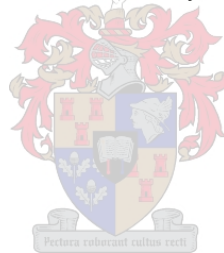


Attitudes, understanding and perceptions of teenagers about the use of contraceptives
(Buffalo City Municipality – Eastern Cape)

By
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Declaration

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Thanking God Almighty for always being there when I need Him.

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Dedication

I dedicate this work to all the selfless women and men who are working tirelessly to curb the spread of HIV in the Eastern Cape.

Abstract

Contraception is defined as the prevention of pregnancy through temporary or permanent means and it is a fundamental element of family planning (Bafana 2010). A contraceptive helps and protects women from unwanted pregnancies. While contraceptives are widely and easily available the statistics for teenage pregnancy remains high and the use of contraceptives is very low in South Africa. The South African Demographic and Health Survey (SADHS) statistics show that there has been an increase in the number of teenage pregnancy when comparing the statistics of the two periods 1998 and 2008. The numbers have almost doubled to 16% of the learner population being pregnant in some provinces. The Eastern Cape (EC) Province is no exception. Aims and objectives of this study were to understand if teenagers today know enough about the use of contraceptives and about social and medical problems associated with teen pregnancy? If yes, why are they not using contraceptives and how can we change that to prevent teenage pregnancy and unwanted babies.

This study made use of a triangulation methodology whereby both qualitative and quantitative research methods were used. The study was two-pronged with the target group being teenagers at school and pregnant teenagers attending ante-natal clinics (age 13-19yrs). About 120 teenagers were recruited for the study. In-depth interviews were conducted through use of questionnaires amongst the school youth which involved both boys and girls. In ANC interviews and focus groups were conducted when the girls were in their second to fifth month of pregnancy.

Results indicated that understanding of contraceptives and reproductive health amongst teenagers was poor, condoms were the contraceptive method most known by teenagers and their understanding of the menstrual cycle was inaccurate. Most teenagers who knew about contraceptives perceived them as bad saying they make you wet. They do perceive pregnancy as a negative event with consequences such as loss of a boyfriend, loss of friends, blame from friends and family members, feeling guilty, difficulty and school dropout, complications during pregnancy or delivery and risk of HIV. They regarded abortion as the better pregnancy preventative method and were poorly informed about secondary infertility if abortion is done.

The study identified a number of factors that may influence the use and acceptance of contraceptives by teenagers and that will help in decreasing teenage pregnancy rate. These factors may influence teenagers' behavioural intentions through altering their perceptions of the personal and social consequences of falling pregnant and their self-efficacy in relation to sexual behaviour.

Strategies to promote use of contraceptives should focus on making information on contraception more accessible and offering programmes that empower teenage girls and boys in the area of sexuality. This should also focus on building social capital for teenagers in communities, targeting trans-generational sexual norms, applying the law on underage drinking, empowering of parents or parent mentorship programs about sexuality. Multi-faceted and intersect oral approaches are required and it is likely that the strategies put in place to promote use of contraceptives by teenagers will also impact on reducing HIV

transmission especially mother to child transmission, illegal and septic abortions and other sexually transmitted infections.

OPSOMMING

Die doel van die studie was die bepaling van die kennisvlakke teenoor MIV/Vigs asook die persepsies en houding teenoor voorkoming van die pandemie by 'n steekproef van jong seuns en dogters binne die Oos-Kaap.

Inligting is deur middel van 'n vraelys sowel as deur middel van verskeie fokusgroepe ingesamel. Vraelyste is professioneel in isiXhosa vertaal en die meeste fokusgroepe is ook in isiXhosa gehou. Klem is veral geplaas oor die kennis van bestaande voorbehoudmiddels en die mate waartoe die jongmense dit gebruik ten einde die verspreiding van die pandemie te beperk.

Belangrike inligting oor die kennisvlakke van kinder op hoërskool word aangebied en in konteks geplaas. Oor die algemeen is bevind dat kennisvlakke baie swak is en dat die kinders se persepsie oor die pandemie beperk is en dat die houding daarteen dikwels onverskillig is. Daar word ook gevind dat daar nog verskeie ou mites bestaan wat deur die jongmense ondersteun en toegepas word.

Voorstelle ter verbetering van die situasie binne die Buffalo City Municipality in die Oos-Kaap word aan die hand gedoen en gemotiveer.

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CHAPTER 1: INTRODUCTION, AIMS AND JUSTIFICATIONS

Contraception is defined as the prevention of pregnancy through temporary or permanent means and it is a fundamental element of family planning (Bafana 2010).

A contraceptive helps and protects women from unwanted pregnancies. Since early 1960s family planning programs have helped women around the world avoid millions of unwanted pregnancies; as a result many women's lives have been saved from high risks pregnancies and maternal deaths. Without contraception a woman's total fertility rate would be beyond control and this would have undesirable consequences. Medically a woman is advised to be emotionally and physically healthy before starting to have babies and the suggested age is age 23 or around that. Teenagers are not advised to fall pregnant. Emotionally they are still immature and physically their body is still developing and they won't be able to fulfil the social and economic demands which comes with parenting and thus leads to socio-economic problems. The future and upbringing and future for the child are bleak. It is even more so with high level of HIV transmission teenage pregnancy is a high risk behaviour predisposing the teenager to HIV infection.

Contraceptives can be divided into modern and traditional contraceptive methods. These include the pill, IUD, injections, diaphragm/foam/jelly, condom, female sterilization, male sterilization as the modern forms and periodic abstinence, withdrawal and herbs as the traditional methods.

The most significant factors that influence contraceptive use are known to be the knowledge about contraception, attitudes on issues related to contraception such as smaller family sizes, birth spacing, etc., socio-economic development, poor socio-economic development is associated with low contraceptive use, and urbanization is associated with greater contraceptive use, women's education and status. There is a belief that improving women's educational and economic opportunities can have an important impact on their use of contraception, and their control over sexual and reproductive matters, cultural values, beliefs and norms. However, what influences teenagers might be different (Department of Health: National contraception policy guidelines; 2004)

South African legislation 1996 (Act No. 108 of 1996) promotes reproductive rights and the right of access to reproductive health care: "Everyone has the right to bodily and psychological integrity, which includes the right: to make decisions concerning reproduction; to security in and control over the body and not to be subjected to medical and scientific experiments without their informed consent." (Freedom and security of the person). "Everyone has the right to have access to health care services, including reproductive health care; sufficient food and water; and social security, including, if they are unable to support themselves and their dependents, appropriate social assistance." (Health care, food, water and social security). Child Care Act 1983 (Act No. 74 of 1983) The Act states that minors of 14 years and older may consent to their own medical treatment without the assistance of parents or guardians. Any person of 18 years and older may consent to surgical procedures (operations) being performed on themselves without the assistance of parents or guardians. (An exception (amended 2004) to this general rule is that girls under the age of 18 can have an abortion without their parents' or guardians' permission. They can also access family planning from any public health facility and can go for HIV test.) In practical terms, this means that children of any age can approach a clinic for sexual and reproductive health information and condoms. The clinic may not inform the child's parents or guardians of the

visit. Girls of 14 years and older can be prescribed any form of medical contraceptive without the assistance or knowledge of their parents or guardians. Girls under the age of 14 years need the consent of their parents or guardians before being supplied with the pill or other prescription forms of 14 contraceptive. However, adolescents who may be sexually active and/or request contraception, but are unwilling or unable to obtain their parents' or guardians' consent, should have their health and social needs met. Policy Guidelines for Adolescent and Youth Health, 2001, National Department of Health include Sexual and Reproductive Health among its six top health priorities for adolescents and youth. Key intervention strategies that relate to contraception include promoting delayed childbearing and promoting marriage preparedness, facilitating easy, cheap and private access to all forms of contraception (including emergency contraception and condoms), using multimedia methods to provide information to adolescents, youth and their families about all sexual health matters; building skills specifically relevant for sexual health such as negotiating contraceptive use; providing sexuality counselling; integrating sexual and reproductive health services (Department of Health: National contraception policy guidelines year).

- In South Africa (especially in the Eastern Cape) teenage pregnancy is a challenge and a huge problem. It is a struggle that needs to receive attention and focus as the struggle against apartheid received and more recently HIV. The high numbers of teenage pregnancy in South Africa indicate that teenagers are still exposing themselves to HIV and unplanned pregnancies and this pose difficulties for South Africa to reach the Global Initiative Goals by 2015(“No Children to be born with HIV by 2015”);
- Target 1 **#Global Target #1:** Reduce the number of new HIV infections among children by 90%.
- **Global Target #2:** Reduce the number of AIDS-related maternal deaths by 50%.

The goals of the South Africa's; National Strategic Plan (NSP) and Eastern Cape Provincial Strategic Plan (PSP) are zero new HIV infections, zero mother to child transmission and zero deaths due to AIDS-related diseases.

Young people in the Eastern Cape are facing high rates of sexual-transmitted diseases.

- HIV/AIDS (South Africa Department of Health 2009) is still a huge problem. About two thirds of South Africans youth are experiencing pregnancy before they reach the age of twenty (South Africa Demographic and Health Survey 2008). Both outcomes have major implications for the life chances of young women and men. Hundreds of thousands of babies and mums die needlessly every year because millions of women don't have the power to plan their families. Providing more condoms, injections and pills is crucial. So too is making sure that women are empowered to decide when to have children by that we can be sure that :
 - Fewer babies are dying due to teenagers lack of education and empowerment about pregnancy and childbearing.
 - Fewer unintended pregnancies resulting in illegal abortions, child neglect and depriving the child of the love of both parents
 - Less number of women and girls dying during pregnancy and childbirth.

While contraceptives are widely and easily available and can prevent unwanted pregnancies, the statistics for teenage pregnancy remains high and the use of contraceptives is very low in

South Africa. The South African Demographic and Health Survey (SADHS) statistics show that there has been an increase in the number of teenage pregnancy when comparing the statistics of the following two periods, namely 1998 and 2008. The numbers have almost doubled to 16% of the learner population being pregnant in some provinces. The Eastern Cape (EC) Province is no exception.

Teenage pregnancy and childbearing is linked to a host of critical social issues and medical complications e.g. baby's 'wellbeing. The Eastern Cape Provincial Prevention of Mother to Child Transmission (PMTCT) program experiences major problems with regard to contraception, one of them being "late booking of pregnant women at Ante natal clinic (pregnant women need to come for their first Ante-natal clinic (ANC) first visit for the effectiveness of the PMTCT before 14 weeks of pregnancy). "Late booking" then affects the program because the mother's status on HIV is not known in time and thus treatment to prevent transmission cannot be initiated in time thus exposing the child to HIV. In 2011 the majority of the province's districts documented about 66% of late bookers and unbooked pregnant women and high percentage there were teenagers. All this then contributes largely to the incidence of new HIV infections amongst our children, to mother to child transmission, preterm labour, labour complications due to mismanagement and sometimes maternal deaths due to complications.

Complications such as the ones mentioned above can be prevented if contraceptive programs could be understood and used by teenagers and by that it will mean that

- Teenagers everywhere have the power to plan their families.
- They are well informed about their reproductive; sexual rights and protection.
- They have equal access to education, including sex education, to ensure contraception is explained to them and they know the benefits before they are sexual active and it is used effectively.

1.2. Availability of family planning services in BCM (East London)

In SA the Department of Health is the Principal provider of Contraception and provides different methods at no costs at all Public Health services. They are still going through the process of transformation in an attempt to redress past inequalities and improve quality of care (SA Demographic health Survey 1998).

At National Level Maternal Child & Women's health (MCWH) and Nutrition cluster are responsible for policy guidelines; training and support of the service same as in Provincial level.

Contraceptive delivery points range from those at Community Health Centres, mobile clinics, districts hospitals and tertiary and academic hospitals.

Other available family planning services include:

- At BCM (East London area), where the research was conducted, there are about 17 clinics plus the central community health centre and a district Hospital, all providing family planning. The situation is the same in East London central where all suburbs have a clinic plus a CHC and a Hospital to provide family planning.

- There are about 65 general practitioners around the area and about five practicing gynaecologists who provide family planning advice at a charge.
- Clicks Pharmacies, which we having about seven of, and four other leading pharmacies who have professional nurses and who are providing the service.
- There are NGOs around East London (BCM) which are rendering the services for minimum charge e.g. Marie Stopes and others like Love life, Life Line and FSH which focus more on education and condom supply.

1.3 Quality of Care

The quality of services can be summarised as follows:

- The range of contraceptives offered by public sector remains is limited depending on the area. In the rural and semi urban only contraceptive injections, the pill and male condoms are available. Female condoms are not available.
- There is a lack of counselling and patient information due to overcrowded clinics. Nurses who provide this service are multi tasked mostly doing consulting other Primary Health care ailments and family planning.
- There are very few Health centres which are Youth friendly
- Verticalisation of services family Planning services are not inclusive of STI and HIV and AIDS clinics. (S.Ndlebe Fort Hare 2011)
- Even though SA legislation and policy (National Contraception Policy Guidelines)allows 14 years and up children to come and ask for contraceptives without parental consent ; there still exist a lot of staff negative attitudes towards them; they claim they are shouted for their behaviour by Health care workers; there is no counselling provided when they visit clinics(S.Ndlebe Fort hare 2011)

1.4. Status of Teenage pregnancy

Teenage pregnancy is still high and undesirable as it perpetuates HIV transmission to new-borns. There are also high numbers of abortions (especially those that are illegal) resulting in severe medical complications and unwanted children.

It is reported that teenage pregnancy increases progressively from age 14 to 19 and almost quadrupling by age 19 (SHRC report 2010). In one school in one year (in Mdantsane BCM 2010//11) 259 children were reported to be pregnant and about 1200 young girls in one district (in the Eastern Cape 2010/11) were pregnant. From statistics it seems that the use of contraceptives in the age group 14-20 yrs. was about 15%.

The South African Demographic and Health Survey (SADHS) statistics show that there has been an increase in the number of teenage pregnancy when comparing the statistics of the following two periods: 1998 and 2008. The numbers have almost doubled to 16% of the learner population being pregnant in some provinces. Researchers are not sure if this increase is real or the effect of better reporting.

Health statistics in fact show a decline in teenage fertility and in overall fertility in South Africa progressively over the years since the early 1970s. It is difficult however to say whether the decline is due to reduced fertility or the effect of good contraceptive use and termination of pregnancy.

What is clear though is that teenage pregnancy is still very high and undesirable as it perpetuates poverty and the oppression of women. In most cases the father of the baby in

teenage pregnancy is of similar age and thus is also financially and emotionally unprepared to raise a baby. Dependence on his parents is also contributing to this unhealthy situation.

The greatest concern in teenage pregnancy is seen when the mother was below the age of consent when the child was conceived while the father was clearly above the age of consent.

If a teenage mother chooses not to keep the child she has two options:

- Abortion. The child is not even born and the pregnancy is interrupted (Edelman, 2003).
- Adoption. The child is born, yet the mother gives it away.

Two major hospitals around Buffalo city Municipality and two community health centres when my research was conducted have seen a massive increase in the number of teenagers seeking termination of pregnancy. In one Health Centre they say they do have about 45 teenagers per week coming for termination of pregnancy (to prove once more than most of the teenagers don't want to be pregnant)

Mothers under the age of 16 are four times more likely to have health problems during pregnancy or immediately after it than females are in the age group 20 to 24. Their children of these 16 years old mothers are likely to experience more problems than children of females aged 20 to 24 (Newcomb, 2001).

There is no formal studies been done in this area which will give us the follow up of this young parents but a study done by (Daily Dispatch, 2010), 67 percent of families begun by a teen mother live in poverty, and 52 percent of all mothers currently on welfare had their first child as a teenager. Perhaps this is because teen moms are less likely to complete high school, making it difficult for them to obtain higher-paying jobs.

Teen pregnancy in the SA is believed to be a national epidemic since more and more teenage girls after giving birth keep their babies.as the they are allowed to go to school while pregnant and are offered maternity leave (Department of Education policy guidelines 2010)

Teenage pregnancy it is believed to be extremely bad for a society's economy. Robinson (2003) refer to this situation as "when children have children" . One has to remember that teenage mothers are emotional, physically and economically not ready to have children. They don't have long-term plans for their babies and an attempt to concentrate on their baby is usually very poor. On the contrary, teenagers who plan long-term and expect a lot from their future delay pregnancy as much as possible and certainly for a longer period of time than those who lack hope and expectation of the future (Finkel et al, 2002).

It is on this basis that a study that investigates and explores the attitudes, understanding and perceptions of youth specifically in the Eastern Cape Province has been imperative

1.5. Problem question

Apart from the known medical and mental complications associated with Teenage pregnancy, early pregnancy and childbearing is linked to a host of critical social issues amongst our youth, such as school dropouts, poverty, baby's wellbeing etc. South Africa is one of the leading countries in HIV incidence and prevalence and most children today are orphans due to HIV. Some teenagers of today were born with HIV. In the height of that epidemic we are still faced with a society where our statistics showed us daily that our youth are exposing themselves in risky behaviours. Having unwanted pregnancies and unwanted children still happen too often especially since prevention methods are available.

The Province is faced with increasing daily numbers of our youth coming for termination of pregnancies and complications associated with the use of illegal abortion which is a clear indication of unwanted pregnancies by the youth. Contraceptives are easily available across the Province, mostly free of charge but are underutilized by the very same youth.

1.6. Aim of study

The aim of the study was to determine the attitudes; understanding and perceptions of teenagers about the use of contraceptives in Buffalo City Municipality- Eastern Cape)

1.7. Research Question

The research question that the study sought to address was:

Why teenagers are not using contraceptives?

1.8. Study objectives

The objectives of the study were to determine the understanding of contraceptives by teenagers, reasons for and attitudes associated with not using contraceptives and perception and attitudes towards contraception and teen pregnancy

Another objective was to determine the level of understanding of the social and medical issues surrounding teen pregnancy and parenting

CHAPTER TWO: LITERATURE REVIEW

This chapter introduces to what other researchers and publishers are saying about sexuality of the South African youth, demographics of South African youth, education on contraceptives to the youth and prevalence of HIV amongst adolescents in the Eastern Cape underutilization of existing services and lastly factors contributing to underutilization of reproductive health services by teenagers.

Current statistics show that South Africa has the sixth highest prevalence rate of HIV in the world, with the disproportionate share of those infected being young women and girls. Females aged 15 – 24 are four times more likely to be infected with HIV than men (UNAIDS; iEpic Report 2006). Studies conducted in South Africa have found that present day teenagers are having sex at an earlier age. Kelly (2005) noted that higher levels of sexual frequency are found in rural and informal areas than formal housing areas and also amongst adolescents living in the poorer socio economic circumstances. The recent study by the Human Sciences Research on household survey show an increase in HIV prevalence amongst young people in the Eastern Cape (Shisanoet et..al, 2009)

There is different understanding and practice of these issues by teenagers in rural setting and urban settings.

The evidence in the relationship between rural setting and HIV is found in the study conducted in the Eastern Cape that shows that levels of sexual frequency in rural and informal areas are higher than in formal housing areas and also among adolescents living in poorer socio-economic circumstances (Kelly, 2005).

The study conducted to evaluate HIV/AIDS baseline in the Eastern Cape schools shows that constraints and stigma appear to have impacted on HIV/AIDS education in most schools in the province. For an example: Parents feel that talking to their children about sex and sexuality means encouraging them to have sex. However the role of family is very important during adolescence. The concept of self-related to family as a social system with reciprocal relationship and alliances are constantly evolving. Families socialize adolescents to acquire the beliefs, values and behaviours deemed significantly appropriate by the society. Most adolescents lack information on sexuality and contraception, as most of the education that is presented on this matter is limited (Arai 2003; Bankole, Ahmed, Ouedraogo, Neema & Konyani 2007). The study by Kaufman, De Wet and Stadler (2001) indicated that there was a slightly lower level of knowledge about modern methods of contraception amongst teenagers. The authors further reported that young mothers in Soweto, South Africa, did not have knowledge of sexuality and information on contraception and contraceptive use. Morake (2011) indicated that in the reports of the Department of Health of the Limpopo Province, adolescents were reportedly not good contraceptive users, because they might not admit to being sexually active. Other studies reported that adolescents had inaccurate knowledge on the use of contraceptive (Bankole et. al. 2007).

The education on sexuality became compulsory in SA in 1996 and sexuality program became entrenched in the Life orientation subject offered in schools. Life orientation became compulsory as a subject in 2005 and sex education was made to be age appropriate

Even though education on sexuality is happening in our schools we are still faced with massive challenges/risks re our youth sexuality. Sexuality involves many disciplines from psychology; sociology to medicine; for education on sexuality to be successful it has to address many disciplines; this education can't be a didactic form of education "Chalk to board" kind of giving all the scientific knowledge it has to deal with issues of Love and gender; teach students how to react on social and mental challenges; work with them develop communication; negotiation and refusal/accepting skills and the current education doesn't equip teachers for that (Naidoo 2007)

With properly realizing the consequences associative with sex and pregnancy; informed teens will be able to decide for themselves whether or not they want to use contraception and whether or not they want to have children. In other words teen marriage will no longer be urgent; same as having child at such an early date (Shah et al, 2003).

Another issue when teaching sexuality to children is issue of abstinence. The South African Education System focuses more on abstinence. There is a general emphasis and belief that abstinence and sex after marriage is the only safe way to reduce teenage pregnancies. At the same time no study had confirmed that such abstinence programs worked effectively to prevent teenage pregnancies or decreased the overall teenage pregnancy rate as such (Amelia Naidoo 2003).

South Africa is a very strong religious country. It can be said that Christianity around here, especially amongst black SA, is a way of life. The religious groups on the other hand believe that teenagers should not be given any information on sexual development and contraception since it would lure them to try absolutely everything from putting on a condom to having sinful adulterous and promiscuous sex. Teens should on the other hand be shielded from any information regarding sex and sexual reproduction yet rather should be told all the negatives related to sex such as sexually transmitted diseases, teenage pregnancies and what else that will prevent them from wanting to have sex. The current US funding PEPFAR (President Bush's initiative on AIDS support in Africa) and his administration at present effectively fund abstinence programs across the and AFRICA promulgating life without sex and reminding teens about dangers of sex before marriage.(Robinson, 2003). PEPFAR won't fund programs promoting condoms, contraceptives and termination of pregnancy amongst our youth.

The study conducted by Kelly (2005) shows that the mean age sexual debut among young people is reported to be between ages of 13-16 years (Makiwane M, et al, 2008). In the survey that included six provinces 90 % of females and 97 % of males had had sex in the Eastern Cape. This was the highest number compared to Gauteng and Northern Cape provinces with 23 % and 88 % respectively for females and 38 % and 88 % for females. A big difference between girls and their first sexual partners is common in poorer communities. For example in the six province's study 20 % of girls in the Eastern Cape reported to have had sex at the age of 14 or lower with a partner who was three or more years older, this was higher than Northern and KwaZulu Natal provinces whose prevalence for early sexual debut with older partner was 3% and 16% respectively (Kelly, 2002)

It is on this basis that a study that investigates and explores the attitudes, understanding and perceptions of youth specifically in the Eastern Cape Province is imperative

1.7. Study Justification

In a country where HIV prevalence is 18.8 percent, the high level of teenage pregnancy has heightened concerns. According to the South African Medical Research Council (MRC),” Over the past years in South Africa we have seen large numbers of Teenage pregnancies; we have seen young boys becoming fathers and refuse to take responsibility.

"South Africa has a huge teen pregnancy problem - one in three girls has had a baby by the age of 20," David Harrison, Chief Executive Officer of Love Life, South Africa's largest youth-Organisation.

Almost all public health facilities across the country and the province do provide contraceptives free of charge and the usage by the youth according to recent stats is very minimal.

Research has been done as to why teenagers are having unwanted pregnancies. Somehow there are schools where 60 to 70 percent of pupils were pregnant. There is no doubt that this is associated with things like gang activity, coercion and substance abuse," Harrison said, adding that according to a 2006 survey, 30 percent of girls in South Africa said "their first sexual experience was forced or under threat of force".

But other factors are also driving the high teenage pregnancy rate in some areas. According to a recent MRC study, 'Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive Use in South Africa', "Nurses' attitudes were a major barrier to teenagers getting hold of contraception. The nurses were uncomfortable about providing teenagers with contraception, as they felt they should not be having sex. They responded to requests for contraception in a manner that was highly judgmental and unhelpful. The girls described it as 'harassment'".

The study also found that social pressures often prevented young women from using contraception: "The girls felt they would only be accepted as women once they had proved their fertility - many mothers wanted their teenage daughters to become pregnant so they could have prove a baby at home again.

Having said all that the numbers for illegal abortion is increasing mostly by the youth. Abandonment of children by the youth is also escalating; there are still a lot of indicators to prove that thou getting pregnant these babies are not wanted: why then not use family planning ? Do these kids know much about contraceptive? What is the reason for them not using? What do we need to do to correct that?

The findings of this study will be shared with the Department of Education and Health Eastern Cape and will help in the planning of strategies to deal with issue of children becoming pregnant or parents.

CHAPTER THREE: RESEARCH METHODOLOGY

This chapter focuses on the data collection approach that has been used in this study. It presents a summary of the characteristics of the participants, description of the study site. In this chapter a summary of the material and the approach used to ensure validity and reliability of the data is explained. Ethical considerations are also included in this chapter.

3.1 Study Design

The study made use of a triangulation methodology whereby both qualitative and quantitative research methods were used.

About 120 teenagers were recruited for the study; In-depth interviews were conducted through use of questioners amongst the school youth it involved boys and girls, In ANC we continued with interviews and focus groups when the girls were in their second to fifth month of pregnancy.

The questioners included questions on knowledge of contraception, sexuality, sex socialization, socio economic factors, family coherence and reproductive functions.

Analysis was conducted on sex socialization, knowledge of and attitudes toward contraception, socioeconomic factors, and family coherence as preventive aspects of teenage pregnancy. In this study an attempt was made to obtain information from pregnant teenagers and to identify human behaviour that contributes to teenage pregnancy and their failure to use contraceptives

The qualitative study entailed 20 in-depth interviews with school pregnant teenagers; 75 interviews with non-pregnant school going teenagers and three focus groups: one with 15 women aged 14 to 19 years who had a baby as a teenager, one with 15 teenage girls aged 13 to 19 years who had never been pregnant, and one with 15 males aged 14 to 19 years. Qualitative data was analysed through the framework method

The descriptive design was selected as it is concerned with gathering more information about the phenomenon studied. This research design was suitable to obtain relevant information and to describe and identify factors that contribute to teenage understanding and attitudes towards contraceptives. (Brink 2006).

3.2 Study site

The study site was Buffalo City Local Municipality.

Buffalo City is a metropolitan municipality situated on the east coast of Eastern Cape Province, South Africa. It includes the towns of East London, Bhisho and King William's Town, as well as the large townships of Mdantsane and Zwelitsha.



The study target groups were teenagers at school and pregnant teenagers attending Ante natal Clinic (age 13-19yrs). We targeted teenagers from three High schools around Buffalo City Municipality; one in Mdantsane (Black township second biggest in South Africa) 2nd was at Kwelera (rural area just outside East London) and East London Central High School Former Model C School. The department of Education Eastern Cape didn't allow me to do the research in school so the students were met out of the school yard. I also went to two Community Health Centres in Mdantsane and East London was interviews and focus groups were done to pregnant teenagers.

3.3 Recruitment; Sampling and Participation

About 120 teenagers were recruited for the study and in-depth interviews were conducted. Teenagers from three High School were interviewed. The respondents of the study were consenting students from grade 8 -12 . A total number of 75 students from these high schools were selected of which 45 were females and 30 were boy. Three focus groups were conducted around each school and five pupils participated in each focus group, bringing the total number of participants to15. An additional two focus groups have been held at the Ante-Natal clinics. The age group of participants at Ante-natal clinics was between 14 and 19 years of age.

3.4. Data collection

The researcher sought permission arranged with three youth centres on the High school. After- school afternoons were identified as the most convenient and suitable time to conduct the focus group discussions and interviews because most of the learners go to the youth centres. Respondents who gave verbal consent for participation were assembled in one venue and a group informed consent was obtained before the FGD was conducted. In all FGDs a digital recorder was used to capture the proceedings, researcher facilitating the sessions, and the research assistant be taking notes.

An open ended, semi-structured interview guide was used as a guide for all focus group discussions. Additional data on the demographics of participants was collected from the

participants at the end of the FGD to ensure that during the FGD to ensure during the FGD participants were free to view their views on the topic without disclosing their identity.

Interviews were done by giving each participant a questionnaire. The questionnaire was self-administered and anonymous and was placed in a box after completion.

During the interviews there were answers to some questions that were answered in previous questions, and in that case such questions were ignored.

3.5. Validity and Reliability

Trustworthiness addresses validity and reliability in qualitative research. Strategies to ensure trustworthiness of qualitative studies include credibility, dependability and transferability (Creswell, 2009; Patton, 2002; Denzin and Lincoln 1994, Lincoln and Guba, 1985). In ensuring trustworthiness in this study, the researcher attended the youth centres before the study. I became part of the activities they doing and I introduced the research to the group and interest was shown. I also attended the ante-natal clinic and abortion clinics at Nontyantyambo health Centre where the research was done to conduct observations and interviews with key stakeholders and role players in the program. This assisted the researcher in understanding the clients and probing and engaging the participants. However, during the group discussion the researcher received maximum participation from participants as most of them were very outspoken on the subject although there were few quieter ones. However the discussions did not seem to censor those few because from time to time the researcher invited them to participate. This was not a problem as the participants could relate to the researcher because she came from the same background in terms of language, community, race, gender, dress. The researcher and the research assistant are both first language sharing background characteristics have been found to be important influencing respondents, and insuring maximum participation (Breakwell 1995).

All the focus group discussions were conducted and recorded using the tape recorder during the discussions by the same interviewer and research assistant to ensure consistency and control for interviewer effects. The questionnaires were translated from English to IsiXhosa to ensure that the participants who are not fluent and eloquent in English participate maximally during the discussions. During the FGDs English and IsiXhosa were the main languages used.

3.6. Bias

To eliminate selection bias, learners were randomly selected from three grades to ensure maximal participation during the discussions. During data collection, participants were recruited from the Youth Centres randomly. To eliminate researcher biasness during coding and data analysis the researcher engaged peers and the supervisor during coding, data analysis and reporting.

3.7. Data Analysis

The data analyses were descriptive and reported percentages and frequencies for categorical data and percentages for continuous data

The interpretation of data was enhanced by the fact that the researcher circulated the transcripts to clinic supervisors and the peers for comparison in interpretation, coding and the development of themes.

The researcher transcribed data by playing the recorded discussions over and over again. The discussions were mainly in IsiXhosa even though there were English used. She then, translated the discussions directly from IsiXhosa to English. The researcher read the transcripts over and over again, using the research guide to follow the questions. There was no attempt to quantify the narratives, but the comparability of themes across all focus groups was sought. The researcher drew key themes that emerged from the discussions and in the presentation of findings these were illustrated through the use of quotations from the participants. This was done to ensure that the findings are the result of experiences and participants and not the preferences of the researcher (Patton, 2002; Denzin and Lincoln; 1994).

3.8. Ethics

Ethical clearance was sought from the Research Ethics Committee of the Africa Centre for AIDS University of Stellenbosch. Department to continue with the We did get approval from the Buffalo City Municipality Health to continue with the research.

Informed written consent was obtained from the individual learners and a group informed written consent was obtained from the focus group participants.

Participation in the focus group discussions was entirely voluntary; there were no incentives to lure them to participate, and no coercion. The researcher explained to the participants that if for any reason the participants feel uncomfortable during the discussions, she could leave; and also with the questioners if one feels like not answering she/he must. However none of them left, they all stayed for the entire interview. All participants gave verbal& written consent before participating in the study.

Participants were encouraged to keep the discussions within the group. The researcher offered all participants pseudo names ensure the identity of participants is protected, despite them having cited no objection to using their names. Participants will be treated with respect and their views and opinions respected and maintained during the FGD

The focus group discussions were conducted in the Youth Centre grounds and Ante natal Clinics, and therefore there were no uncertainty for the participants' safety or other risks that could be posed by the study.

CHAPTER 4. RESULTS

4. 1.The results

Ninety teenagers answered the questionnaire. Of this 90 participants 60 were girls and 30 were boys. Three focus groups consisting of 20 school going teenagers were conducted. In these focus groups 10 participants were boys and 10 were girls. There was also another focus group of 10 ANC clients. Eighty-five percent of the females were aged between 13-17 and 80 % of the males were aged between 15-19. About 52% of them lived with both parents and about 28% lived with grandparents.

1. Understanding of contraceptives.

The table below shows much teenagers know about contraceptives ; a staggering 56% of boys and 3% of girls didn't know what are contraceptives; the only methods known as well by those was a pill and injectable. Mostly believed condom was the only choice.

Contraceptives	males	Females	
What are contraceptives	Don't know :56 %	Don't Know: 32%	
Have you ever heard of the following contraceptive Methods?	Condom-81% Pill- 36% Injectable- 7% Withdrawal 1.2% (no other method was known by the boys)	Condom 86.4 Pill-42% Injectables:56% Morning after pill:6.2% Withdrawal :2%	
Which method are you using?	Condom 72% Withdrawal 1.2%	Condom 88% Pill: 4% Injectable: 9.6%	

4.2 Attitudes and perceptions towards contraceptions

A large percentage of participants believed there are dangers associated with contraceptives. It also came strongly also in the focus group where others were quoting their mothers saying to them “ never use those things you will never have children” there are a lot of myths as well around their understanding of condoms

	Males	Females	
Do you like using contraceptives	14% Yes	31% Yes	
Do you know any dangers in using contraceptives what	Yes: 38% Don't Know:41% Dangers :loss of	Yes:52% Infertility:38% Don't Know:28%	

are they?	erection/libido 18% Causing drop: 12%	Man loose interest don't enjoy you 32% Wet: 16%	
Do you think it is correct and acceptable to use contraceptives	Yes:28%	Yes:24%	
At what age do you think people should start using contraceptives	At 18:20% At 25:32% At 35: 48%	At 14: 26% At 25: 14% At and after 30:40%	
Who should give you information about contraceptives	Parents : 48% Teachers:40%	Parents: 58% Teachers: 38%	
Where contraceptives should be administered?	At school: 42% Youth Centres:54% Clinic/Health facility:4%	At school: 67% Youth Centres:24% Clinic :6%	

4.3. Sexual maturity and sexual behavior

Interestingly, boys became sexual active late than girls and also few boys were parents and many girls were parents meaning fathers are not this age group.

	Males	females
Are you sexual active	44% Yes	79 % Yes
What age did you start engaging in sex	At 15: 4% At 17: 28% At 18: 38% Still a virgin: 20%	At 12/13: 11% At 15/16: 49% At 18 : 21% Still a virgin : 7.5%
Have you ever been pregnant /are you a parent	Parents Yes: 4.6% Father to be :Nil	Parents Yes: 39% Pregnant before/now : yes :44%

4.4 Knowledge of Contraception & Sexuality

About 72% of boys and over 80% of females knew that condom prevent pregnancy and it must be used once. There was very minimal knowledge about other types of contraceptives; some where even shocked that they exist

“Contra what? Is that the same as family planning? That one moss it’s for married guys”
(asked a 16 year old boy from a model C school in East London)

Their understanding of the menstrual cycle was very inaccurate and they couldn't master their safe period. In the focus group they made fun of each other about the possibility of withdrawal and how impossible that can be:

“ndiyikhube xa ndizochitha ? yhu Mums yi CLIMAX nje leyo ngeke”(18 year old boy from Mdantsane: take it out when am about to ejaculate that I will never do that’s the best part mam)

Of those women who use contraceptives only about 18% knew that even if they miss their pill once they could fall pregnant.

Most participants agreed that parents are suppose to tell them about contraception and second were teachers. There were a lot of myths about contraceptives and surprisingly most of those were had from parents

“Yhu wati umama ndingaze ndisebenzise ezonto inaliti iyondivala and iyabandisa emadodeni” (said an 18 yr. old pregnant with the second baby and the members in the group synonymously said “ewe”) (my mom said I must never use that will be infertile and man wont enjoy me)

4.5 Sexual Maturation and Sexual Behavior

The mean age of boys were 15 and the mean age of girls was 12. There were about 49% boys who were sexual active and a staggering 72% girls were sexually active. Boys were very much aware of sexual activities and over 20% were virgins and they enjoy masturbating. Masturbating amongst boys was acceptable and they even joked about them

“Yho ngaske ndiskomore daily I don’t care these girls zimdaka two twos ungutata yho hayi mna soze ndipelelele apa yilo nonsosno” (17 year old Mdantsane boy saying: I will rather masturbate daily because these girls are dirty; you sleep with her then in the morning you are a dad; no can’t let that happen I need to follow my dreams; can’t stay here forever”)

Over 32% girls did indicate that their boyfriends were not in high school but were busy with tertiary education or working.

“I can’t have a relationship with these stupid’s man you” (16 year old rural girl said in the focus group)

4.6. Attitudes toward teenage pregnancy

Most participants believed teenage pregnancy was wrong in spite of the 49% who have been pregnant before. Of the pregnant girls, 92% still believed teenage pregnancy is wrong and 88% boys believed that too.

Another result which has been found by other researchers is that only 4.6% boys were fathers while a staggering 44% girls were mothers. About 36% of girls knew about abortion and some felt strongly that rather than having a baby they will go for abortion. Yhu andifuni mntana mna ndoya noba kupi ndosikhupa bazele o Dr Eric aphe Oxford” group laughed (I don’t want a child will go anywhere for abortion the Oxford is full of Dr Eric) this came out as joke from a 15 year model C girl but the popularity that statement had from the group indicated to me the threat illegal abortion are to these kids and they seem not to have a clue about its dangers whoever is doing it..

CHAPTER 5 DISCUSSION, CONCLUSION AND RECOMMENDATIONS.

5.1 Discussions

The overwhelming majority of these kids (80 percent) either perceive contraception as a risk to their health and fertility, regard it as unacceptable, or do not know which method to choose. The participants believed in condom use and more than 70 % believed condoms alone will do the trick. There were very minimal knowledge about dual protection. Only about 21% claimed they won't sleep with their girls if they are not using condoms. Those who were knowledgeable about contraceptives chose not to use them or keep the use of any contraceptives a secret. Other reasons for not utilizing the contraceptives were that teenagers were reluctant to take contraceptive precautions for fear of complications and parental detection, despite their knowledge about the importance of the use of those contraceptives (Ritcher & Mlambo 2005). The findings by Ritcher and Mlambo (2005) outlined that teenage pregnancies resulted from lack of knowledge about contraception and many other misconceptions

The analysis of findings revealed four main factors that influenced Teenage' pregnancies: lack of contraceptive knowledge, ambiguous feelings about pregnancy and contraception, conflicting messages concerning the reproductive role of young women, and the girls' low self-esteem in their interaction with older, experienced male partners. The study revealed that existing family planning programs fail to address the needs of the sexually active school-age population. It also revealed that teenagers believe the school 54% as the best convenient place for them to receive contraceptives than clinics; youth centres also received 40%.

Over 50% accused the clinics of being not youth friendly; accused staff of being judgmental and cruel and complain about long lines and claim clinic hours are flexible to their times and needs

Inspired by about 49% of the kids who have been pregnant/pregnant and the minimal usage of contraceptives, most of the kids believed teenage pregnancy is wrong. (More than 90% of boys believed that and over 80% girls believed it as well)

5.2 Conclusion

From this study it became clear to me that information on contraceptives to the youth at Buffalo city Municipality was very minimal and that the majority of kids know nothing and they hear nothing about them.

Most kids believed the condom alone is efficient for the prevention of teenage pregnancy very few know anything about dual protection. Very limited knowledge of different methods especially IUCD. Only about three percent knew of IUCD. What makes it even more frightening is that IUCD is the most effective in young people and for HIV positive community as it won't cause complications

Most kids won't use clinics for family planning they would rather have them at school or the youth centres. And they believe that parents are the main people in giving them the information before teachers. Most kids believed teenage pregnancy was wrong meaning they don't approve of teen parenting.

Sixty-six per cent of the respondents started engaging in sexual activities between the age of 13 years and 15 years; 44% engaged for the first time in sexual intercourse between the age of between 16 years 19 years whilst 4% started at the age of 12 to 13 years. This is supported by Cooper et al. (2004) who found that amongst teenage girls interviewed in South Africa, 35% were teenagers aged 19 years of which 53% of the pregnancies had either been unplanned (36%) or unwanted (17%). In addition, Morake (2011) revealed that the age of the first pregnancies, as a result of the first sexual intercourse, was experienced by teenagers between the age of 13 years and 16 years.

5.3 Recommendations

From this study it became clear that teenagers know very little about contraceptive. It is recommended that:

1. A multi-sectorial media campaign on contraceptives at Buffalo City Municipality be undertaken and the youth be targeted.
2. Public clinics all be made 'youth-friendly' through existing support programmes. These programmes have been proven to improve the quality of care and expand access to contraceptives, support and counselling. There should be increased access to dual method contraception at clinics and contraception should be available to all girls and young women who need them.
3. Increase awareness and knowledge about and availability of emergency contraception (morning after pill) be created since this, effective and reliable method of post-coital contraception, is paramount to tackle the unplanned pregnancy rates and to promote IUCD as method of choice to teenagers
4. The establishment of adult-teenage communication programmes with guidelines to give adults information and skills to communicate effectively with young people about reducing risky behaviour be promoted. Promote mentorship as most kids don't have parents and lack role models
5. Partnering with schools be introduced in order to improve and coordinate sexuality and family life education in schools

6. Male involvement programmes for prevention efforts that specifically target boys and young men be promoted. Effective programmes for boys at Buffalo City Municipality include pre-initiation classes and other out-of-school activities with a cultural component. Boys and young men have information needs and anxieties about sex and relationships.

7. Multispectral agreement be entered into to ensure that pregnancy prevention programme with guidelines /contraceptives should be available and utilized appropriately in all areas where teenagers are found

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