5.8 contradict the literature, as the majority (26 or 81%) of the partners were considerate of the physical strain of the pregnancy.

#### **5.4.4 Mesosystem**

The following section explores the mesosystem of the pregnant adolescent. Her social life in relation to her friends, boyfriend and community is considered. Furthermore, the adolescent’s knowledge and involvement with support groups is investigated. These aspects give valuable insights into the adolescent’s support from social relationships outside of the family.

##### **5.4.4.1 Social life**

In examining the adolescents’ relationships within the mesosystem, the participants were asked to indicate whether the pregnancy had a positive, negative or no effect on their relationships. A positive effect was described as greater closeness and support. A negative effect was described by greater loneliness, or stigma.



**Figure 5.15 Impact of pregnancy on the social life of the adolescent**

#### **(i) Friendships**

Figure 5.15 shows that twelve (38%) of the participants said they felt more isolated from their friends during pregnancy. Eleven (34%) said that they felt closer to their friends and nine (28%) said that their pregnancy had no noticeable impact on their friendships. According to the literature (Holgate *et al.*, 2007:2-4; Wiemann *et al.*, 2005:352.e4-e5), pregnant adolescents experience stigma and isolation from their friends. Many peers view pregnancy as unfavourable and have a negative view of their peers who fall pregnant. In this study the participants gave mixed responses about their friends' support during the pregnancy. Some spoke about how good their friends were to them, whilst others commented that their friends rejected them and that they were lonely.

The findings in Figure 5.15 with regard to friendships are relatively evenly dispersed. According to the findings, the majority (12 or 38%) said that their pregnancy had a negative impact on their friendships. These findings hence support the findings of the literature.

### **(ii) Romantic relationships**

With regard to the impact of the pregnancy on romantic relationships, nine (28%) of the adolescents said that the pregnancy had a positive impact on their relationships. Thirteen (41%) of the participants said that it had a negative impact on their romantic relationships, whilst 10 (31%) said that the pregnancy had no effect on this aspect.

According to Trad (1999:225-228), the adolescent's pregnancy limits her relationships with possible and current romantic partners, which can lead to increased social isolation. The majority (13 or 41%) of the participants indicated that the pregnancy had a negative impact on their romantic relationships, and hence the findings correlate with those in the literature.

### **(iii) Place in the community**

Furthermore, 26 (81%) of the participants indicated that their pregnancy had a negative influence on their place in the community. Six (19%) said that it had no effect on their place in the community, and none (0%) of the participants said that their pregnancies positively influenced their place in the community. The adolescents felt that they were stigmatised and that people were talking about them. Some of their comments were:

*“The people look at you and judge you.”*

*“I didn't want to walk around the streets, everyone is talking about me because I'm so young.”*

*“The people are always talking about me when I was pregnant.”*

*“It was embarrassing. Even though there are so many pregnant girls around they still gossip about us.”*

Although unplanned adolescent pregnancy is generally more accepted in the community and the girls are not sent away to hide their pregnancies, pregnant adolescents still face stigma. They are visible to their community, school, friends and family. Increased visibility in the community means increased stigma (Panday *et al.*, 2009:27; Wiemann *et al.*, 2005:352.e1). This is supported by the findings in Figure 5.15 and by the participants' comments. The adolescents were aware of the stigma and that people were judging them and, as a result, they avoided being in the community.

#### 5.4.4.2 Support groups

The participants were asked to indicate whether they had ever been in a support group and to elaborate on their experiences or knowledge of support groups.

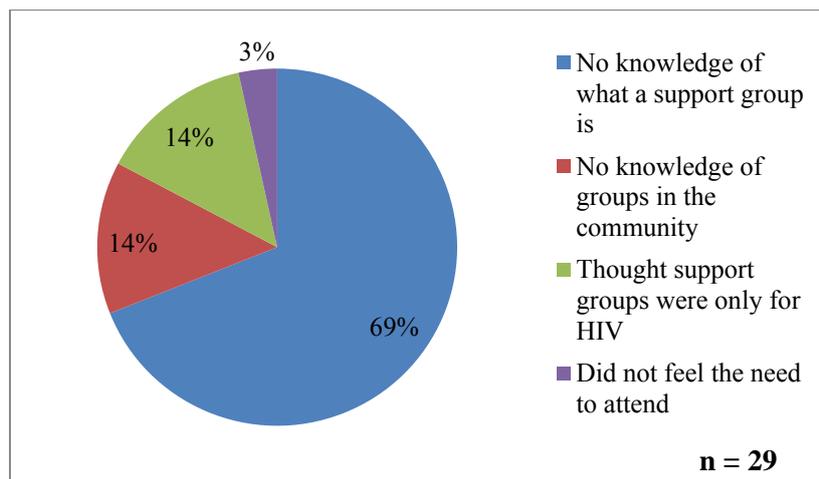
**Table 5.9 Involvement in a support group**

<b>SUPPORT GROUP PARTICIPATION</b>	<b>RESPONSE: f (%)</b>
Been part of a support group	3 (9%)
Have not been part of a support group	29 (91%)

**N = 32**

Table 5.9 indicates that only three (9%) of the participants had been part of a support group. Twenty-nine (91%) said that they had never been part of a support group. This is a significant majority of the participants. Panday *et al.* (2009:49) suggest that services for adolescents are limited in South Africa and that adolescents appear to have a limited knowledge of what support groups are and how they could be of benefit, as a result, adolescents do not attend support groups. This is supported by the findings in Table 5.9, as the majority (29 or 91%) of the participants had never been part of a support group.

The participants' reasons for not attending support groups are summarised in Figure 5.16 below.



**Figure 5.16 Reasons for not being in a support group**

The majority of the participants (20 or 69%) had no knowledge of support groups. They were unable to explain what a support group is and were unable to identify any in the community. Four (14%) said that they knew what a support group is, but could not identify a support group in the community. Four (14%) of the adolescents thought that support groups were only for people who were living with HIV. Only one (3%) participant knew what a support group was, but did not feel the need to attend one.

These findings indicate that adolescents have poor knowledge of support groups and of services in the community. This once again supports the findings of Panday *et al.* (2009:49) that adolescents have limited knowledge of support groups and how they could be of benefit.

### **5.4.5 Exosystem**

In exploring the exosystem the main systems that were considered were health care services and social service providers. For the purpose of this study health care services referred to state clinics and social service providers referred to social workers or counsellors, and these delimitations ensured that the participants understood the terminology.

#### **5.4.5.1 Health care services**

The participants were asked questions about their experience of health care providers during their pregnancy.

**(i) Utilisation of health care services**

The participants were asked to indicate whether they had utilised health care services early, late or not at all during their pregnancy.

**Table 5.10 Utilisation of health care services**

<b>UTILISATION OF HEALTH CARE SERVICES</b>	<b>RESPONSE: f (%)</b>
Yes, early in the pregnancy	15 (47%)
Yes, late in the pregnancy	17 (53%)
No, not utilised at all	0 (0%)

**N = 32**

According to Table 5.10, fifteen (47%) of the adolescents utilised health care services early in their pregnancy. Seventeen (53%) of the adolescents accessed health care services late in their pregnancy. None (0%) of the participants did not utilise health services at all during their pregnancy.

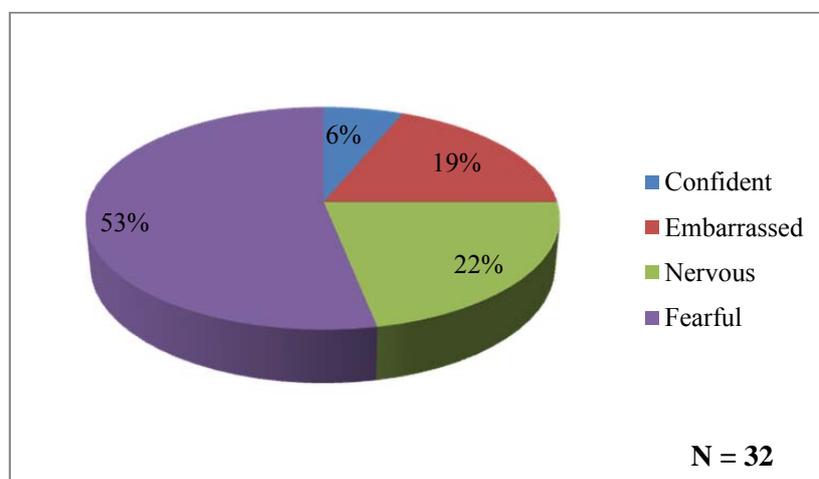
Various researchers (Atuyambe *et al.*, 2009:783; Hudson & Ineichen, 1991:63) agree that adolescent pregnancy is marked by poor use of medical services. Adolescents often present late to clinics and are on a whole poor clinic attendees. This limits the potential impact of quality care on the well-being of the adolescent and the foetus.

The majority of the adolescents in the study who went to the clinic early during their pregnancy went in order to get a pregnancy test. They noticed that something was different with their body and wanted to find out what the reason for this was. The findings in Table 5.10 support the literature in that majority (17 or 53%) of the adolescents presented to clinics late. However, the majority is barely more than half of the participants. Hence it would be significant to consider that, although some participants presented to the clinic late, nearly half (15 or 47%) went to the clinic early in their pregnancy.

There are many reasons why adolescents utilise health services late in their pregnancy. These reasons are explored in detail in the sections that follow.

### (ii) Feelings about utilising health care services

Many adolescents are wary of utilising health care services. The participants in this study were asked to indicate how they felt about utilising health care services when they were pregnant.



**Figure 5.17 Feelings about utilising health care services**

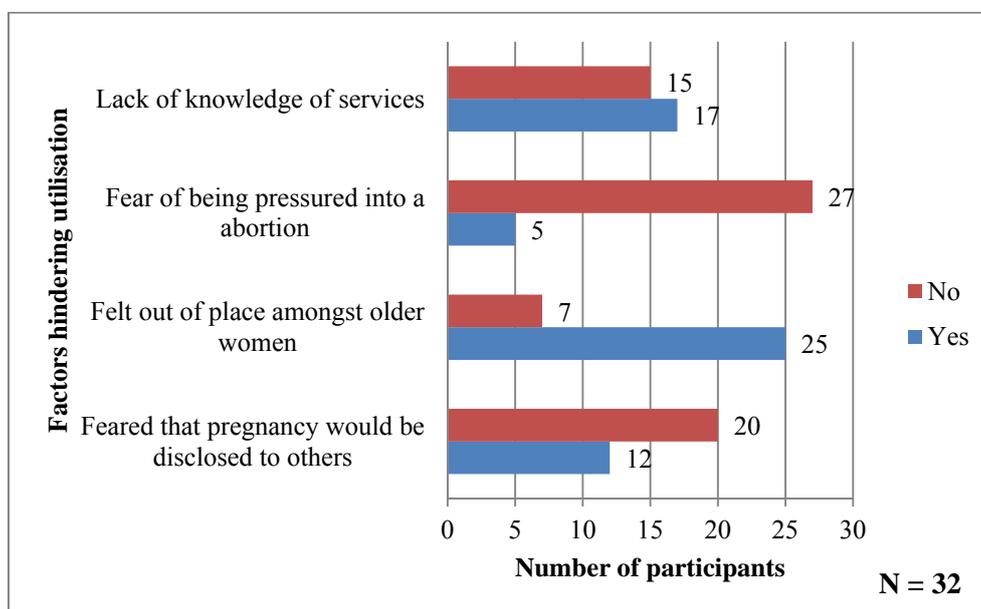
Figure 5.17 indicates that two (6%) of the participants felt confident about utilising health care services during their pregnancy. Six (19%) of the adolescents said that they were embarrassed to go to the clinic, seven (22%) said that they were nervous, and 17 (53%) of the participants said that they were fearful about accessing health care services. The majority hence said that they were fearful about going to the clinic when they were pregnant.

The minority of the adolescents (2 or 6%) expressed a positive feeling of confidence in utilising health care services. The primary reason given for this was that these participants had someone who went with them to the clinic. For most of the participants this was their boyfriend or their mother. Having this support helped in reducing anxiety and gave them confidence to access health care services.

According to Hudson and Ineichen (1991:65) the adolescent is nervous, embarrassed and fearful about going to the clinic. She is anxious and defensive about people's responses and attitudes towards her. Often the adolescent is terrified and confused about the situation and lacks the skills to communicate what she needs. This is supported by the findings presented in Figure 5.17, which show that the adolescents predominantly felt embarrassed (6 or 19%), nervous (7 or 22%) and fearful (17 or 53%) about utilising health care services.

### (iii) Factors hindering the adolescent from utilising health care services

From the above it is clear that the majority of adolescents felt negatively about utilising health care services. The participants were hence asked to indicate which aspects were reasons for them not utilising health care services.



**Figure 5.18 Factors hindering utilisation of health care services**

Twelve (38%) of the participants said that they did not want to go to the clinic because they feared that the clinic staff would tell other people, namely the adolescent's friends and family, about the pregnancy. Twenty (62%) of the adolescents did not identify this as a reason for not utilising health care services.

Figure 5.18 also indicates that 25 (78%) of the participants felt out of place amongst the older women at the clinic, especially because they themselves were still so young. This was one of their reasons for not wanting to utilise health care services during their pregnancy. Seven (22%) of the participants indicated that this was not a reason hindering them from utilising health care services during their pregnancy.

Furthermore, five (16%) of the participants indicated that they feared that they would be pressured into having an abortion if they went to the clinic, while 27 (84%) said that this was not a factor preventing them from utilising health care services during their pregnancy.

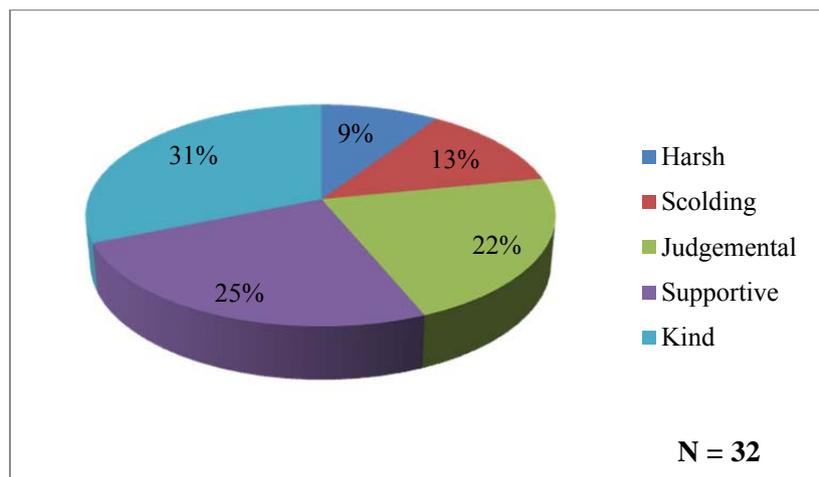
Finally, Figure 5.18 indicates that 17 (53%) of the adolescents did not know what services the clinic offers for pregnant adolescents, and this hindered them from going to the clinic when they were pregnant. Fifteen (47%) participants said that this did not hinder them from going to the clinic.

The literature (Atuyambe *et al.*, 2009:783; Hudson & Ineichen, 1991:63) states that adolescents do not go to health care providers because they have not yet told their parents, and they fear that the staff would disclose the pregnancy to their parents and friends. This is a reason for postponing a visit to the clinic until late in the pregnancy, as by then the pregnancy has been disclosed to the significant people in the adolescent's life. Other reasons that hinder the adolescent from utilising health care services are that the young adolescents feel out of place amongst the older women in the clinic, as well as fear that the clinic personnel will pressurise them into having an abortion. In addition, adolescents lack knowledge of clinics and antenatal services, and for this reason they do not know how accessing a clinic could be beneficial or assist them with their pregnancy.

The findings presented in Figure 5.18 support the findings in the literature, as most of the adolescents identified the same reasons as identified in the literature for not utilising health care services. Feeling out of place amongst older women (25 or 78%) received the highest percentage as a reason for not utilising health care services. Fear of being pressured into having an abortion was the lowest reason, but was still a factor for five (16%) of the participants.

#### **(iv) Adolescents' experiences of health care personnel**

The adolescent's experience of health care personnel is a significant factor in whether or not she will go to a clinic and return for continued services throughout her pregnancy. The participants were asked to indicate how the personnel at the clinic treated them when they visited the clinic during their pregnancy.



**Figure 5.19 Adolescents' experiences of health care personnel**

According to Figure 5.19, three (9%) of the participants experienced the health care personnel to be harsh. Four (13%) of the participants said that the personnel were scolding, and seven (22%) said that the health care personnel were judgemental. In total, 14 (44%) of the participants had a negative experience of the health care personnel.

The other 18 (56%) participants said that they had a positive experience of the health care personnel. Overall, eight (25%) of the participants said that the health care personnel were supportive and ten (31%) said that the personnel were kind.

The attitude of personnel at health care facilities can serve as a significant barrier to adolescents trying to access health care services. The adolescents experience the personnel to be harsh, scolding and judgemental, and the personnel make the girls feel condemned for their behaviour and speak down to them (Wood & Jewkes, 2006:114-115). As a result, the adolescents choose not to return because of the negatives service received from health care personnel.

The participants gave mixed responses to their experience of the personnel. Some of the negative comments were:

*“They judge you at the clinic and make you feel bad.”*

*“The nurses tell us we don’t know what we doing, that we are careless and shouldn’t be pregnant.”*

*“Nurses were rude to me and shouted at me because I was so young.”*

Some of the positive comments were:

*“The nurses were very helpful, they cared about me.”*

*“They were kind and helped me to know what was going on.”*

The findings for this study hence contradict the literature, as the majority (18 or 56%) of the participants experienced health care personnel to be either kind (10 or 31%) or supportive (8 or 25%). However, the positive majority is only 12% more than the adolescents who had a negative experience (14 or 44%). Hence this still is a factor that needs to be paid attention when considering intervention at this level.

#### **5.4.5.2 Social service providers**

The participants were asked whether they had met with a social service provider during their pregnancy, as well as whether they had received information concerning pregnancy resolution.

##### **(i) Utilisation of social welfare services**

The participants were asked to indicate whether they had seen a social service provider or utilised social welfare services early, late or not at all during their pregnancy.

**Table 5.11 Utilisation of social welfare services**

<b>UTILISATION OF SOCIAL WELFARE SERVICES</b>	<b>RESPONSE: f (%)</b>
Yes, early in the pregnancy	0 (0%)
Yes, late in the pregnancy	2 (6%)
No, not utilised at all	30 (94%)

**N = 32**

Table 5.11 indicates that 30 (94%) of the adolescents had not seen a social worker or even a counsellor during their pregnancy. Only two (6%) of the participants had seen a social worker, and this was late in their pregnancy.

Research (Koniak-Griffin *et al.*, 1993:50; Panzarine, 1986:160) indicates that, although social service professionals are available, adolescents attribute low influence to this source of support. Amongst a variety of people and professional services, social service providers have

been reported as the lowest source of cognitive support and information during adolescent pregnancy.

For the adolescent to receive support from a social service provider, she has to see the social service provider. Table 5.11 indicates that only two of the respondents saw a social service provider and hence very little support can be attributed to them during the adolescent's pregnancy. The findings of the literature therefore support the findings as in Table 5.11, as the majority (30 or 94%) of the adolescents had not seen a social service provider during their pregnancy.

### **(ii) Reasons for not utilising social service providers**

In the light of the above question it was then asked why the adolescents (n = 30) had not accessed social service providers during their pregnancy.

All (30 or 100%) of the participants said that they had not utilised social service providers because they did not have knowledge of how a social worker or counsellor could assist them during their pregnancy. In addition, they did not know of any social workers in their communities and hence had never been educated about the role of social workers.

Most of the participants were surprised at being asked whether or not they had seen a social worker. This is a clear indication that they do not know of any social workers and that they do not understand how a social worker could assist them in their pregnancy. This supports the literature (Hudson & Ineichen, 1991:184-190), which states that adolescents have poor knowledge of and are inexperienced in seeking social welfare services.

### **(iii) Information concerning pregnancy resolution**

The participants were asked to indicate whether they had received information about abortion, adoption or options for keeping their child. They were then asked to specify where they had received such information.

**Table 5.12 Information concerning pregnancy resolution**

<b>INFORMATION REGARDING:</b>	<b>YES f (%)</b>	<b>NO f (%)</b>	<b>SOURCES OF INFORMATION (f)</b>	<b>N</b>
Abortion	7 (22%)	25 (78%)	Extended family (3) Clinic(2) Choices (1) Friends (1)	32
Adoption	4 (12%)	28 (88%)	Extended family (1) Clinic (2) Choices (1)	32
Keeping the child	10 (31%)	22 (69%)	Parents (4) Extended family (2) Clinic (2) Choices (1) Friends (1)	32

**(a) Abortion**

According to Table 5.12, seven (22%) of the participants had received information about abortion during the pregnancy. Twenty-five (78%) therefore did not receive any information about abortion during their pregnancy. For the adolescents who did receive information about abortion, this information came from a variety of sources. One of the participants received information from Choices, which is a local crisis pregnancy centre. One received information from her friends, three from their extended family and two received information about abortion from the clinic. The most significant source of information concerning abortion can be identified as the adolescents' extended family, particularly their aunts.

**(b) Adoption**

With regard to adoption, Table 5.12 indicates that four (12%) of the participants had received information about adoption during their pregnancy. Twenty-eight (88%) did not receive any information about adoption. Sources of information concerning adoption were identified as extended family (1), the clinic (2) and Choices (1). Hence the most significant source of information concerning adoption can be identified as the clinic.

**(c) Keeping the child**

Finally, ten (31%) of the participants identified that they had received information with regard to keeping their child. This includes information concerning the Child Support Grant and different areas of support available to mothers. The sources of information included parents (4), extended family (2), the clinic (2), Choices (1) and friends (1). Twenty-two (69%) participants indicated that they had received no information concerning keeping their child from anyone.

In summary, social service providers are identified as key providers of information concerning options for pregnancy resolution (Plotnick, 1993:324). Although social service providers have the knowledge and expertise, it is clear from Table 5.12 that the majority of the participants did not receive information from social service providers to assist them in pregnancy resolution.

**5.4.6 Macrosystem**

The following section explores the macrosystem of the participants. Particular attention was given to whether the participants had been educated on their rights concerning pregnancy and reproductive health. This was measured by testing the participants' basic knowledge of reproductive health and child policies.

**5.4.6.1 Education on reproductive health rights**

The participants were asked to indicate whether they have been educated about their rights concerning reproductive health, as well as where they have received this education.

**Table 5.13 Education on reproductive health rights**

<b>PLACE OF EDUCATION</b>	<b>f (%)</b>	<b>RANK</b>
Home	4 (12%)	4
School	10 (31%)	2
Health care service	6 (19%)	3
Social service providers	0 (0%)	5
No identifiable education	12 (38%)	1

**N = 32**

According to Table 5.13, four (12%) of the participants had received information about their reproductive health rights at home. Ten (31%) said they had received information at school. Health care services were identified by six (19%) of the participants as their source of information concerning their reproductive health rights. None (0%) of the adolescents indicated that they had received education from social service providers. Twelve (38%) of the participants could not recall being educated on their reproductive rights.

The school therefore can be identified as the main source of information and education on the adolescent's reproductive rights. However, the majority (12 or 38%) of the participants indicated that they had never been educated about their reproductive health rights at all.

#### **5.4.6.2 Knowledge of rights and legislation**

The participants were asked to answer questions concerning their reproductive rights. The questions included access to contraceptives, access to health care services, abortion and adoption regulation, information about the Child Support Grant (CSG), as well as school legislation. The results are summarised below.

**Table 5.14 Knowledge of rights and legislation**

<b>LEGISLATIVE KNOWLEDGE</b>	<b>CORRECTLY IDENTIFIED f (%)</b>	<b>INCORRECTLY IDENTIFIED f (%)</b>	<b>DID NOT KNOW f (%)</b>	<b>N</b>
Access to contraceptives	1 (3%)	8 (25%)	23 (72%)	32
Access to clinics	32 (100%)	0 (0%)	0 (0%)	32
Abortion	11 (34%)	1 (3%)	20 (63%)	32
Consent to adoption	7 (22%)	8 (25%)	17 (53%)	32
Application for CSG	18 (56%)	2 (6%)	12 (38%)	32
Amount of CSG	22 (69%)	0 (%)	10 (31%)	32
School legislation	29 (91%)	3 (9%)	0 (0%)	32

**(i) Access to contraceptives**

According to Table 5.14, the majority (23 or 72%) of the participants did not know how old one must be to gain access to contraceptives. Eight (25%) answered the question incorrectly and only one (3%) participant knew that one needs to be 12 years old in order to access contraceptives. This legislation is stipulated in the Children's Act (Act no 38 of 2005, Section 134).

**(ii) Access to clinics**

All 32 (100%) of the participants knew that one should receive free services from the clinic when one is pregnant. The legislation that stipulates that all pregnant women should have free access to health care services is the National Health Act (Act no 61 of 2003, Section 3[a]).

**(iii) Abortion**

Table 5.14 further indicates that 11 (34%) of the participants knew up to how many weeks one can have an abortion without consulting a doctor. One (3%) answered the question incorrectly and 20 (63%) did not know up until which month a foetus can be terminated without consulting a doctor. According to the Choice of Termination of Pregnancy Act (Act no 92 of 1996, Section 2[1a]) a foetus may be terminated up to 12 weeks without consulting a doctor. Only 11 (34%) of the participants knew this information. Panday *et al.* (2009:25) state that adolescents have low knowledge about termination of pregnancy. This is supported by the findings as presented in Table 5.14.

**(iv) Adoption**

With regard to adoption, 17 (53%) participants did not know that one needs the father of the baby to give permission for the baby to be adopted. Seven (22%) of the participants knew that the father of the child needs to give consent, and eight (25%) gave the incorrect answer. The Children's Act (Act no 38 of 2005, Section 233 [1a]) clearly stipulates that each parent of the child must give consent to the adoption, regardless of whether the parents are married or not. Table 5.14 indicates that the adolescents have poor knowledge and understanding of adoption.

**(v) Application for Child Support Grant**

Table 5.14 also indicates the level of the adolescents' knowledge of the Child Support Grant. Eighteen (56%) of the participants knew where to apply for the Child Support Grant, two (6%) gave the incorrect answer and 12 (38%) of the participants did not know where to apply. These findings indicate that the majority (18 or 56%) of the participants knew where to apply for the Child Support Grant.

**(vi) Amount of Child Support Grant**

In addition to knowledge about the application for a Child Support Grant, the participants were asked to indicate whether or not they knew the amount of the grant. According to the South African Social Security Agency (2010), the Child Support Grant is R250. Twenty-two (69%) of the participants knew that the grant amount is R250, and ten (31%) of the adolescents did not know how much the grant is.

**(vii) School legislation**

Finally Table 5.14 indicates the participants' knowledge of school legislation with regard to pregnant adolescents. According to the Department of Education (2007), adolescents should be allowed to remain in school when they are pregnant and return after the birth of the baby. Twenty-nine (91%) of the participants knew that schools were obligated to allow the adolescent to remain in school. Three (9%) of the participants thought that schools should expel students when they are pregnant. The findings of Table 5.14 indicate that the participants were aware of their rights when they were pregnant and still attending school.

In summary, the findings in Table 5.14 indicate that, overall, the participants had good knowledge about accessing clinics, the Child Support Grant and school legislation. The participants had poor knowledge about access to contraceptives, abortion and adoption.

#### **5.4.7 Overall support needs**

The following section looks at the adolescents overall support needs. This section continues to explore the ecological levels (Bronfenbrenner, 1979:7) by considering the family, partner, peer education, support groups, health care services and social service providers. This section was more qualitative and allowed the participants to express their needs openly.

##### **5.4.7.1 Family support**

The participants were asked to indicate what their main problem or need for support from their family was during the pregnancy. Their responses are summaries in Table 5.15 below.

**Table 5.15 Need for support from family**

<b>THEME: NEED FOR SUPPORT FROM THE ADOLESCENT'S FAMILY</b>			
<b>Subthemes</b>	<b>Categories</b>	<b>Narratives</b>	<b>f (%)</b>
<b>Material support</b>	Need for financial support	<i>"I needed money for school, I was scared I had to stop going."</i>	3 (10%)
		<i>"I wanted healthy food when I was pregnant, but my family didn't give me money for it."</i>	
	Need for personal items	<i>"I needed money for scans."</i> <i>"When I was pregnant my family stopped buying me clothes and things that I needed, I couldn't afford these things."</i>	4 (13%)
<b>Physical assistance</b>	Help with daily tasks	<i>"I still had to clean the house, my family should have helped me."</i>	2 (6%)
		<i>"I had to pick up heavy things around the house, I needed help."</i>	
	Help when ill	<i>"I needed help when I was sick, my family wasn't there for me."</i>	2 (6%)
<b>Mediation with parents</b>	Help disclosing pregnancy to parents	<i>"It took time for my parents to accept the pregnancy, it was hard to tell them."</i>	2 (6%)
		Assistance with angry parents	
<b>Positive encouragement</b>	Need for family not to put her down	<i>"My family was judgemental, they didn't stand by me."</i>	6 (19%)
		<i>"My family put me down, they weren't supportive. They should have encouraged me more and told me to carry on with my life."</i>	
	Need for confidentiality	<i>"My mom spoke loud about my pregnancy so everyone could hear, it was embarrassing."</i> <i>"My mother pressured me to tell people, she threatened to tell if I didn't."</i>	2 (6%)
<b>Family was supportive</b>	No support need identified	<i>"My family was great, they helped me a lot."</i>	8 (25%)
		<i>"My parents were supportive and tried to understand what I was going through."</i>	

N = 32

**(i) Material support**

According to Table 5.15, three (10%) of the participants had a need for more financial support from their parents. They needed financial support mainly to continue schooling (*“I needed money for school...”*) and to buy healthy food during the pregnancy (*“I wanted healthy food when I was pregnant, but my family didn’t give me money for it”*). Furthermore, four (13%) participants expressed that they required financial support for personal items, particularly clothes, as their parents had stopped buying them clothing when they were pregnant.

**(ii) Physical assistance**

Two (6%) of the participants indicated that they needed physical assistance in completing tasks around the house. The adolescents were expected to continue with the same tasks as they did before the pregnancy, and this put a high physical strain on them (*“I had to pick up heavy things around the house, I needed help”*). Two (6%) participants indicated that they required physical assistance, particularly when they were ill, as their families did not care for them during these times.

**(iii) Mediation with parents**

In relation to support, two (6%) of the participants indicated that they had difficulty disclosing their pregnancy to their parents. They required support to assist them in the disclosure of their pregnancy, and also desired their family to be more accepting. Three (9%) participants said that their parents were very angry. They required support in mediating with their parents (*“My father wasn’t talking to me, I didn’t know what to do about it”*).

**(iv) Positive encouragement**

In addition, six (19%) of the participants expressed that they needed more positive encouragement from their family, as their family members put them down by being judgemental or critical (*“My family was judgemental, they didn’t stand by me”*). Two (6%) indicated that they also required positive encouragement from their family especially with regard to respect for their confidentiality about the pregnancy (*“My mom spoke loud about my pregnancy so everyone could hear...”*).

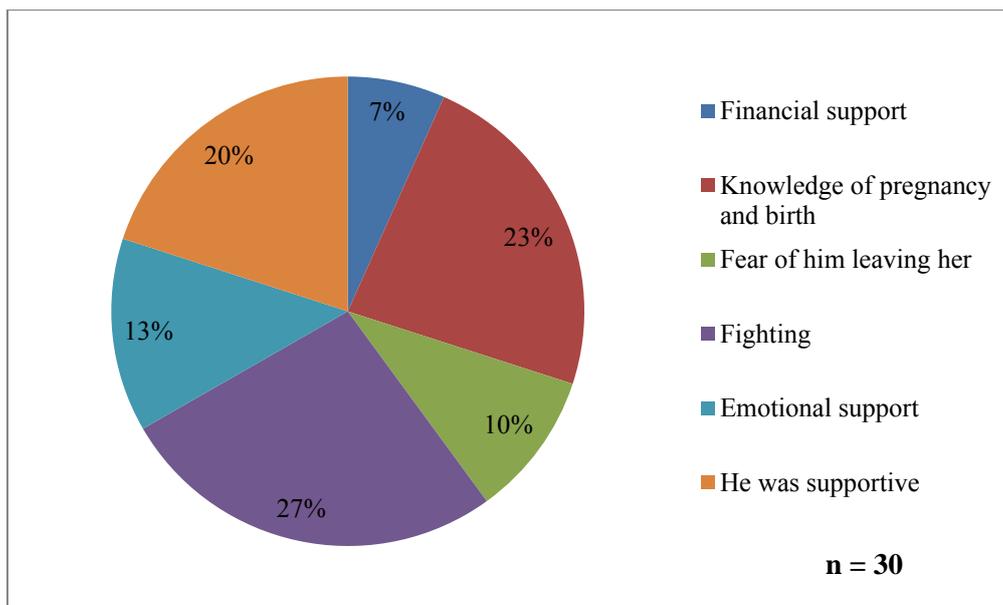
**(v) Family was supportive**

Finally, eight (25%) of the participants indicated that their family was supportive and that there were no particular problems or main support needs that could be identified (“*My family was great, they helped me a lot*”).

Hudson and Ineichen (1991:126) found that adolescents often do not receive the much needed support from their parents and family during their pregnancy. Often this support is unreliable and inconsistent, and the family can be hostile and rejecting. This is supported by the findings presented in Table 5.15, which shows that eight (25%) of the participants said that their families were supportive, which means that the majority (24 or 75%) expressed that they could have received more support from their families.

**5.4.7.2 Partner**

The participants were asked to discuss what their main need for support was with regard to their partner. Two of the partners were not present during the pregnancy. One partner denied being the father and the other partner was not informed of the adolescent’s pregnancy, hence the sample consisted of 30 participants (n = 30).



**Figure 5.20 Problems experienced with partner during pregnancy**

**(i) Financial support**

Two (7%) of the adolescents indicated that their partners needed to support them more financially during the pregnancy. They all said that their boyfriends did not support them financially, either in preparation for the baby or for their personal needs. As a result, all the financial responsibilities fell on the adolescent and her family, while the adolescents wanted their partners to share in the responsibility for the pregnancy.

**(ii) Knowledge of pregnancy and birth**

According to Figure 5.20, seven (23%) of the participants indicated that their partners should have had more knowledge about pregnancy and birth. The participants expressed that this would have helped the partner to understand what the adolescent was going through, that it would have led to increased empathy and support, as well as more involvement in the pregnancy and birth from the partner.

### **(iii) Fear of boyfriend leaving her**

Three (10%) of the participants expressed the fear that their partners would leave them during their pregnancy. The participants said that their partners looked at other girls and this made the participants feel insecure. One participant stated:

*“He looked at other girls, I didn’t know if he was doing stuff with them. But I didn’t want to fight so I didn’t talk about it.”*

### **(iv) Fighting**

Figure 5.20 also indicates that eight (27%) of the participants fought a lot with their partners during the pregnancy. They expressed that they fought about little things and battled with conflict resolution.

### **(v) Emotional support**

Furthermore, four (13%) participants indicated that their partners should have supported them more emotionally. The participants said that their partners were not sensitive to their needs and their feelings. The partners were not always encouraging and were not available for the adolescent to talk to about her feelings concerning their relationship or the pregnancy. This is supported by the findings shown in Table 5.6 concerning the different types of support (5.4.3.1- Type of support), where only three (9%) of the adolescents said that their partners noticeably encouraged them during their pregnancy, and only six (19%) of the partners were indicated as being a significant person with whom the adolescent could talk about her private feelings.

### **(vi) Boyfriend was supportive**

Six (20%) of the participants said that their partners were supportive and that they could not identify any particular problem or need for support during their pregnancy

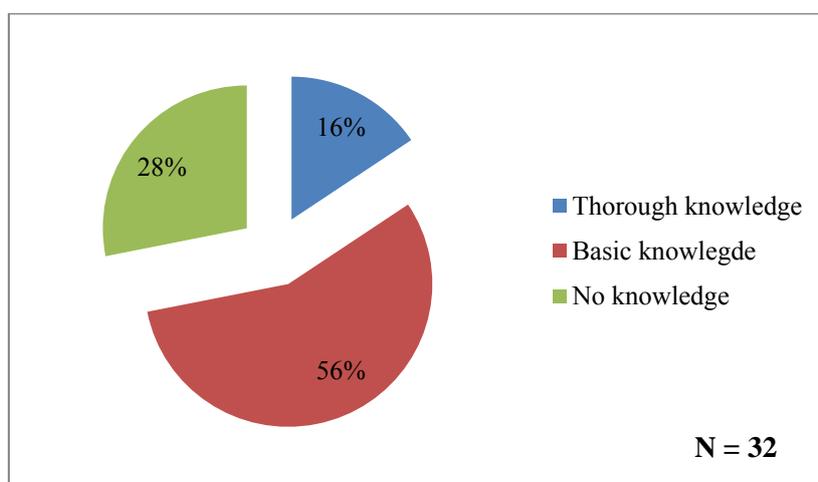
Smith (2006:188-190) suggests that interventions with young couples should focus on communication skills, conflict management and managing responsibilities. This would facilitate increased involvement by the partner, and promote a higher quality of relationship between the couple. This is supported by the findings in Figure 5.20, where it can be seen that

the adolescents indicated difficulty with conflict management, desired higher involvement of the partner and a need for the partner to share in managing the financial responsibilities.

### 5.4.7.3 Education

#### (i) Knowledge of safe sex

The participants were asked to discuss their knowledge of safe sex. This was significant in determining their understanding of using protection when engaging in intercourse.



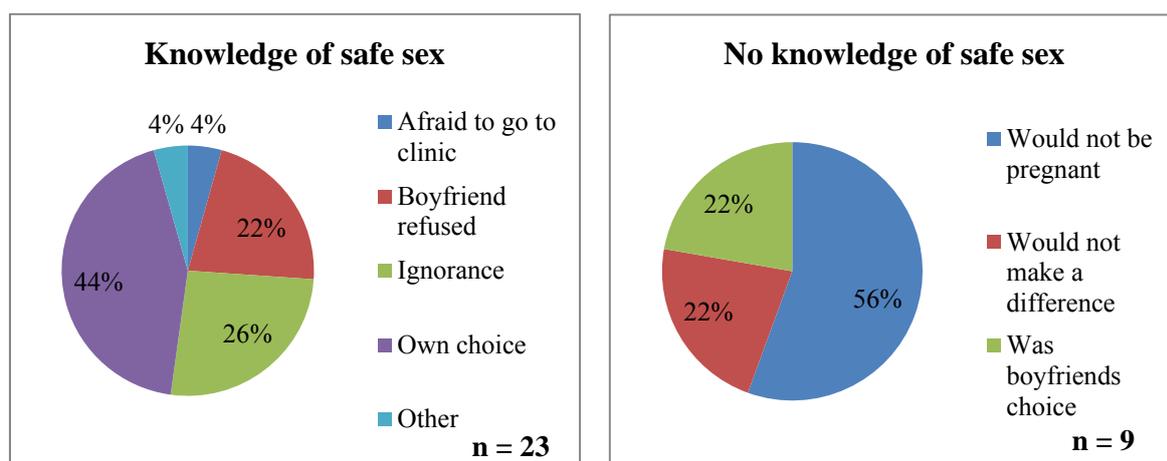
**Figure 5.21 Knowledge of safe sex**

According to Figure 5.21 eighteen (56%) of the participants knew that safe sex means to use condoms. They had no further insight into what it means to use protection or to practise safe sex. Five (16%) participants could identify that condom use prevents pregnancy as well as the spread of sexually transmitted infections, and that it is more effective and safer than using the pill or injection. Nine (28%) of the participants said that they did not know what safe sex meant or how one practised it.

According to Panday *et al.* (2009:30), a lack of education is often incorrectly cited as the main reason for the non-use of contraceptives. Many studies have shown that most young people are well informed about methods of contraception. The findings in Figure 5.12 support Panday *et al.* (2009), in that the majority (18 or 56%) of the participants had basic knowledge of safe sex, and five (16%) had a thorough understanding of safe sex.

### (ii) Impact of knowledge of safe sex

In light of the previous question it was clear that many of the participants (23 or 72%) knew what safe sex was, although not all of them had sufficient understanding about it. As a result they were asked why the knowledge of safe sex did not influence their behaviour which resulted in them falling pregnancy. For the participants who did not know what safe sex was they were asked whether knowledge of safe sex would have influenced their sexual behaviour which resulted in their pregnancy.



**Figure 5.22 Impact of knowledge of safe sex**

#### (a) Knowledge of safe sex

According to Figure 5.22, five (22%) of the participants who had knowledge of safe sex indicated that they had not practised safe sex because their partners did not want to make use of contraceptives at the time.

In addition to partner refusal, 10 (44%) of the participants said that knowledge of safe sex did not have an impact on them because when sex happens they make their own choices and do not think about using contraceptives. This suggests that even though adolescents have knowledge of contraceptives, it does not have a significant impact on their sexual behaviour and use of contraceptives.

Some of the participants also indicated that they were ignorant about sex and pregnancy (six or 26%), as well as afraid to go to the clinic (one or 4%). One (4%) participant indicated 'other', namely that they were using a condom but that it broke.

In summary, the majority (10 or 44%) said that knowledge of safe sex did not have an impact on them because they had made a decision not to use protection. One participant said:

*“When you having sex you do not think about what was taught at school. You do what you want and make your own decisions.”*

### **(b) No knowledge of safe sex**

Of the participants who said that they did not have knowledge of safe sex, five (56%) indicated that if they had the knowledge, they would have used protection and would not have been pregnant. Two (22%) indicated that knowledge of safe sex would not have influenced their behaviour, as once again they did not think about using protection when having intercourse. The other two (22%) said that their boyfriends chose not to use contraceptives and the participants did not have sufficient knowledge to make an informed decision.

### **(iii) Involvement in peer education programmes**

The participants were asked to indicate whether there were any peer education programmes in their schools, and whether or not they had been part of such a programme.

**Table 5.16 Involvement in peer education programmes**

<b>INVOLVEMENT IN PEER EDUCATION</b>	<b>f (%)</b>
No knowledge of peer education programmes	16 (50%)
Not part of selective programme	11 (34%)
Part of peer education programme	5 (16%)

**N = 32**

Table 5.16 shows that 16 (50%) of the participants did not have knowledge of peer education programmes in their school. Eleven (34%) said that they knew of the programme but were not part of it because it was a selection course, which means that only students who were selected by teachers or peers could participate in the programme. Five (16%) participants indicated that they had been part of the peer education programme in their school.

The participants who were part of the peer education group expressed that being part of the group helped them to gain confidence in asking questions and talking to people. They were also able to learn about important life issues, with some of the topics having been sex, HIV

and other sexually transmitted infections. In addition, they also learnt about problem solving, communication and decision-making skills.

Panday *et al.* (2009:47) highlight that peer education serves as a source of information and skills development. It also aids adolescents in gaining confidence and learning decision-making skills. However, such programmes are limited in South Africa, this is reflected by 16 (50%) of the participants who do not know of any peer education programmes in their school.

#### **5.4.7.4 Support groups**

In response to this question, the participants (N = 32) were asked to indicate whether being in a support group during their pregnancy could have benefited them. Almost all (31 or 97%) of the participants thought that being part of a support group would have been beneficial to them during their pregnancy, and they were asked to explain the perceived benefits. One (3%) participant said that she felt being part of a support group would not have helped her during her pregnancy because she was too shy to talk to other people about personal issues.

The majority (31 or 97%) of the participants hence indicated that being part of a support group would have benefited them during their pregnancy. Their main reasons for the perceived benefit are summarised below.

**Table 5.17 Perceived benefit of support groups**

<b>THEME: PERCEIVED BENEFIT OF SUPPORT GROUPS</b>		
<b>Subtheme</b>	<b>Narratives</b>	<b>f (%)</b>
<b>Reciprocal support and advice giving</b>	<p><i>“It would be good to talk to other girls, learn from them, and share my own experiences.”</i></p> <p><i>“I wanted to get advice, and tell people what I knew, to help them.”</i></p>	11 (35%)
<b>Safe place to share feelings</b>	<p><i>“It would have helped to have a place to share my feelings and deal with bad life events.”</i></p> <p><i>“I needed a place to talk about my feelings, it would have been good to know that other people feel them too, and it is normal.”</i></p>	8 (26%)
<b>Gain knowledge of pregnancy, birth and motherhood</b>	<p><i>“I wanted to know what to do. Like what I could eat and drink, practical things.”</i></p> <p><i>“I needed to learn about being pregnant, having a baby, and how to be a mother. I could have learnt this in a support group.”</i></p>	12 (39%)

**n = 31**

**(i) Reciprocal support**

According to Table 5.17 eleven (35%) of the participants indicated that they would have benefitted from being in a support group, as they would have had the opportunity for reciprocal support. The adolescents expressed not only a desire to gain advice and support from others, but also to give their advice and support to adolescents who were going through a similar situation (*“I wanted to get advice, and tell people what I knew, to help them”*).

The literature (Nath *et al.*, 1991:416; Stevenson *et al.*, 1999:111) states that a benefit of being involved in a support group is the opportunity for reciprocal support, where members are able to receive and offer support. The participants in the study also identified reciprocal support as a perceived benefit of attending a support group and as something in which they desired to participate.

**(ii) Share private feelings**

In addition to reciprocal support, another perceived benefit of being part of a support group was that it would be a safe place to share feelings (8 or 26%). Nath *et al.* (1991:416) suggest that the benefits of a support group include the opportunity for the adolescent to share her feelings openly and to learn how to cope with deleterious life events. This is supported by the adolescents' statements that indicate a need to share their feelings in a safe environment and to discuss life issues with other adolescents (*"I needed a place to talk about my feelings, it would have been good to know that other people feel them too, and it is normal"*).

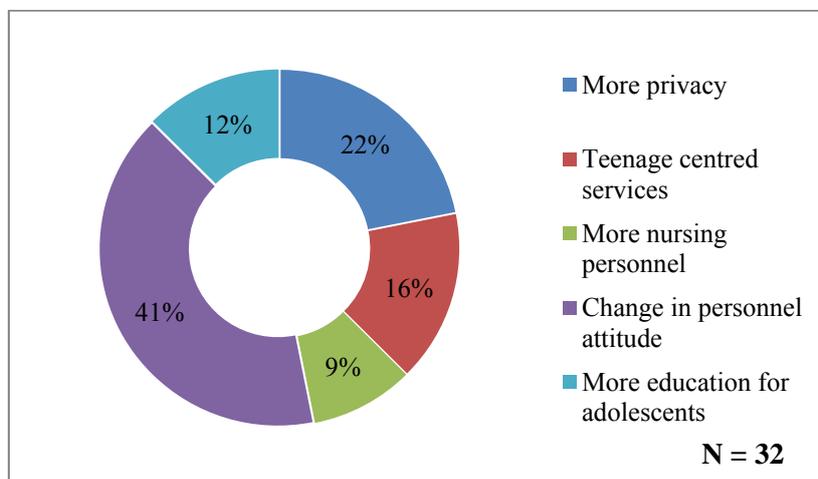
**(iii) Gain knowledge of pregnancy, birth and motherhood**

The final perceived benefit of support groups was the possibility of gaining knowledge of pregnancy, birth and motherhood. Support groups are seen as effective in helping adolescents learn about pregnancy, develop new skills and become more prepared for motherhood (Nath *et al.*, 1991:412). The participants in the study expressed that they had wanted to learn more about what to do when pregnant, and how to be a mother (*"I needed to learn about being pregnant, having a baby, and how to be a mother. I could have learnt this in a support group"*).

Overall, the majority (31 or 97%) of the participants felt that they would have benefitted from being part of a support group during their pregnancy.

### 5.4.7.5 Health care services

The participants were asked what they thought health care services, in particular clinics, should change or improve to make the services and facilities more accessible to pregnant adolescents.



**Figure 5.23 Suggested changes to health care services**

The participants identified five main changes that clinics could make to make them more accessible to adolescents when they are pregnant. The main change identified by the participants (13 or 41%) was that there should be a change in the attitude of personnel. Although not all of the participants experienced the health care personnel to be rude, many of them said that they had heard about the difficult personnel at the clinic and this made them and their friends not want to go. In other words, the perceived negative attitude and behaviour of the personnel at the clinics towards pregnant adolescents acted as a deterrent to adolescents utilising health care services during their pregnancy.

The participants also indicated a need for more privacy at the clinic. This was suggested by seven (22%) of the participants. The need for more privacy was due mainly to the fact that people from the community watched the adolescents and made assumptions about why they were there:

*“There is a separate room you talk in when you are pregnant, everyone knows that room is just for pregnant women, so they all know what I am doing there. If I want to keep my pregnancy private I should be allowed to do that.”*

*“They should separate the pregnant women from everyone else. Then at least we just pregnant women and not everyone together, watching each other.”*

Furthermore, five (16%) of the adolescents suggested that having specific services for teenagers would make the clinic more accessible. They suggested having an area just for adolescents, as many of them felt uncomfortable around older women. This was also expressed when the participants were asked what factors hindered them from going to the clinic (5.4.5.1 - (iii) Factors hindering the adolescent from utilising health care services). According to Wiemann *et al.* (2005:352.e4) very few clinics have adolescent focussed antenatal care; however in situations where clinics have focussed on adolescents and attempted to meet their needs appropriately there have been positive effects on behaviour. Preston-Whyte (1991:47) supports this, stating that adolescent services should be established in order to ensure optimal services and anonymity for adolescents seeking services.

A few of the participants (3 or 9%) also said that there should be more nursing personnel, as well as more education for adolescents (4 or 12%). The need for more personnel was identified because the adolescents often had to wait very long hours in the clinic. In addition, the older nurses were kinder than the younger nurses, and the participants felt that if there were more personnel then the older women could deal with the pregnancies.

Finally, the need for more education was highlighted in terms of greater education about contraceptives, as well as what services the clinic offered. The participants expressed that if they knew what services the clinic offered and what to expect before they went it would not have been such an intimidating experience. Tonelli (2004:69) supports this by saying that adolescent educational focussed services lead to increased contraceptive use and more frequent visits to health facilities during and after pregnancy.

### 5.4.7.6 Social service providers

The participants (N = 32) were asked to discuss whether they thought that speaking to a professional person, such as social worker or trained counsellor, would have benefited them during their pregnancy.

**Table 5.18 Participant's need to speak with a professional**

<b>NEED TO SPEAK WITH A PROFESSIONAL</b>	<b>f (%)</b>
No, it would not have helped	5 (16%)
Yes, it would have helped	27 (84%)

**N = 32**

Five (16%) participants said that it would not have helped them. They all said that they did not understand how a professional could be of assistance and hence could not say whether it would have been beneficial to speak to one or not. A lack of knowledge of social services providers is highlighted by Hudson and Ineichen (1991:184-190) as a barrier to pregnant adolescents accessing social workers or counsellors.

The other 27 (84%) participants said that it would have been beneficial to speak to a professional when they were pregnant. Thirteen (40%) said that they would have wanted to see a professional in order to learn about motherhood and to be educated. The participants said that they would have wanted information about abortion, adoption, and services available to them in the community, in order for them to make good decisions about their pregnancy and their baby. In the literature, social services providers are identified as playing a significant role in providing adolescents with information, making referrals and helping them to make informed decisions (Plotnick, 1993:324).

The second perceived benefit of seeing a professional was that the adolescents felt that it would have helped to talk to someone whom they could trust and who had experience in dealing with adolescent pregnancy. Overall, they expressed the need for emotional support and the opportunity to talk about the pregnancy in a safe environment. This was indicated by 14 (44%) of the adolescents. Some of them said:

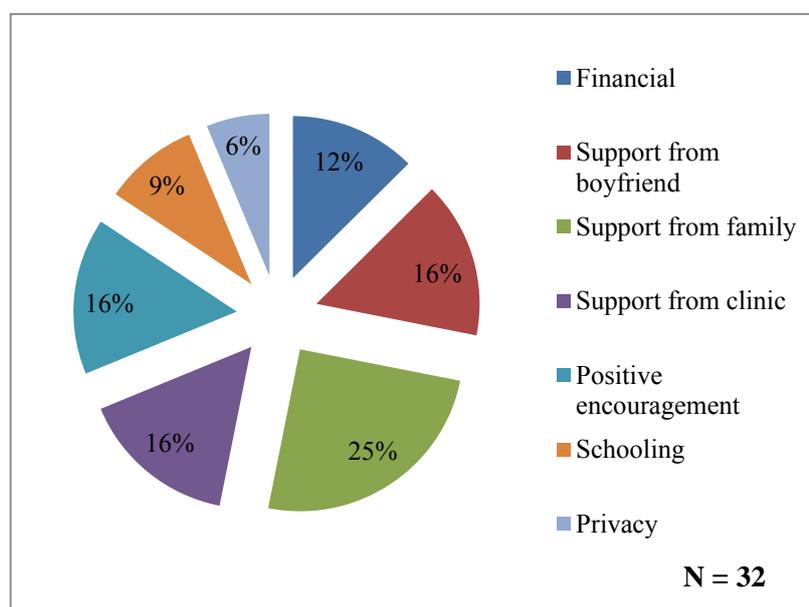
*“It would have helped to get encouragement and to know what to do about the pregnancy.”*

*“I could have spoken about my feelings. There are not many people I can talk to, I needed someone who understood my situation.”*

It is clear that the adolescents felt that they would have benefited from speaking to a professional during their pregnancy, and this is an area of support that adolescents have not had sufficient access to, as identified earlier in the study (5.4.5.2-(ii) Reasons for not utilising social service providers).

#### 5.4.7.7 Greatest support need during pregnancy

The adolescents were asked to reflect on their pregnancy and on the topics that had been discussed throughout the interview. In the light of this they were asked to identify their greatest support need during their pregnancy.



**Figure 5.24 Greatest support need during pregnancy**

The majority (8 or 25%) of the participants indicated that their main need for support during their pregnancy was from their family. Many of the participants said that they felt less loved by their families during their pregnancy. The participants expressed that they needed their family, in particular their parents, to be more understanding and not to be so angry with them.

Figure 5.24 also indicates that the participants needed support from their boyfriends during their pregnancy. This was identified by five (16%) of the participants as their main support need during the pregnancy. The adolescents wanted their boyfriends to be more supportive emotionally and to be more involved in the pregnancy and during labour.

Five (16%) participants also indicated that their main need for support during the pregnancy was from the clinic. Not only did the participants desire more interest and empathy from the medical personnel, but they also expressed a need for more information and education about pregnancy, medication, contraceptives and labour.

A further five (16%) participants said that they needed more positive encouragement. The participants needed people not to be judgemental, but instead to motivate them and encourage them to keep going.

Four (12%) of the participants said that their greatest need during the pregnancy was financial support. They needed money to buy pregnancy clothes, healthy food and items in preparation for the arrival of the baby.

Figure 5.25 also indicates that three (9%) of the participants said that they needed more support with regard to their schooling. The participants discussed how they were anxious about having to drop out of school. They said that they needed more understanding from the teachers. They also needed more time to do their work, as they were very tired and had difficulty concentrating.

Finally, two (6%) participants said that they needed more privacy in their homes when they were pregnant. The participants said that they did not want to wash or change their clothes in front of other people, and for this reason they wanted more privacy in their homes.

In summary, the greatest need for support as expressed by the majority of the participants was better support from families (8 or 25%). Support from the clinic (5 or 16%), from the boyfriend (5 or 16%) and positive encouragement (5 or 16%) were also significant areas in which greater support was needed.

#### **5.4.7.8 Advice for pregnant adolescents**

Finally, the participants were asked to share what advice they would give to other adolescents who were having an unplanned pregnancy. Their comments are summarised in Table 5.19 below.

Table 5.19 Advice for pregnant adolescents

<b>THEME: ADVICE FOR PREGNANT ADOLESCENTS</b>				
<b>Subtheme</b>	<b>Category</b>	<b>Narratives</b>	<b>f (%)</b>	
<b>Health care</b>	Visit the clinic	<i>“Preg girls must go to the clinic, it’s free to go. They must look after the baby.”</i>	6 (19%)	
	Know your HIV status	<i>“Girls must go to the clinic to test for HIV, to keep them and baby safe.”</i>  <i>“They must know their HIV status, they can have a healthy baby like I did.”</i>	2 (6%)	
	Do not drink alcohol	<i>“Preg girls must not drink, it is very bad for the baby and can do damage to the baby.”</i>	2 (6%)	
<b>Subtotal</b>			<b>10 (31%)</b>	
<b>Positive encouragement</b>	Continue with education	<i>“Accept that you are pregnant, life goes on and you must carry on with school.”</i>  <i>“You can still achieve your dreams, don’t drop out of school.”</i>	2 (6%)	
	Make good decisions	<i>“Don’t rush into decisions about abortion or adoption. You can be happy, don’t be irrational.”</i>	2 (6%)	
	Listen to parents	<i>“Listen to your parents, they can help you decide what to do.”</i>	2 (6%)	
	Be wise with boyfriends	<i>“Care for yourself, don’t let your boyfriend take advantage of you or abuse you.”</i>  <i>“Think about yourself and your baby, and what is best for you, not about your boyfriend.”</i>	3 (9%)	
	General encouragement	<i>“Stay positive and talk to people about your problems, don’t keep them in.”</i>  <i>“Don’t listen when people say bad things. Don’t care about what other people think.”</i>	2 (6%)	
	<b>Subtotal</b>			<b>11 (34%)</b>
	<b>Use protection</b>	Emphasis on prevention	<i>“Use a condom or stay away from boys, study and finish school until you are ready to get married.”</i>  <i>“Girls shouldn’t have sex if they are not ready, they must also go to the clinic”</i>  <i>“Don’t get preg at such a young age, it is not right. You will regret it, practise safe sex.”</i>	11 (35%)
<b>Subtotal</b>			<b>11 (35%)</b>	

N = 32

According to Table 5.19 there were three main subthemes in which the participants shared the advice that they would give to pregnant adolescents. These are summaries below.

### **(i) Health care**

Ten (31%) of the participants shared advice that was concerned with health care. The categories included visiting the clinic, knowing one's HIV status and not drinking when pregnant. The participants stressed the importance of taking care of one's body and of the foetus during pregnancy (*"Preg girls must go to the clinic, it's free to go. They must look after the baby"*).

### **(ii) Positive encouragement**

The second subtheme was related to positive encouragement, and 11 (34%) of the participants shared advice in this subtheme. Categories included encouragement to continue with one's education, to make good decisions and to listen to one's parents. The participants also shared advice about boyfriends, and said that pregnant adolescents should prioritise themselves and their babies before their boyfriends (*"Care for yourself, don't let your boyfriend take advantage of you or abuse you"*). Finally, some of the participants made general remarks of encouragement (*"Stay positive and talk to people about your problems, don't keep them in"*).

### **(iii) Using protection**

The third subtheme was about using protection. Eleven (35%) of the participants thought that it was more significant to focus on the girls before they were pregnant. They felt strongly about not falling pregnant at such a young age, and said that they would advise girls to use protection or not to have sex (*"Don't get preg at such a young age, it is not right. You will regret it, practice safe sex"*).

The advice that these participants shared is significant, as they have been through an unplanned pregnancy and know what they needed during the time when they were pregnant. This advice could have a significant impact on other pregnant adolescents. Kidger (2006:112-117) says that the most effective way of educating is through peer education. Peer education for pregnant adolescents has been proven to have a greater impact when it came from young

people who had engaged in sexual activity and were now mothers. Hence the advice shared in Table 5.19 could be effective in educating other pregnant adolescents.

#### **5.4.7.9 General comments**

The participants were given the opportunity to make general comments about the interview or to ask questions. None of the 32 participants had any comments to make about the interview, or any questions to ask.

The participants were also given an opportunity to be debriefed, or to receive a referral for further counselling. None of the participants expressed a need for debriefing or a referral.

### **5.5 CONCLUSION**

The aim of this study was to explore the support needs of pregnant adolescents. This chapter gave the results of the empirical study.

First, a general profile of the participants' ages, race, living arrangements and the nature of their pregnancy was compiled. Then the ecological levels were explored, namely the individual and the micro-, meso-, exo- and macrosystems.

The individual level looked at the adolescent's self-esteem, as well as issues of relatedness and competence. Then the adolescent's sexual activity and use of contraceptives were explored. Once this had been established the adolescent's emotional response to the pregnancy and education during pregnancy were examined.

The micro-level explored the different types of support available to the adolescent. The relationships between the participant and her family and between her and her partner were explored. The meso-level looked at the social life of the participants and their involvement in support groups.

The exosystem, with its wider focus, explored the adolescent's access to and experience of health care and social service providers, with a specific focus on why adolescents do not utilise these services readily during their pregnancy. Then the macrosystem sought to determine what knowledge the participants have of the policies and legislation that impact on their reproductive health rights.

Finally, the participants' overall need for support was explored, and they were able to express themselves more qualitatively.

The chapter successfully explored the support needs of pregnant adolescents. The empirical study verified the data presented in the literature review chapters, and highlighted areas in which the pregnant adolescent needs increased support. This information provides useful guidelines for social workers to gain an ecological understanding of how to improve support for adolescents when they are pregnant.

The following chapter will present the conclusions and recommendations for support for pregnant adolescents with regard to social work interventions.

## **CHAPTER 6**

### **CONCLUSIONS AND RECOMMENDATIONS**

#### **6.1 INTRODUCTION**

The exploration of pregnant adolescents need for support originated from an identified gap in the literature and an apparent lack of support services available to pregnant adolescents. The exploration was achieved by presenting an overview of the adolescent life phase and the possible consequences of adolescent pregnancy, and this fulfilled the first objective of the study, as set out in chapter 2. The second objective of the study was met in chapter 3, where the ecological perspective was explored in terms of its relevance to adolescent pregnancy. Chapter 4 considered how support can be provided to pregnant adolescents from an ecological perspective, thus fulfilling the third objective of the study. The fourth objective of the study was achieved in chapter 5 by exploring the support needs of pregnant adolescents by means of an interview, and the findings of the empirical study were also presented.

The aim of this chapter is to present the conclusions drawn from the study and to make appropriate recommendations. The recommendations will serve as a guideline for social work interventions to improve the support available to adolescents during pregnancy from within the different ecological levels. In doing so, this chapter meets the final objective of the study, which was to offer guidelines for social work interventions to improve support for pregnant adolescents.

Through conducting a thorough literature review and an empirical study, conclusions can be drawn and recommendations can be made. The conclusions and recommendations are related to the aim and objectives of the study, and fulfil the objectives of the study, as summarised in Table 5.20.

**Table 5.20 Conclusions and recommendations as evidence of meeting the objectives of the study**

<b>OBJECTIVE</b>	<b>CONCLUSIONS AND RECOMMENDATIONS</b>
<p><b>Objective 1:</b> To present an overview of the adolescent life phase and describe the consequences that unplanned pregnancy has on the adolescent</p>	<p>6.2.1 Identifying details 6.2.3 Sexual activity 6.2.4 Use of contraceptives 6.2.5 Emotional response to pregnancy 6.2.6 Education 6.2.8 Family 6.2.10 Social life 6.2.12 Health care services</p>
<p><b>Objective 2:</b> To discuss the ecological perspective and explore the relevance of the theory to adolescent pregnancy</p>	<p>6.2.2 Relatedness, competence, self-esteem and self-direction 6.2.4 Use of contraceptives 6.2.7 Support received from various people 6.2.8 Family 6.2.10 Social life 6.2.14 Education on reproductive health rights 6.2.15 Knowledge of rights and legislation</p>
<p><b>Objective 3:</b> To describe how support can be provided for female adolescents during pregnancy from an ecological perspective</p>	<p>6.2.5 Emotional response to pregnancy 6.2.7 Support received from various people 6.2.8 Family 6.2.9 Partners 6.2.10 Social life 6.2.11 Support groups 6.2.12 Health care services 6.2.13 Social welfare services 6.2.14 Education on reproductive health rights 6.2.15 Knowledge of rights and legislation 6.2.16 Suggested advice for pregnant adolescents</p>

## **6.2 CONCLUSIONS AND RECOMMENDATIONS**

The following conclusions and recommendations are based on the findings of the empirical investigation. The conclusions and recommendations are presented in a similar format to that in chapter 5, the empirical study, hence following the sequence of the questionnaire. The last section of the empirical study, concerning overall support needs (5.4.7), will be incorporated into the relevant sections in order to ensure that an accurate and rich understanding of each level of support is achieved.

In addition, the recommendations will be presented according to the levels of service in social work practice; these levels include prevention, assessment, intervention and advocacy. Specific tasks that social workers should carry out when dealing with adolescents in the practice setting are related primarily to assessment and intervention functions. The conclusions and recommendations will also be indicated in relation to practice, policy and educational issues, where possible.

### **6.2.1 Identifying details**

All the participants who took part in the study were between the ages of 14 and 18 years, thus are classified as being in the early adolescent life phase. Three quarters of the participants came from low-income black communities, and one quarter came from low-income coloured or mixed race communities. No white participants were identified, and no participants from middle- or high-income communities were identified.

The participants had varied family structures. The majority of the participants lived with both their parents, and a quarter lived with only their mother. The other participants lived either with their mother and had no father present, or lived within reconstructed families. In addition to details on family structure all of the participants indicated that their pregnancy was unplanned.

From these findings it can be concluded that the general profile of adolescents with an unplanned pregnancy varies between age, race and family structure. Hence there is not one specific characteristic that stands out above the others.

It is recommended that, with regard to services aimed at prevention:

- Awareness programmes regarding prevention and the consequences of adolescent pregnancy should be rendered by social service providers and schools to adolescents of all ages, race groups and family structures, as unplanned adolescent pregnancy does not distinguish between these factors.
- Awareness programmes regarding the support services available to pregnant adolescents should be rendered by clinics and schools to all adolescents, as adolescent pregnancy does not distinguish between age, race or family structure.

### **6.2.2 Relatedness, competence, self-esteem and self-direction**

The majority of the participants expressed that they had high self-esteem before the pregnancy. However, nearly all the participants said that their self-esteem dropped when they were pregnant as a result of decreased body image, a loss of confidence and disappointment in themselves.

With regard to relatedness the majority of the participants said that they were able to form close relationships with their family and friends. Three quarters indicated that they were able to go to their family and friends for support or help during a stressful life event.

Finally, concerning competence and self-direction, only one participant indicated that she wanted other people to make decisions for her. All the other participants said that they made their own decisions.

The conclusion that can be drawn from these findings is that poor relatedness, competence, self-esteem and self-direction do not appear to be significant contributing factors to adolescent pregnancy, as most of the adolescents were able to successfully practise these attributes before their pregnancy.

Adolescents appear to be successful in building healthy relationships and using these relationships as a source of support during stressful life transitions. The participants also displayed a capability to make decisions based on their own motivation and needs, not on others people's demands.

Furthermore, low self-esteem does not appear to be a factor that places adolescents at risk of unplanned pregnancy. However, during pregnancy there is a significant drop in the self-

esteem of the adolescent. This implies that pregnancy during adolescence has an impact on the adolescent's perception of herself, and the adolescents indicated that they experienced feelings of inadequacy, inferiority, and a lack of self-respect.

It is recommended that, with regard to assessment in the practice setting:

- Social workers, when dealing with pregnant adolescents, should determine the impact of the pregnancy on the adolescent's self-esteem.
- Social workers, when dealing with pregnant adolescents, should identify close relationships that the adolescent generally uses as a source of support for stressful life events. These could be a significant source of support and assistance during interventions.

It is recommended that, with regard to intervention in the practice setting:

- Social workers should focus on assisting the adolescent in regaining a higher sense of self-esteem during the counselling process. In doing so, the adolescent would feel more competent in accessing resources and addressing relational problems that resulted from the pregnancy.

### **6.2.3 Sexual activity**

The age at the first sexual experience of the adolescents varied from 13 to 18 years. The majority of the participants were 16, and the minority were 13 years old. Exactly half of the participants said that their primary reason for engaging in sexual behaviour was pressure from their boyfriend. There was also considerable pressure from the adolescents' friends to engage in sexual activity and to conform to the norms of the peer group. Only a few of the participants indicated that it was their own choice to engage in sexual activities. In addition, most of the participants had not previously been physically, sexually or emotionally abused.

From these findings it can be concluded that the majority of the participants had their first sexual experience at 16 years or younger. As most of the participants were 18 years old at the time of pregnancy, the early sexual experience may be considered a contributing factor to

unplanned adolescent pregnancy. It can also be concluded that abuse does not appear to be a predominant experience among the pregnant adolescents, and for most of the adolescents this did not contribute to their reasons for falling pregnant.

The study further implies that adolescents fall pregnant predominantly due to pressure from their boyfriends. The adolescents feel fearful that they will lose their partners should they refuse sex. Adolescents also lack adequate skills to negotiate desired sexual boundaries and contraceptive use. In addition, adolescents feel noticeable pressure from their friends to engage in sexual activity. This is due to the fact that their friends talk about sex and adolescents feel that they need to engage in sexual activity to be accepted by their peer group.

Peers have a significant impact on the sexual behaviour of adolescents, but it does not have to be a negative impact. Peers can be effective in educating each other about sexuality, boundaries and contraceptive use, as well as about delaying sexual activity. As previously discussed (4.4.1-Peer education), a study conducted in England found that learners were more open to learn about sexuality from their peers (Kidger, 2006:112-117). Projects that used young mothers as school-based peer educators have proven to be very effective in positively changing the sexual attitudes of adolescents to negotiate for safer sexual practices and to make rational decisions concerning sex.

It is recommended, that with regard to services aimed at prevention:

- Awareness programmes in schools should focus on educating children about sex related topics, possibly before they enter the early adolescent life phase in order to delay sexual activity.
- Prevention programmes in schools, as well as peer education programmes that focus on dealing with peer pressure and negotiating healthy sexual boundaries, should be promoted to all adolescents. This would help adolescents to know how to deal with pressure from their boyfriends and friends, as well as assist them in negotiating healthy sexual boundaries with which they are comfortable.

It is recommended that, with regard to assessment:

- When dealing with pregnant adolescents, social workers should determine the nature of the adolescent's first sexual experience, as this might be an issue that causes the adolescent emotional difficulty. This is most likely to occur if the adolescent was young when she had sex or if she was pressured into it by her boyfriend.

#### **6.2.4 Use of contraceptives**

Most of the participants indicated that they had not used contraceptives before their pregnancy. For the participants that did use contraceptives, most of them used them from their first sexual experience.

The participants said that their main reason for not using contraceptives was lack of knowledge of contraceptives; some of the participants were also ignorant about their bodily functions and thought that they could not fall pregnant. In addition, the adolescents failed to use contraceptives because their boyfriends refused to use them.

From this it can be concluded that, overall, adolescents have poor knowledge of reproductive health and contraceptives. Had the adolescents known about contraceptives and been educated about fertility and menstruation, it is less likely that they would have fallen pregnant. Further, the adolescents placed their boyfriends' desires above their own, which indicates that adolescents are not able to negotiate with their boyfriends for safe sex. It also suggests that adolescents are not deterred from sex by sexually transmitted diseases and HIV, even less so by the possibility of falling pregnant.

It is recommended that, with regard to services aimed at prevention:

- Awareness programmes concerning contraceptive use, reproductive health and pregnancy should be made available by clinics to all adolescents who visit clinics, and once again also to children before they enter the early adolescent life phase.
- Prevention programmes offered by the clinic should focus on sexually transmitted infections, HIV and unplanned pregnancy. This could motivate adolescents to use contraceptives, even if their boyfriends refuse to use them.

- Clinics and health care providers should make contraceptives accessible to adolescents. Furthermore, they should promote safe sex and contraceptives to all adolescents who visit the clinic.
- Adolescents should also be taught at schools and in peer education programmes how to negotiate for safe sexual practices through safe sex programmes.

### **6.2.5 Emotional response to pregnancy**

All the participants, barring one, expressed that they had a negative emotional reaction when they found out about their pregnancy. These emotions included feelings of fear, anger, denial, guilt and worthlessness. Only one adolescent felt excited about having a baby, as she realised that she needed to accept her fate.

The primary reason why adolescents have a negative reaction to the news that they are pregnant is that the pregnancy is perceived as a crisis. Nearly all of the participants said that the pregnancy was a crisis for them. They expressed fear about disclosing the pregnancy to their family, as well as about how the community would perceive them. Most of the participants said that they were worried about telling their parents about the pregnancy, and about half said that they were worried about telling their boyfriend. Fear of disclosing the pregnancy is a significant contributor to the adolescent perceiving the pregnancy as a crisis.

In conclusion, unplanned adolescent pregnancy is a negative experience for nearly all adolescents and the pregnancy is also experienced as a crisis. Adolescents should have access to crisis intervention services in order to reduce the deleterious effects of having an unplanned pregnancy. Adolescents do not have the foresight to realise that pregnancy is a possible consequence of them not practising safe sex, and this adds to the shock and panic when they find out that they are pregnant.

It is recommended that, with regard to tasks related to assessment:

- When dealing with pregnant adolescents social workers should determine if the adolescent is currently in a crisis as a result of the pregnancy. The social worker should carry out the crisis intervention process in order for balance to be restored and for the intervention to proceed.

It is recommended that, with regard to intervention in the practice setting:

- Social workers should assist the adolescent to work through the negative emotions related to the pregnancy. This would aid the adolescent in accepting her pregnancy and her baby.
- Social worker, when dealing with a pregnant adolescent, should equip the adolescent to disclose the pregnancy to her family and partner.

### **6.2.6 Education**

Most of the participants stayed in school when they found out that they were pregnant. For these adolescents pregnancy made their schooling more challenging, but they were motivated to complete their education. The participants who dropped out of school indicated that the pregnancy was their main reason for leaving school, and for not returning at a later stage to complete their education.

Adolescents who choose to remain in school are faced with a number of issues that make it hard for them to maintain a good standard of work and to work at the same pace as their classmates. Issues of health, such as morning sickness, fatigue and difficulty concentrating, interfere with the adolescent's ability to focus on her school work. Further issues, such as stigma and unsupportive teachers, make attending school awkward and uncomfortable for the pregnant adolescent.

It can be concluded that adolescents have a high motivation to stay in school and to progress well academically. Consequently, low educational drive and commitment cannot be considered a contributing factor to adolescent pregnancy. It is clear that the adolescents wish to complete their schooling, but are faced with many health and social challenges, as the schools do not provide enough support for the adolescent during her pregnancy.

It is recommended that, with regard to services aimed at prevention and policy:

- Schools should promote their support for pregnant adolescents to remain in school and be clear on their legal obligation to the adolescent.
- Schools should provide additional academic support for pregnant adolescents in order to make their school experience less challenging and to encourage them to continue with their education.

It is recommended that, with regard to tasks related to advocacy and policy:

- Social workers should advocate for the adolescent's educational needs during pregnancy so that she can remain in school. Advocacy should focus on attaining school support and flexibility in order for the adolescent to complete her education.

### **6.2.7 Support received from various people**

In order to gain a clear assessment of the most supportive people in the adolescent's life during pregnancy, the adolescents were asked to indicate who gave them the greatest support within certain categories. Categories included financial support, giving advice, positive encouragement, physical assistance and sharing private feelings.

Mothers ranked as the person who gave the most support in all the categories. They were undoubtedly a valuable source of support for the adolescent during her pregnancy. Not only did mothers provide practical support, but they also provided emotional support.

Boyfriends, friends and fathers all ranked considerably lower than the adolescents mother as sources of support. These are social relationships that should have a greater positive impact on the adolescent and, the people concerned should show greater support; however, it is clear that support is lacking from these sources.

The conclusion that can be drawn from this is that mothers are an important source of support for the pregnant adolescent, and that they help her significantly in adjusting to the pregnancy. This is a relationship that can be used as a buffer against the stressful life experience of an early, unplanned pregnancy. Fathers are severely lacking in offering their daughters support, and this is an indicator of a poor relationship between the father and the daughter. Finally,

friends and boyfriends could also offer considerably more support to the adolescent, which would make her social adjustment to the pregnancy much easier.

It is recommended that, with regard to services aimed at prevention:

- Awareness programmes on adolescent pregnancy and support should be presented by social service providers and NGOs to communities as a whole. This would have a broader effect on the family, partner and friends of adolescents who are pregnant.

It is recommended that, with regard to tasks related to the assessment phase:

- Social workers, when dealing with pregnant adolescents, should identify which people are offering the adolescent support and in which areas, in order to identify where interventions aimed at poor support should be addressed.
- Social workers should determine during the assessment phase with the pregnant adolescent if the adolescent's relationship with her father has been strained as a result of the pregnancy. This could be an important area for intervention.

### **6.2.8 Family**

In evaluating family life and parenting style, it is apparent that most of the adolescents came from homes where their parents enforced rules, disciplined them and monitored their behaviour. This suggests that the parents are relatively involved in their daughter's life and ensure that there is structure, not just freedom, in the adolescent's life. Nearly all the families were also perceived as supportive families, and this suggests that the adolescents appreciated having some form of discipline and that they felt safe in their homes.

Although the parents enforced rules and tried to monitor the adolescent's behaviour nearly all the parents failed to educate their daughters about sex. This means that the adolescents find out about sex from sources outside of the home. It hence makes sense that many adolescents feel pressured to engage in sex because of their friends. If their friends talk about sex, this could be a primary source of information. Considering that most adolescents exaggerate their

sexual experiences when talking to their friends, it lays a foundation of expectation which the adolescent accepts as normal, and makes her feel pressure to conform.

Significantly, when the parents found out that their daughter was pregnant, the majority of the mothers and fathers responded in a negative manner, with disappointment, anger or shock. Considering that most of the parents did not educate their daughters about sex and contraceptives, it seems unrealistic that they should be so alarmed to find out that their daughter is pregnant. The minority of the mothers and even fewer fathers responded to the pregnancy in a supportive manner. Considering the negative response of the parents, it is understandable that the majority of the adolescents were fearful about disclosing the pregnancy to their parents (5.4.2.6 - (iii) Disclosing the pregnancy).

Some of the participants indicated that they needed mediation with their parents when they disclosed their pregnancy, particularly with their father. Furthermore adolescents also felt a need for their families to be more supportive, both financially and emotionally, and to be less judgemental. There does not appear to be a specific drastic shortfall of families in supporting the pregnant adolescent, however, in general the families offered the adolescent limited support, understanding and encouragement. It is important for the adolescent to receive this support in her home if she is to successfully cope with the pregnancy.

In conclusion, many of the participants' families provided structure and discipline, but failed to educate their daughters about sex and contraceptives. Education in this aspect is of great importance, as adolescence is the time when the individual starts to explore her sexuality as part of her development.

It is recommended that, with regard to services aimed at prevention:

- Awareness programmes for parents should be presented by clinics and NGOs in as many communities as possible. Parents should be educated about the risk of adolescent pregnancy and sexually transmitted disease. Furthermore, parents should be equipped to talk to their children about sex and contraceptives.

It is recommended that, with regard to tasks related to intervention in the practice setting:

- Social workers dealing with pregnant adolescents should equip adolescents to talk with their families and, where necessary, act as a mediator between the two.
- Social work interventions should include family counselling services in order to help the family adjust to the pregnancy and learn how to support one another. This is important in order to ensure that the family system maintains, or restores, a state of homeostasis.
- Social workers should encourage the family to support the adolescent throughout the pregnancy, as the family forms a significant foundation for the adolescent.

### **6.2.9 Partners**

Nearly all of the participants stayed in the relationship with their partner, the alleged father of the baby, when they found out that they were pregnant. A small number of the participants indicated that their partners responded negatively to the pregnancy and that the relationship was ended as a result, while some also indicated that they did not want to be in a relationship with their partner at the time. For those who stayed in the relationship, the majority of the adolescents indicated that their partners encouraged them to go to the clinic when they pregnant. The partners were also said to be considerate of the physical strain of the pregnancy on the adolescent.

Although many of the partners stayed in the relationship with the participant when she found out that she was pregnant, the overall support that the partners offered was generally poor. The adolescents expressed that they needed more financial and emotional support from their partners. There also was an expressed desire for the partners to have more knowledge and to be more involved in the pregnancy and during labour. In addition to the limited support, the partners and the pregnant adolescents tended to fight frequently, and this placed additional pressure on the adolescent in dealing with the pregnancy, as well as created fear that her partner would leave her.

It can be concluded that contrary to the findings of previous research, partners are choosing to stay involved with the mothers of their baby. This suggests that they are accepting responsibility for the baby and that they wish to support their adolescent partner in the pregnancy. Support is shown by encouraging the adolescent to go to the clinic, and often

accompanying her. However, the support that was attributed to the partner overall within the various categories was relatively low (5.4.3.1 Type of support). Although the partners appeared to stay in the relationship and take responsibility for their child, the overall level of support that they gave the adolescent was fairly minimal. It appears that the tension of the fighting and the fear of the relationship ending outweigh the support that the partner attempts to offer.

It is recommended that, with regard to services aimed at prevention:

- Clinics should promote services for pregnant adolescents and their partners so that the partner is involved in the pregnancy and in the labour process.

It is recommended that, with regard to tasks related to the assessment phase:

- Social workers who deal with pregnant adolescents should evaluate the nature of the adolescent's relationship with the partner, as well as what the adolescent's intentions are for the relationship.

It is recommended that, with regard to tasks related to intervention in the practice setting:

- Social workers should assist adolescents and their partners to learn communication and conflict-management skills.
- Social workers, when dealing with the pregnant adolescent and her partner, should encourage the partner to be involved in the pregnancy and to offer emotional support to the adolescent.

### **6.2.10 Social life**

When considering friendships, romantic relationships and the participant's place in the community majority of them indicated that their pregnancy negatively impacted all three these areas of their social life. The most negatively affected aspect was the adolescents' place in the community. The adolescents felt uncomfortable being in the community as they felt stigmatised. They were aware of people judging them and gossiping about their pregnancy.

From these findings it can be concluded that the pregnancy only marginally affected the adolescents' romantic relationships and friendships in a negative manner. However, the pregnancy had a definite negative impact on the adolescents' place in the community, as they were shunned and stigmatised. This added to the difficulty of adjusting to and coping positively with the pregnancy.

It is recommended that, with regard to services aimed at prevention:

- Community awareness programmes on adolescent pregnancy should be promoted by NGOs and social service providers, with an emphasis on how to support pregnant adolescents.

It is recommended that, with regard to the assessment of pregnant adolescents:

- Social workers should assess the impact of the pregnancy on the adolescent's friendships and romantic relationships. Poor relationships could indicate areas for improved support, and strong relationships could indicate areas of support that can be utilised.

It is recommended that, with regard to intervention in the practice setting:

- Social workers, when dealing with pregnant adolescents, should buffer the relationship between the adolescent and the community. The social worker should assist the community and the adolescent to develop healthy person-environment exchanges.

### **6.2.11 Support groups**

The participants reflected a relatively poor knowledge of and involvement in support groups. Nearly all of the participants had not ever been part of a support group. Reasons for not being part of support groups were that the participants had no knowledge of what a support group was or of any in the community. In addition to lacking knowledge, the participants who did know what a support group was thought that they were only for people who had HIV. Only one participant knew what a support group was but did not feel the need to attend it.

The adolescents expressed a genuine desire to have been involved in support groups during their pregnancy. They could identify a great need for reciprocal support, as well as the opportunity to learn more about pregnancy and motherhood. This is a resource that is a much-needed support system during pregnancy and it is lacking in many communities.

It can be concluded that adolescents lack knowledge of support groups. They do not understand the purpose of support groups and have very limited knowledge of groups in their community. It is clear that the adolescents had not ever been educated about support groups, nor had they been informed about them when accessing services in the community during their pregnancy. In addition to this it is apparent that there also is a lack of support groups for pregnant adolescents to attend in their communities.

It is recommended that, with regard to tasks related to group work intervention:

- Social workers should facilitate and promote support groups for pregnant adolescents.

It is recommended that, with regard to services aimed at education:

- Adolescents should be informed by social workers and clinics about the existence of support groups in the community. Furthermore, adolescents should also be educated about the benefits of support groups.

It is recommended that, with regard to tasks related to advocacy and policy:

- Social workers should advocate for support groups at clinics, as this is a key resource accessed by all adolescents during pregnancy.

### **6.2.12 Health care services**

The study indicates good use of health care services by pregnant adolescents, although half of the participants only accessed health care services late in their pregnancy. The participants presented to health care services late because there were many factors that caused apprehension. Before accessing health care services, the participants felt mostly fearful, nervous and embarrassed.

Among the reasons for these feelings were that the adolescents did not know what services the clinic offered, and this made them anxious about what to expect. Further, they are wary that they would be pressured into an abortion and they feared that their pregnancy would be disclosed to others. Most of all adolescents felt out of place amongst the older women in the clinic.

In addition to feelings of apprehension related to the mentioned reasons, the adolescents also often had undesirable experiences at the clinic because of the negative attitude of the clinic personnel. The personnel were experienced as being harsh, scolding and judgemental towards the adolescents during their pregnancy. However, just more than half of the participants said that they had experienced the health care personnel to be supportive and kind towards them during their pregnancy.

It appears that, although adolescents experience health care personnel to be supportive when they actually visit the clinic, there is a misconception about the personnel before the time. Adolescents are apprehensive to attend the clinic because they hear from other adolescents that the staff are unkind and judgemental. This was expressed by the girls when asked what the clinics should change in order to make them more accessible to pregnant adolescents.

It can be concluded that the adolescents were nervous and afraid about attending the clinic when they were pregnant. The negative reputation of the nurses appears to play a key role in deterring adolescents from accessing health care services. The adolescents felt uncomfortable

amongst the older women in the clinic, and there is a definite need for more privacy and for health services that are aimed specifically at adolescents.

It is recommended that, with regard to services aimed at prevention:

- The services that are provided at clinics should be promoted by the clinics, schools and NGOs, and be made known to all adolescents.
- The misconceptions and factors that hinder adolescents from utilising clinics should be addressed through awareness-raising programmes by health care service providers and social workers.

It is recommended that, with regard to tasks related to advocacy and policy:

- Social workers should advocate for more privacy for adolescents when accessing health care services.
- Social workers should also advocate on behalf of the adolescents for clinics to have more adolescent friendly services, or services specifically for adolescents.

### **6.2.13 Social welfare services**

Of all the areas of support evaluated during the empirical study, it is clear that social service providers were the least accessed during pregnancy and that the lowest level of support can be attributed to them. Adolescents have a limited knowledge of social welfare services and social workers. In all three communities the adolescents did not know of a social worker in their community or of any social welfare services.

As a result, many of the participants did not have an opportunity to talk to anyone about their options when it came to pregnancy resolution. The adolescents expressed that it would have helped them to speak to a professional, particularly a social service provider, during their pregnancy. The adolescents recognised a need for more information regarding adoption, abortion and social security, as well as more emotional support.

From these findings it can be concluded that social workers have relatively low visibility within the various communities. Adolescents also lack knowledge of social welfare services, but were able to identify this as a gap in their support during pregnancy.

It is also significant that many of the recommendations of the study are for social workers, or require active social welfare services within a community. The recommendations can only be achieved if social welfare services are more prominent in communities and adolescents have the opportunity to utilise such services.

It is recommended that, with regard to the tasks related to prevention and promotion:

- Social workers should promote the social welfare services available to the community and explain the role of the social worker.
- Adolescents should also be educated in schools about social workers and how they can be of assistance during stressful life events, and particularly during pregnancy.

It is recommended that, with regard to tasks related to the assessment phase in the practice setting:

- Social workers must determine where the adolescent is in the pregnancy resolution process and offer the adolescent information on adoption, abortion and social security.

#### **6.2.14 Education on reproductive health rights**

In assessing sources of education for the participants concerning their reproductive health rights, it was noticeable that most of the participants had not received any education on such topics. For adolescents who did receive education on reproductive health, the school was identified as the greatest source of information. Peer education would be expected to be a main source of education, but the majority of the participants had never been involved in any sort of peer education programme, neither as a peer educator nor as a learner.

Adolescents generally have an inadequate knowledge of safe sex. A small number of the participants could express a thorough understanding of the need to use protection to prevent pregnancy as well as the spread of sexually transmitted infections and HIV. This suggests that

the adolescents' understanding of reproduction, fertility, menstruation, sexually transmitted infections and prevention is low, and clearly insufficient to protect them against unplanned pregnancy.

Many of the participants who had a general knowledge of safe sex, and even the adolescents who did not have knowledge, indicated that knowing about safe sex did not, or would not, have an impact on them when choosing to engage in sexual activity. This is primarily due to the fact that they make their own decisions when it comes to having sex and they do not appear to be concerned about the risks involved in engaging in unprotected sex.

Although the adolescents had reasonably regular contact with their family, health care services and schools, it can be concluded that these sources are relatively poor sources of information regarding reproductive health rights. The adolescents had little exposure to education on their reproductive health rights. This could be a significant contributing factor to pregnancy, as the adolescent did not have knowledge about contraceptives.

It is recommended that, with regard to services aimed at prevention and education:

- Awareness programmes in schools should be aimed at all adolescents to educate them about their reproductive health rights.

It is recommended that, with regard to tasks related to advocacy and policy:

- Social workers should advocate that schools and clinics should have rights promotion programmes for adolescents to learn about their reproductive health rights.

### **6.2.15 Knowledge of rights and legislation**

The participants' overall knowledge of rights and legislation was relatively low. Adolescents have good knowledge of areas in which they have had practical experience. For example, the adolescents knew that the clinics were free, that schools are obligated to allow one to remain in school, as well as how much the Child Support Grant is. The adolescents had poor knowledge about adoption, abortion and accessing contraceptives.

Therefore, it can be concluded that there is not sufficient education for adolescents concerning their rights and the legislation that has an impact on their reproductive health. Adolescents have poor knowledge of these topics, and this increases the risk of early unplanned pregnancy and also contributes to the difficulty of pregnancy resolution.

It is recommended that, with regard to services aimed at prevention and education:

- Adolescents should be exposed to educational programmes offered by NGOs and schools concerning their rights and the legislation that has an impact on their sexual behaviour, as well as their rights as a pregnant woman and mother.

It is recommended that, with regard to tasks related to advocacy and policy:

- Social workers should advocate for the rights of and legislations that has an impact on adolescents to be clearly promoted in the community, and in public places such as schools and clinics.

### **6.2.16 Suggested advice for pregnant adolescents**

The participants felt strongly about sharing advice with other adolescents. Overall, the adolescents were encouraging and recognised a need for pregnant adolescents to receive positive encouragement and motivation to keep going. There was also a strong emphasis on health care and more so on using prevention.

From the advice shared it can be concluded that pregnant adolescents wished that they had the foresight to see the negative consequences of pregnancy at such a young age, and consequently they regretted not using prevention. Adolescents also need encouragement during their pregnancy, as well as more health care advice. The suggested advice that was shared by the participants indicated that peer education would be significant as a key to prevention, and that peer support groups would be valuable during pregnancy.

This reiterates the significance of peer education and support, as indicated by Kidger (2006:112-117). The study found that the most effective peer education programmes were presented by young mothers. Their personal life experiences and ability to relate to their peers allowed for them to effectively educate adolescents about sexuality and motherhood. The peer educators' personal life experiences were their greatest asset in educating other adolescents.

It is recommended that, with regard to the tasks related to group work interventions:

- Social workers should facilitate peer group programmes for the purposes of education and support.
- Social workers should utilise ideas shared by pregnant adolescents in order to learn how to engage with and educate other adolescents at risk of unplanned pregnancy.

### **6.2.17 General comments**

The participants did not have any general comments to make regarding the interview. It can be concluded that they shared everything that they were willing to share during the interview. The opportunity to offer advice to other pregnant adolescents allowed for the participants to share something that was meaningful, and this appeared to give them a sense of conclusion. The adolescents also had no further questions once the interview was complete.

## **6.3 FURTHER RESEARCH**

In the light of the results of the investigation with regard to support for pregnant adolescents, it is suggested that further research focus on the development of effective educational and awareness-raising programmes by NGOs, schools and clinics. This may increase adolescents' knowledge with regard to the available support services, and may decrease the number of adolescents who have unplanned pregnancies.

Further research could also explore the relationship between the pregnant adolescent and her partner. There appears to be ambiguity around the nature of these relationships. Research would help to identify areas in which partners could be more supportive and also help to bring clarity as to why the adolescent chooses to continue with the relationship.

Finally, research could also be conducted on the role that social workers and NGOs can play in low-income black and coloured or mixed race communities with regard to educational and prevention services.

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## APPENDIX 1 - SEMI-STRUCTURED QUESTIONNAIRE

**STELLENBOSCH UNIVERSITY**

**DEPARTMENT OF SOCIAL WORK**

### SEMI-STRUCTURED QUESTIONNAIRE

**An ecological perspective of adolescents' need for support  
during pregnancy.**

All the information recorded in the questionnaire will be regarded as confidential.

Please read the following questions and answer them honestly.

#### **1. IDENTIFYING DETAILS**

1.1 Age: \_\_\_\_\_

1.2 Who are you currently living with? \_\_\_\_\_

1.3 The nature of the pregnancy:

Was your pregnancy:

Planned	
Unplanned	

## **2. THE TEENAGER**

*The following section applies to your individual characteristics, how your pregnancy impacted you, and what your needs were during pregnancy.*

### **2.1 Self esteem**

2.1.1 How did your feelings about yourself change when you found out that you were pregnant?

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### **2.2 Relatedness**

2.2.1 Do you feel that you are able to:

<b>BEHAVIOUR</b>	<b>YES</b>	<b>NO</b>
Form close relationships with your friends and family		
Go to your close family or friends to help you cope with stressful experiences		

### **2.3 Competence and self-direction**

2.3.1 In which of the following ways do you make decisions:

<b>BEHAVIOUR</b>	<b>YES</b>
You make decisions on your own	
You rely completely on others to help you make decisions	

**2.4 Sexual activity**

2.4.1 Please indicate your age at your first sexual experience: \_\_\_\_\_

2.4.2 Did you engage in sexual activity as a result of:

Pressure from your friends	
Pressure from your boyfriend	
It was your personal choice	
Other	

2.4.3 Have you ever been physically, emotionally or sexually abused?

<b>YES</b>		<b>NO</b>	
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**2.5 Use of contraceptives**

2.5.1 Did you use contraceptives before you fell pregnant?

<b>YES</b>		<b>NO</b>	
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If YES:

2.5.2 Did you use contraceptives from your first sexual experience?

<b>YES</b>		<b>NO</b>	
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2.5.3 Why did you not use contraceptives (either at all, or when you fell pregnant)?

You did not have knowledge about contraceptives	
You did not plan to have sex	
Your partner did not want you to use contraceptives	
You did not know that you could fall pregnant	

## **2.6 Emotional response**

2.6.1 Which one of these feelings did you experience the most when you found out that you were pregnant?

<b>FEELING</b>	<b>YES</b>
Fear	
Anger	
Denial	
Guilt	
Worthlessness	
Joy	
Excitement	

2.6.2 Did you feel like you were in a crisis when you found out about your pregnancy?

<b>YES</b>		<b>NO</b>	
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Explain:

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2.6.3 How did you feel about disclosing your pregnancy?

<b>ACTIVITY</b>	<b>FEARFUL/ WORRIED</b>	<b>CONFIDENT</b>
Disclosing your pregnancy to your parent/s		
Disclosing your pregnancy to your boyfriend		

**2.7 Education**

2.7.1 Did you stay in school when you found out that you were pregnant?

<b>YES</b>		<b>NO</b>	
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If NO:

2.7.2 Which grade were you in when you left school? \_\_\_\_\_

2.7.3 How do you feel that your pregnancy affected your schooling career?

(Choose one option)

Pregnancy made your schooling more challenging	
Pregnancy was your main reason for dropping out of school	
Pregnancy has not had a negative effect on your school performance	

2.7.4 Did any of the following make it hard for you to remain in school?

(Choose one option)

<b>Reason</b>	<b>YES</b>
Morning sickness	
Fatigue/tiredness	
Difficulty concentrating/focussing	
Stigma	
Unsupportive school/teachers	
Other:	

### **3. MICROSYSTEM**

*The following section applies to how your pregnancy impacted on relationships with your family and partner, and what your needs were during pregnancy.*

#### **3.1 Type of support**

3.1.1 Who gave you the highest form of support when you were pregnant, within the following categories:

<b>TYPE OF SUPPORT</b>	<b>MOTHER</b>	<b>FATHER</b>	<b>PARTNER</b>	<b>FRIENDS</b>	<b>OTHER: (specify)</b>
Money/financial					
Giving advice					
Positive encouragement					
Physical assistance					
Sharing private feelings					

#### **3.2 Family**

##### **3.2.1 Family Life**

3.2.1.1 Do your parents, or parent, usually:

<b>BEHAVIOUR</b>	<b>YES</b>	<b>NO</b>
Discipline you		
Enforce rules in the house		
Monitor your behaviour		
Provide a supportive family environment		
Teach you values about sexuality		

##### **3.2.2 Parents' response to pregnancy**

3.2.2.1 How did your mother react to the news of your pregnancy?

Disappointed	
Angry	
Supportive	
Shocked	

3.2.2.2 How did your father react to the news of your pregnancy?

Disappointed	
Angry	
Supportive	
Shocked	

### **3.3 Partner**

*Please note that partner (boyfriend) refers to the alleged father of your baby.*

3.3.1 When you found out you were pregnant, did you stay in the relationship with your partner? Explain:

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3.3.2 What factors listed below are applicable to the relationship with your partner:

	<b>YES</b>	<b>NO</b>
Your partner encouraged you to access health care facilities during your pregnancy		
Your partner was considerate of the physical strain of the pregnancy		

#### **4. MESOSYSTEM**

*The following section applies to how your pregnancy impacted on your social relationships, and what your needs were during pregnancy.*

##### **4.1 Social life**

4.1.1 Did your pregnancy affect any of the following aspects of your social life?

<b>SOCIAL ACTIVITY</b>	<b>POSITIVELY</b>	<b>NEGATIVELY</b>	<b>NO EFFECT</b>
Friendships			
Romantic relationships			
Your place in the community			

##### **4.2 Support groups**

4.2.1 Have you ever been part of a support/self-help group?

<b>YES</b>		<b>NO</b>	
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Explain:

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## **5. EXOSYSTEM**

*The following section applies to how health care services and social service providers impacted on you and your pregnancy, and what your needs were during pregnancy.*

### **5.1 Health care services**

*Please note that health care services refer mainly to state (government) clinics and hospitals.*

#### **5.1.1 Utilisation of health care services**

5.1.1.1 Did you utilise health care services during your pregnancy?

Yes, you did so early in your pregnancy	Yes, you did so late in your pregnancy	No, you did not utilise health care services at all

5.1.1.2 How did you feel about utilising health care services when you were pregnant?

Confident	
Embarrassed	
Nervous	
Fearful	

5.1.1.3 Did any of the following hinder you from utilising health care services during your pregnancy?

	<b>YES</b>	<b>NO</b>
You feared that staff would disclose your pregnancy		
You felt out of place among older women		
You feared that you would be pressured into having an abortion		
You did not know what type of services were provided by health care services		
None of the above		

5.1.1.4 What was your experience of health care providers during your pregnancy?

Harsh	
Scolding	
Judgemental	
Supportive	
Kind	

## **5.2 Social service providers**

*Please note that social services refer mainly to social work/social welfare services.*

### **5.2.1 Utilisation of social welfare services**

5.2.1.1 Did you utilise social welfare services during your pregnancy?

Yes, you did so early in your pregnancy	Yes, you did so late in your pregnancy	No, you did not utilise social services at all

If NO:

5.2.1.1 What was your main reason for not utilising social welfare services during your pregnancy?

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### **5.2.2 Social service assistance**

5.2.2.1 Did you receive information about the following choices regarding your pregnancy:

<b>CHOICES</b>	<b>YES</b>	<b>NO</b>
Abortion		
Adoption		
Keeping your child		

If YES:

5.2.2.2 Where did you receive the above-mentioned information?

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## **6. MACROSYSTEM**

*The following section applies to how policies impacted on you and your pregnancy, and what your needs were during pregnancy.*

### **6.1 Education on individual rights**

6.1.1 Have you been educated about your rights for when you are pregnant or having a baby at any of the following places?

	<b>YES</b>	<b>NO</b>
Home		
School		
Health care services		
Social services		
No identifiable education		

### **6.2 Knowledge of rights and legislation**

#### **6.2.1 Health care services**

6.2.1.1 Do you know how old must you be to access contraceptives?

10	
12	
14	
16	
18	
Do not know	

6.2.1.2 Do you know how health care services should charge you when you are pregnant?

Free	
At a reduced rate	
At a high rate	

### 6.2.2 Abortion

6.2.2.1 Do you know up to how many weeks you may have a normal abortion without consulting a medical practitioner?

10	
12	
20	
24	
Do not know	

6.2.2.2 Do you know whether you need the father of your baby to give permission for your child to be adopted?

<b>YES</b>		<b>NO</b>		<b>DON'T KNOW</b>	
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### 6.2.3 Social security

6.2.3.1 Do you know where to apply for the Child Support Grant?

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6.2.3.2 Do you know how much the Child Support Grant is?

R 150	
R 250	
R 350	
R450	
Do not know	

### 6.2.4 School legislation

6.2.4.1 Do you know what schools should do when you fall pregnant?

Allow you to remain in school	
Expel you from the school	
Schools have no legal responsibility	

## **7. OVER ALL SUPPORT NEEDS**

*In light of the above questions please consider which areas need improved support and how this can be achieved.*

### **7.1 Family**

7.1.1 What was the main problem you experienced during your pregnancy with your family and how could this have been addressed?

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### **7.2 Partner**

7.2.1 What was the main problem you experienced during your pregnancy with your partner and how could this have been addressed?

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7.2.2 Do you know of any services for young pregnant couples?

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### **7.3 Peer education programmes**

7.3.1 What do you know about safe sex? Explain:

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### 7.3.2 Impact of knowledge:

(a) Why did knowledge of safe sex not influence your sexual behaviour which resulted in you falling pregnancy?

OR

(b) How would knowledge of safe sex have influenced your sexual behaviour which resulted in you falling pregnancy?

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7.3.3 Are/were there any peer education programmes in your school or community and have you attended such programmes?

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## **7.4 Support groups**

7.4.1 How could/did being part of a group of other girls who are pregnant assist you in your pregnancy?

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**7.5 Health care services**

7.5.1 What would have made health care services more accessible during your pregnancy?

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**7.6 Social service providers**

7.6.1 Would it have helped you to talk to a professional person during your pregnancy?

For example a social worker or counsellor?

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**7.7 Conclusion**

7.7.1 Overall, what has been your greatest support need related to your pregnancy?

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7.7.3 What advice would you share with other adolescents who are pregnant?

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7.7.2 Any other remarks:

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Thank you very much for your participation and co-operation in the study.

## **APPENDIX 2 – INFORMED CONSENT**

University of Stellenbosch

Department of Social Work

Research conducted by: Lorién Parker

Supervisor: Prof S. Green

### **An ecological perspective of adolescents' need for support during pregnancy**

I confirm that:

- I have been informed about the purpose of the study concerning an ecological perspective of adolescents' need for support during pregnancy.
- I understand that information will be collected by means of a semi-structured questionnaire during an interview.
- I have been informed that the information that is gathered during the interview will be treated confidentially and my personal identifying details will not be made known.
- I understand that the information that is gathered will be presented in the form of a research paper.

I hereby agree to voluntarily participate in the above-mentioned study:

Signed by: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_