

**Teenage pregnancy among high school students in South Africa's former
African schools that could lead to or increase HIV infection**

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degree of Master of Philosophy (HIV/ AIDS Management) in the
Faculty of Economics and Management Science at Stellenbosch
University



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DECLARATION

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Melania Moyo

Date: December 2014

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Abstract

The present young generation is the largest population in history and young girls are the most threatened and vulnerable with regards teenage pregnancy and HIV infection. The survey study was conducted among teenage girls at Masibambane high school in the Western province of South Africa. Forty young girls volunteered to participate in the study by responding to structured questionnaires concerning their perceptions about teenage pregnancy, their personal sexual experiences, attitudes with regards the use of condoms and knowledge on HIV/AIDS and sexuality. Both qualitative and quantitative methods were used to collect data from the girls. The study found a variety of factors place young girls at the centre of teen pregnancy and HIV vulnerability. Only 30% of the participants interviewed were living with both parents while the remaining 70% were with relatives, step parents, siblings, one parent and or friends. The study also established 85% of the participants lived in shacks and government RDP houses, with the remaining 15% living in houses and flats respectively. Furthermore, 70% had sexual intercourse by the time of the study and those (50%) practiced safe sex. Prior to the study 14.28% had been pregnant and 10.71% had an abortion. The study found 38.45% were involved with sexual partners between the ages of 21 to 34. The study concluded there are many socio-economic factors that lead to teenage pregnancy. These include broken homes, poverty, low condom use, early sexual maturity, exploitation by older men, lack of knowledge and information on sexuality and HIV/AIDS, peer and social pressures and ignorance.

Opsomming

Die huidige jong generasie is die grootste bevolking in geskiedenis en jong meisies is die mees bedreigde en kwesbaarste met betrekking tot tiener-swangerskap en MIV-infeksie. Die studie is gedoen onder tienermeisies by Masibambane Hoërskool in die Westelike Provinsie van Suid-Afrika. Veertig tienermeisies het vrywilliglik deelgeneem in die studie deur te reageer op gestruktureerde vraelyste met betrekking tot hulle persepsie aangaande tiener swangerskap, hulle persoonlike sekseule ondervinding, houdings met betrekking tot die gebruik van kondome en kennis van MIV/VIGS en seksualiteit. Beide kwalitatiewe en kwantitatiewe metodes is gebruik om die data te versamel. Die studie het bepaal dat 'n verskeidenheid faktore plaas jong meisies in die middel van tiener-swangerskap en MIV-kwesbaarheid. Slegs 30% van die deelnemers met wie onderhoude gevoer was het by beide ouers gewoon, die oorblywende 70% het by familieledes, stiefouers, broers of susters, een ouer en of vriende gewoon. Die studie het ook bepaal dat 85% van die deelnemers in plakkershuise en staats landelike ontwikkelingsplan huise gewoon het, met die oorblywende 15% wie in huise en woonstelle gewoon het. Verder het 70% reeds seks gehad teen tyd van die studie en 50% van hulle beoefen veilige seks. 14.28% was voor die studie swanger gewees en 10.71% het 'n aborsie gehad. Die studie het ook bepaal dat 38.45% betrokke was met seksmaats tussen die ouderdom van 21 tot 34. Die studie bevind dat daar baie sosio-ekonomiese faktore is wat lei tot tiener-swangerskappe. Hierdie sluit in betbokke huisgesinne, armoede, minder gebruik van kondome, vroeë seksuele volwassenheid en uitbuiting deur ouer mans, gebrek aan kennis en inligting oor seksualiteit en MIV/VIGS, groep en sosiale druk en onkunde.

Acronyms

AIDS.....	Acquired Immune Deficiency Syndrome
ARVs.....	Antiretroviral
BCC.....	Behavior Change Communication
HIV.....	Human Immunodeficiency Virus
NGO.....	Non-Governmental Organization
STI.....	Sexual Transmitted Infection
UN.....	United Nations
UNAIDS.....	Joint United Nations Programme on HIV/AIDS
UNICEF.....	United Nations Children’s Fund
WHO.....	World Health Organization

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CHAPTER 1

INTRODUCTION

1.1 Introduction

There is evidence in the literature South Africa has one of the highest rates of young girls becoming pregnant as compared to other regions both in Africa and internationally. Most of the young girls who fall pregnant do not only leave school but some have to face and live with the challenges to find employment. Due to their being unemployed they have to face poverty and the majority end up in the sex industry thereby making themselves vulnerable to HIV/AIDS at a young age.

The South African Government and various stakeholders have worked tirelessly in trying to educate people through awareness prevention programs emphasizing the use of condoms and abstinence, but the number of teenagers becoming pregnant and infected with HIV still remains high. The reason is most young girls tend to have unprotected sex at a tender age thus Kirby (2001) indicates programs aimed to support these girls reach the children only after they have been involved sexually.

Although the issue of teenage pregnancy is a worldwide issue its magnitude in sub-Saharan and especially in South Africa causes a great concern. According to the figures the provincial education department of Gauteng released, the number of school children getting pregnant is high and is actually doubling from year to year thereby limiting better possibilities of the girls' future. The rate of teenage pregnancy in South Africa has been rated by Holborn and Gail (2011) as high by international comparison. The risk factors due to teenage and unplanned pregnancy include education disruption, uncertain future and poverty due to future unemployment, poor mentality, STIs and HIV infection.

1.2 Research problem

In South Africa the rate of teenage pregnancy is high among high school students in former African schools hence making them vulnerable to HIV infection. The problem is the factors are not known what influence teenage pregnancy. What factors are responsible for the high rate in

teenage pregnancy among high school students in South Africa's former African schools that could lead or increase their vulnerability to HIV infection?

1.3 Rational of the study

The aim is to investigate the factors that are responsible for the high rate in teenage pregnancy in a selected sample. Through assessing the perceptions of teenagers and identifying their needs could assist they gain the necessary information and knowledge on safe sex practices. Lack of knowledge on sexuality and ignorance is a cause for unsafe sexual behavior practices. When the teenagers have the knowledge, their decision making and problem skills will be enhanced assisting them to have foresight and are in a position to assess and evaluate their own present actions and of others thereby becoming aware of the consequences in the future.

Investigating the problem could create public pressure for various stakeholders to review the existing laws and recommend amends. At the same time appropriate services could be made easily available to cater for those who are at higher risk of getting pregnant.

The social workers have to deal with many social issues surrounding people and especially children. This research could bring answers to those in the social work profession where they could have insight and be in a position to effectively assist the teenagers and assist them to deal with everyday social issues they have to confront.

1.4 Aim of the study

The aim of the study is to establish factors that are responsible for the high rate in teenage pregnancy among high school students in South Africa's former African schools in order to find strategies and interventions to prevent the incidence of HIV infection while at the same time trying to mitigate the impact of teenage pregnancy.

1.5 Objectives of the study

- To assess the perceptions of teenagers that leads them to engage in high risk unsafe sexual behavior and practices.
- To identify the needs of teenagers in order to encourage safe sex practices.

- To establish teenagers perception of the physical, psychological, social and economic implications of teenage pregnancy.
- To establish the teenagers' knowledge on pregnancy and HIV/AIDS.
- To suggest strategies, interventions and recommendations to various stakeholders and policy makers based on the study findings on streamlining teenage pregnancy among school children.

1.6 Research methodology

A mixed research design was implemented in this research, using both qualitative and quantitative research designs. Both quantitative and qualitative research using questionnaires as a survey method were used to collect data from the participants through closed (quantitative design) and open-ended (qualitative design) questions.

A quantitative research approach was chosen for this study because it emphasizes objectivity and uses systematic procedures to measure human behavior by using formal structured instruments when collecting data from respondents (Brink 2006). This approach has been used to provide hard objective facts about factors that contribute to teenage pregnancy that could be statistically analyzed and interpreted.

The qualitative 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 the participants' perceptions with issues regarding teenage pregnancy; this enabled the triangulation of the data. According to O'Donoghue and Punch (2003) triangulation [T1] is the use of different methods to conduct a research which allows cross checking or validation of results thus increasing the quality of the results.

1.7 Structure of the study

1. Chapter 1: Introduction on background information of the topic, research problem, rationale of the study, aim of the study, and study objectives, a review of the methodology chosen to solve the stated problem.

2. Chapter 2: Literature review with regards teenage pregnancy, relevance of the study and the knowledge gap.

3. Chapter 3: Description of research design and methodology in which the study adopted both quantitative and qualitative paradigm, data collection tools, sampling techniques, reliability and validity, ethical considerations, informed consent, data confidentiality, voluntary participation, behavior and objectivity of participants, maintenance of data, sampling procedure, data collection, statistical analysis, operational definitions, assumptions and limitations of the study.

4. Chapter 4: Data analysis based on the quantitative and qualitative data from the study sample.

5. Chapter 5: Discussion of research findings and conclusions.

1.8 Summary

This chapter outlined the background history of the research, the research problem and rationale of the study. The aim of the study, research question and objectives of the study were also outlined.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Msimanga (2007) in her report in the Gauteng Education Department press stressed many young girls become pregnant at a very tender age, making the teenage pregnancy rate in the country to reach an alarming level. Health Statistics (2007) observed the number of young girls who fall pregnant before they reach the age of 18 add up to an estimated 1 million every year thereby creating a challenge for the country as it is currently involved to deal with the issues of HIV/AIDS.

2.2 Teenage pregnancies

Panday, Makiwane, Ranchod and Letsoalo (2009) argue the issue of teenage pregnancy in South Africa has been a norm which although it is not expected has been accepted by society. There seem to be support within the Government when a girl falls pregnant they see the social grant as additional financial support. The present law states when a girl falls pregnant they are entitled to receive social grants and are not expelled from school has consequently given many an outcome to support unacceptable behavior. The rate of teenage pregnancy is low in other neighboring countries due to the strict laws that once a young girl becomes pregnant they cannot continue with their formal education. Until a few years ago in Zimbabwe a young female student could even be expelled for getting pregnant at college or university.

An individual can become pregnant by engaging in unprotected sexual activity. HIV prevalence among the youth in South Africa clearly shows there is minimal use of condoms by males. Kanku (2010) believes teenage pregnancy and HIV/AIDS are vital issues that need special attention as the two are co-related. The co-relation between the two reflects many young girls become pregnant because they do not take prevention measures and their partners are not using condoms; making themselves vulnerable to HIV infection.

In most cases teenage pregnancy is usually outside marriage and Thompson (2006) indicates it is a catastrophe for the young girl and the whole society at large because of the stigma and complexities that come with it especially in the African culture. Thus Kail and Cavanaugh (2004) emphasize young girls should be educated before they are caught in the trap of becoming pregnant and in turn become HIV positive. Adolescents are curious, experiments and experience peer pressure without realizing what the consequences would be due to their behavior. As children advance into adolescence according to Mac Phail and Campbell (2001) they want to discover, explore and bring out their feelings with regards behavior and the way they relate to those around them. They are curious and want to experience life before they are mature enough to realize the consequences and discriminate between right and wrong.

According to the Department of Education (2010) an increase of 153% in teenage pregnancy was recorded since 2003 with at least 53 children getting pregnant while in grade 3. In most cases the young girls fail to cope and choose abortions and adoptions.

According to the Health Statistics (2007) there were 9 895 abortions in 2006 as compared to 4432 in 2001; an increase of over 100%. Thus it is deemed necessary to look at the reasons for this increase in sexual activity that exposes young girls to be vulnerable and become infected with HIV before they are able to process motherhood before they become of age (table 2.1).

Table 2.1
Learner Pregnancy Rate: 2004 -2008

Province	Pregnant Learners pregnant per 1000.	Learners Captured.
Limpopo	63.66	12 749
Gauteng	37.28	4 978
KZN	67.61	16 168
North West	69.34	3 432
Free State	54.28	2 791
Mpumalanga	61.74	6 710

Northern Cape	63.12	1 736
Western Cape	39.67	2 765
Eastern Cape	78.19	12 348
Total	53.50	63 677

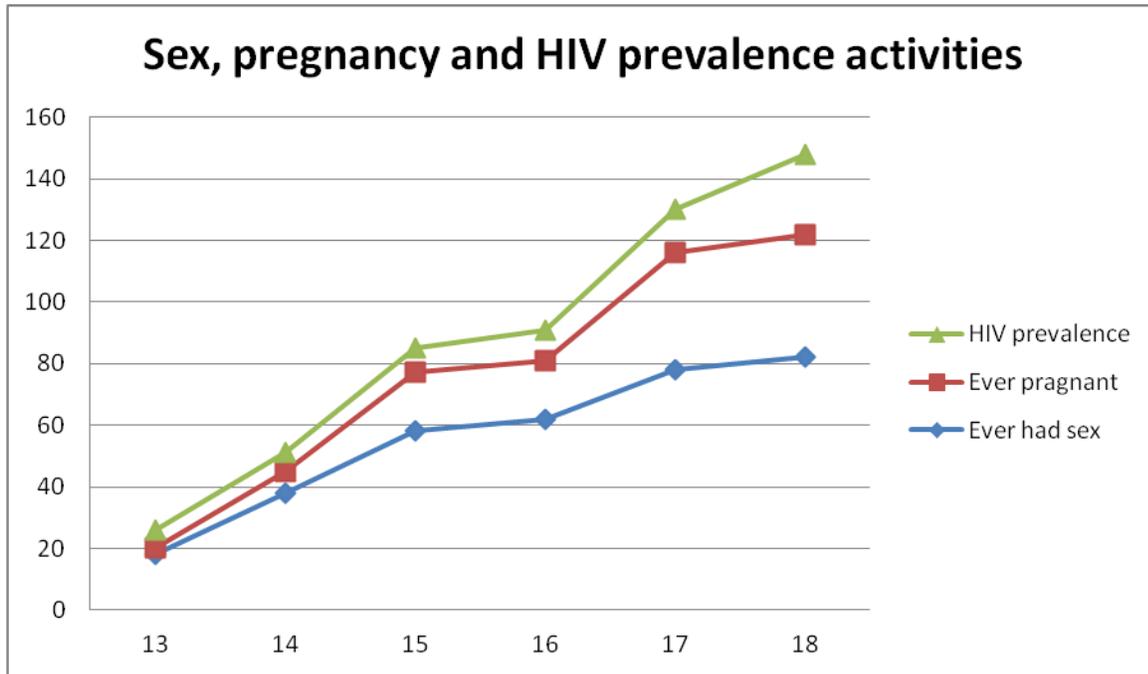
Source: Health Statistics (2009)

The figures in table 2.1 indicate there is lack of safety precautions when children engage in sexual behavior thereby making them pregnant and contracting STIs and HIV.

Although parents are the trusted ones as information providers Pandey et al., (2009) believe most children especially in the African culture tend to miss the opportunity as it is taboo for a parent to openly discuss the issues about sexuality. At the same time some parents do not have the right information due to lack of knowledge about sexuality.

Tiendrebeogo, Meijer and Engleberg (2003) share the same sentiment when they endorse that ignorance with regards to sexuality and fertility remains pervasive even where knowledge of HIV/AIDS is present. Nevertheless, when an individual is immature and lacks knowledge, communication and negotiation skills with a partner becomes ineffective and in some cases absent. Hepburn (2001) thus believes the socio-cultural conditions, social and economic factors, biological and increased inequality keep on deteriorating and as a result young girls become the victims of teenage pregnancy and vulnerable to HIV as soon as they become sexually active. This sense of disempowerment is due to the knowledge gap between children and parents (figure 2.1).

Figure 2.1
Sex, pregnancy and HIV prevalence activities



Source: National HIV and Sexuality Behavior Survey (2003)

Macleod (1999) explains teenagers as they go through the stage of development are often faced with ambiguity because they want to explore and experiment with all forms of life. It is during this phase due to many factors such as peer pressure, behavior might become uncontrollable and they end up risking their lives. UNAIDS (2007) indicates vulnerability results from a range of factors outside the control of the individual that reduces their ability and the communities to avoid pregnancy and HIV risk.

2.3 Sexual partners

Multiple and concurrent sexual partners is common among teenage girls in most sub-Saharan Africa and especially in South Africa. Dube and Sachingongu (2008) in the Communications Programmes report in Zambia explained concurrent sexual partnerships as sexual relationships

happening at the same time and concurrently, where two or more sexual partners continue over the same period of time or where one sexual partnership starts before the other comes to an end.

Multiple sexual partners have been associated with high number of teenage pregnancy (Harperin and Eppstain 2004). Numerous studies have proved multiple and concurrent sexual relationships among the teenage girls, in most cases are as a result of economic needs especially where one faces economic deprivation; thereby giving room for vulnerability. The practice of having more than one sexual partner concurrently and coupled with inconsistency or incorrect condom use thus has been indicated as a high risk factor for teenage pregnancy. Girls in these relationships are disadvantaged to negotiate for safer sex.

Condoms are available and are in two forms for a male and females serving as dual protection for pregnancy and HIV and other sexually transmitted infections. Male condoms if used correctly and consistently are known to be effective to prevent pregnancy and HIV by 70%-90% (Tiendrebeogo et al., 2003). Studies conducted in South Africa demonstrated girls who come from economic deprived backgrounds had a greater risk and more vulnerable to both pregnancy and HIV. It was difficult for them to suggest the use of a condom (Jewkes et al 2010) A perception about condoms reducing sexual pleasure are reasons provided by girls risking having unprotected sexual intercourse. In an African setting due to inequalities between the sexes most girls are socialized and grow up with the idea that a man is in control and needs to be sexually happy and satisfied, therefore many would rather risk and have sex without protection therefore the girls' power to negotiate safer sex is hindered.

In spite of having knowledge about sexuality and reproductive health, Sarker (2008) in her study about low condom use, established for fear of being labeled as being unfaithful by their partner, both partners end up not discussing condom use before having sexual intercourse. The study also revealed many girls did take risk by having unprotected sex as a way of showing closeness and affection to their partners.

The South African Human Rights Watch (2004) reported for fear of violence especially when an individual is involved with an older sexual partner, many girls did not report sexual coercion or rape by their intimate partner. They are socialized to believe they do not have the right to control

sexual interaction and therefore the partner has the right to make demands and decide whether to/not use a condom. Traditionally and culturally it is an accepted norm in many sub-Saharan regions for girls and women to remain silent especially with issues regarding sex. These factors acting alone or combined exacerbate and create individual and collective vulnerability among the girl child.

2.4 Summary

In this chapter, literature from other studies on teenage pregnancy rate, HIV prevalence and factors that play a role in teenage pregnancy was reviewed.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

In a quantitative research design, a self-report paper and pencil questionnaire is used and the participants were asked to complete the questionnaire individually (Babbie 1998, De Vos 2000, Salkind 1997). Both quantitative and qualitative research using questionnaires as a survey method were used to collect data from the participants.

3.2 The problem statement

The problem statement of the study is thus: What factors are responsible for the high rate in teenage pregnancy among high school students in South Africa's former African schools that could lead or increase their vulnerability to HIV infection?

3.3 Objectives of the study

- To assess the perceptions of teenagers that leads them to engage in high risk unsafe sexual behavior and practices.
- To identify the needs of teenagers in order to encourage safe sex practices.
- To establish teenagers perception of the physical, psychological, social and economic implications of teenage pregnancy.
- To establish the teenagers' knowledge on pregnancy and HIV/AIDS.
- To suggest strategies, interventions and recommendations to various stakeholders and policy makers based on the study findings on streamlining teenage pregnancy among school children.

3.4 Research methodology

Research can be conducted using either qualitative or quantitative approaches. Qualitative research attempts to study human action from the insiders' perspective. Quantitative research is an approach where raw data are collected and turned into usable information by mathematical

manipulation that leads to forward-looking predictions. Statistical comparisons and percentages are common numerical metrics used in quantitative research (Babbie and Mouton, 2008).

Advantages/disadvantages of qualitative research are:

- Not everything can easily be quantified and an advantage is identifying human experiences.
- Individuals can be studied in more depth
- Usually fewer people studied
- A disadvantage is to make systematic comparisons may be difficult if people give widely differing responses that are highly subjective.
- It is dependent on skills of the researcher particularly in the case of conducting interviews, focus groups and observation.

Advantages/disadvantages of quantitative research are:

- ✓ When the data is collected it can conveniently be placed in tables or charts
- ✓ The data can be subjected to testing for significance
- ✓ A disadvantage of quantitative research when based on figures may be out of date.

3.4.1 Data collected

Prior to data collection, approval was granted by the WCED and the school at which the study was conducted. After the University of Stellenbosch's Research Ethics Committee granted approval, data was collected over a period of 3 months. Data on social demographic characteristics of the participants, perceptions and knowledge on teenage pregnancy, individual experiences and knowledge on sexuality, knowledge on HIV/AIDS and perceptions on education and the future was collected.

3.4.2 Sampling technique

One of the best ways to achieve unbiased results in a study is through random sampling. Random sampling includes choosing subjects from a population through unpredictable means. In its simplest form, subjects all have an equal chance of being selected out of the population being researched (Babbie and Mouton, 2008).

The study focused on a target group, the teenage girls who were currently in high school. Kazdin (1992) defines a target population as the aggregate of the individual units of analyzing from which a survey shall be conducted. A sample of 40 grade 10 students was drawn from the high school. The participants were informed of voluntary participation prior to the research. However, the number of participants who wanted to participate in the study became 65 instead of the intended 40; a random sample was drawn excluding some volunteers. Using random sampling ensured there was no bias because there was no manipulation of random numbers used to select the participants.

3.5 Ethical considerations

Leedy and Ormrod (2001) advise since the research projects deal with humans, research procedures must be carefully considered. Thus the rights, dignity welfare, respect and courtesy of the participants are some of the ethical issues that the researcher had to consider.

❖ Informed consent

This comprises the purpose of the study, expected duration and the principles that need to be followed (Struwig and Stead 2001). The researcher in this study detailed all the necessary information and steps that were going to be taken during the study and the participants were familiarized with the necessary. Consent and assent forms were distributed to and signed by both the parents/guardians and the participants. These guaranteed the participants their personal information and all other data provide would not be used against them but only for the purpose of the research.

❖ **Data confidentiality**

The participants were rest assured of confidentiality owing to all the data they were going to provide. Confidentiality is necessary at all times because as it helps protect people from being stigmatized and discriminated against.

❖ **Voluntary participation**

Putting pressure on someone to be part of the study is seen by Pelham and Blanton (2007) as coercion. It was in the interest of both the researcher and the participants the research is carried out of willingness. The respondents at any time had the right to withdraw from participating in a study.

❖ **Behavior and objectivity of participants**

Due to the nature of the research which involved sensitive issues and being time consuming, the researcher was accommodative for individual differences. However, no participants reacted badly nor did any one of them show signs of stress or discomfort, negative feelings which might be as a result of painful memories. This meant that no further referrals to the school social worker were conducted.

❖ **Maintenance of data**

It is the researcher's duty to keep the generated responses safe all the time and ensure anonymity. In other words confidentiality of information collected must be maintained well to avoid violation of the principle of trust. Thus a password protected computer is used to protect data from unauthorized access.

3.6 Data collection

A questionnaire was utilized in the study with the aim to collect data and produce information to respond to the defined objectives. A questionnaire is defined by Christensen et al. (2011) as an instrument that is used to collect data. The questionnaire will be distributed to the selected sample and requested to respond to the various questions. Both closed and open ended questions will be used to gather data. The participants had to provide their opinions and perceptions about the issue of teenage pregnancy and HIV/AIDS through the questionnaire.

3.6.1.1 Advantages of a questionnaire

Using questionnaires is less expensive as compared to other data collection methods. If the participants are in one place then less time is used and the questionnaires can easily be distributed without having to travel long distances. The researcher is likely to get the desired information especially where closed-ended questions are used. Utilizing a questionnaire according to White (2000) it allows the researcher to compare data owing to the uniformity of questions. At the same time when the participants write their views by using their own words as in open-ended questions, more detailed and varied information is gathered.

By using open-ended options, the respondents are given the opportunity to suggest a range of possibilities which are unknown to the researcher thereby avoiding bias of a list of response possibilities. Open-ended options also promote a positive feeling for the respondent and this can actually help them in expressing their perceptions thereby generating ideas for the future responses in closed-ended options.

3.6.1.2 Disadvantages of a questionnaire

Participants can ignore certain items if they are not motivated by the type of questions or find it too personal. Open-ended questions are time consuming and might need verbal ability to express their perspectives and the way they think. When questions are closed and kept short, participants can become less enthusiastic as they feel they are bound in a certain situation where there is less choices to respond. This according to Patton (1990) might make the research participants to lack self-awareness as they cannot recall vital information. Even when the questionnaires are dealt with independently, some respondents might be influenced as they are not keen to ask for clarification regarding terminology; the validity of responses might be questioned. At the same time, open-ended options are time consuming for large samples.

3.7 Statistical procedures

The researcher administered a total number of 40 questionnaires to the participants. Frequency tables and descriptive statistics were used in the study to determine variables.

By using quantitative descriptive method, theories were able to be analyzed and made sense owing the data from which they were analyzed. At the same time qualitative data allowed the participants to have room in exploring their ideas without being limited. The information collected from the respondents was interpreted through pie charts, tables and graphs.

3.8 Operational definitions

The following definitions were used for the study purpose:

Concept	Operational definition
Decision-making skills	Thinking skills that enable students to arrive at appropriate solutions to problem situations, to judge assertions and be able to separate facts.
Problem-solving skills	Skills that allow students to analyze the facts of a situation so that they can use that to analyze to come to a conclusion about the situation.
Negotiation skills	A method by which compromise or agreement is reached while avoiding argument.
Communication skills	The ability to convey information to another person effectively and efficiently.
Sexuality	Feelings and attractions one feels towards someone.
Teenage pregnancy	Pregnancy by a female between the ages of 13-19 which is understood to occur in a girl who has not completed her core education.

3.9 Assumptions

The following assumptions were made for the purpose of this study.

- All respondents were going to provide accurate information and would cooperate in good faith.
- All respondents would be able to understand the questions to enable them to give meaningful responses.

- All respondents would be able to talk freely on their perceptions and views about teenage pregnancy, sexuality personal experiences and HIV/AIDS.
- The sample used in the study would be a true reflection of the entire teenage girls in South Africa.

3.10 Limitations of the study

The study had some noteworthy limitation:

Response Bias - Some participants might not have provided accurate data especially regarding their own personal sexual experiences. At the same time others might not have given meaningful responses because they did not understand the questions and because the questionnaires were conducted and answered at the same time and under the same roof, they might have lacked courage and confidence to ask where clarification was needed.

3.11 Summary

The problem statement, objectives of the study, research methodology, data collected, sampling technique, ethical considerations, data collection tools, statistical procedure, operational definitions, assumptions and limitations were outlined in this chapter.

CHAPTER 4

RESEARCH RESULTS

4.1 Introduction

An outline of the research findings is presented in this chapter. The outline includes the participants' demographic, social and economic characteristics, personal experience on sexual relationships and behaviors, knowledge on sexuality and reproductive health, knowledge on HIV/AIDS and perceptions about education and the future.

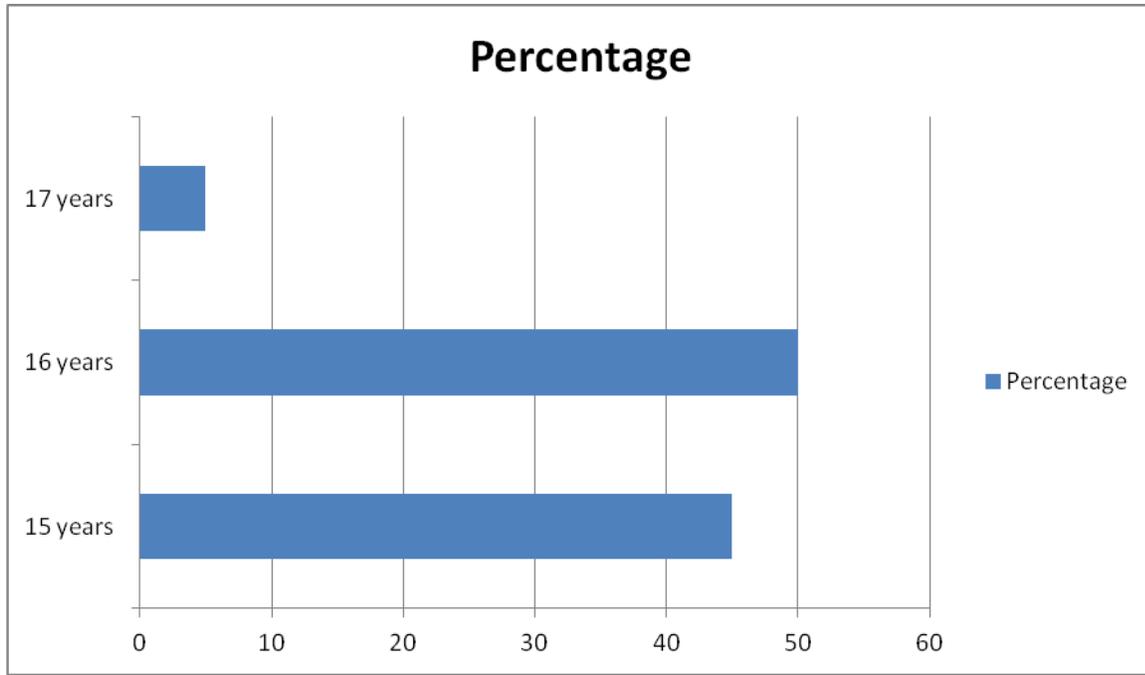
4.2 Sample size and distribution

Forty questionnaires were administered to the female participants. Of the 40 participants, 18 (45%) were 15 years, 20 (50%) were 16 years and 2 (5%) were 17 years old. Therefore the minimum age of the participants who were interviewed was 15 years and 17 years was the maximum age interviewed (table 4.1 and figure 4.1).

Table 4.1
Sample size by age

Age	Frequency	Percent
15	18	45.0
16	20	50.0
17	2	5.0
Total	40	100.0

Figure 4.1
Age distribution as of last birthday



4.3 Race of participants

The number of participants according to race were 38 (95%) were Blacks and 2 (5%) were Colored (table 4.2)

Table 4.2
Race distribution

Race	Frequency	Percent
Black	38	95.0
Colored	2	5.0
Total	40	100.0

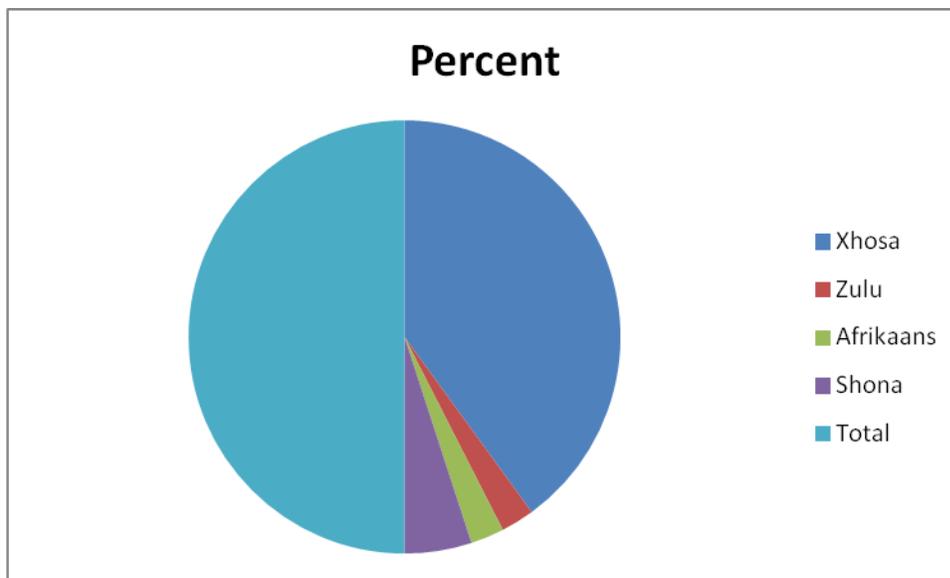
4.4 Primary spoken language of participants

The total number (40) of participants interviewed were divided according to language between 32 (80%) being Xhosa, 4 (10%) Shona from Zimbabwe, 2 (5%) Afrikaans speaking and 2 (5%) Zulus (table 4.3 and figure 4.2).

Table 4.3
Primary spoken language of distribution

Spoken Language	Frequency	Percent
Xhosa	32	80.0
Zulu	2	5.0
Afrikaans	2	5.0
Shona	4	10.0
Total	40	100.0

Figure 4.2
Distribution of primary spoken language of participants



4.5 Whom participants live with

Participants who lived with both parents are 12 (30%) while 9 (22.5%) are with their mother and step father, 5 (12.5%) lived with a father and step mother, 4 (10%) participants and their mother live together, 6 (15%) lived with relatives, 1 (2.5%) lived with siblings, 1 (2.5%) lived with the father while 1 (2, 5%) lived with a friend (figure 4.3, table 4.4).

Figure 4.3

Whom participants live with.

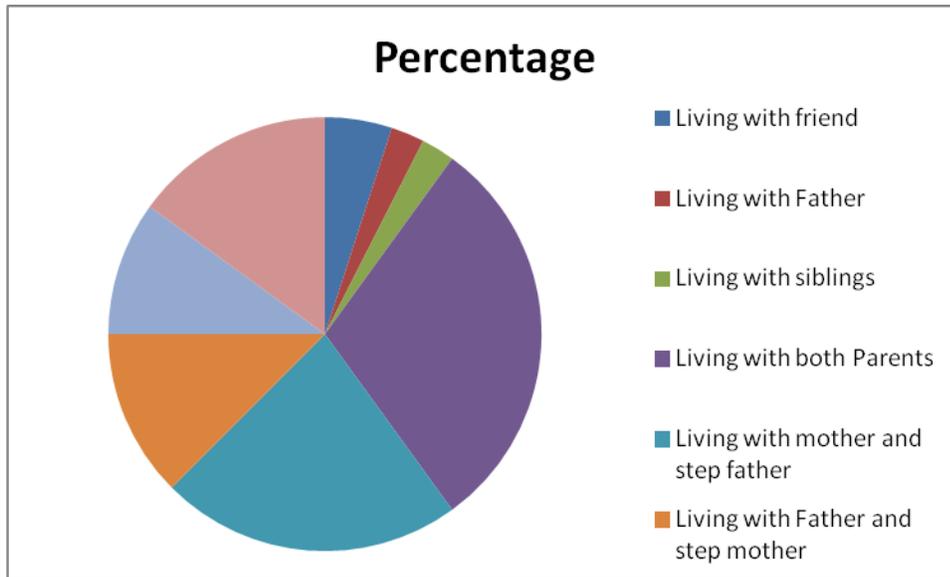


Table 4.4

Whom participants live with.

Parent/guardian whom participant live with.	Frequency	Percent
Mother/father	12	30.0

Mother/Step father	9	22.5
Father/Step mother	5	12.5
Mother	4	10.0
Relatives	6	15.0
Father	1	2.5
Friends	1	2.5
Siblings	2	5.0
Total	40	100.0

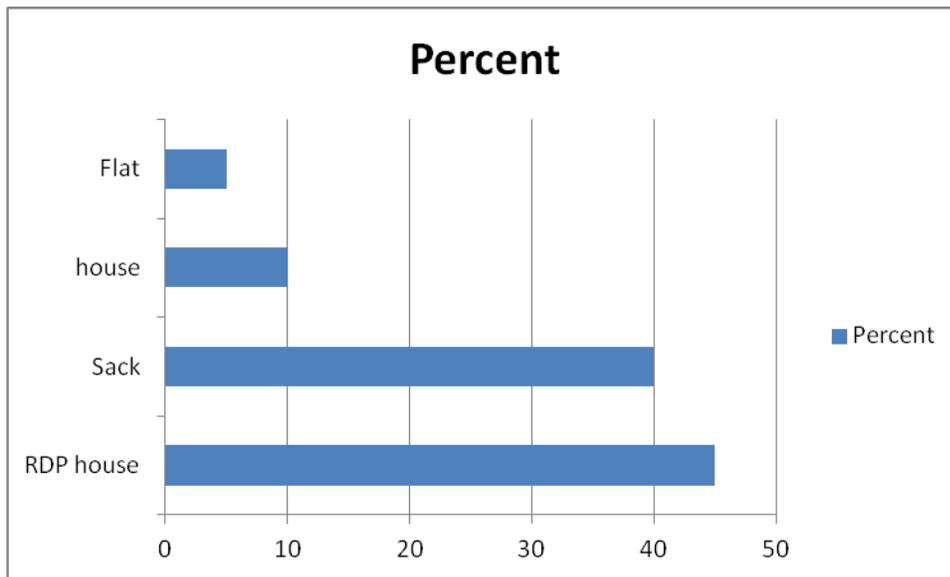
4.6 Type of shelter/accommodation of participants

The participants (40) indicated 18 (45%) lived in Government's sponsored RDP houses, 16 (40%) in sacks, 4 (10%) in houses while the remaining 2 (5%) were in flats (table 4.5 and figure 4.4)

Table 4.5
Type of shelter

Shelter	Frequency	Percent
RDP house	18	45.0
Shack	16	40.0
House	4	10.0
Flat	2	5.0

Figure 4.4
Distribution of type of shelter



4.7 Relationships and behaviors

The study established 36 (90%) respondents have been involved in kissing using tongues, while 4 (10%) had never kissed. At the same time 15 (41.67%) were 12 years old when they had their first kiss while 10 (27.78%) had kissed another person when they were 13 years, 5 (13.89%) had kissed when they were 14 years while 6 (16.67%) had started kissing when they were 16 years old (table 4.6).

The results indicated 30 (75%) had been involved in touching each other's genitals, while 10 (25%) did not. Most of the participants 20 (66.67%) did not indicate their age when it was the first time they had touched each other's genitals, while 2 (6.67%) said they were 14 and 15 years respectively, 6 (20%) were 13 years and 2 (6.67%) were 16 years old.

The data revealed 28 (70%) had sexual intercourse and 12 (30%) had not been involved in sexual intercourse. Of the 28 who had sexual intercourse 14(50%) indicated they did not practice safe sex (use condoms) while the other 14(50%) had safe sex. At the same time of the 28 who had sexual intercourse, 13 (28.57%) were 16 years old, 3 (10.71%) were 12 years, 5 (17.85%) were 15 years, 2 (7.14%) had their first sexual experience when they were 14 years old while 1 (3.57%) and sexual intercourse when she was 17 and the other 4 (14.28%) did not indicate their age when they had their first sexual experience.

The 28 who had sexual intercourse, 4 (14.28%) had fallen pregnant while 24 (85.71%) had never been pregnant. Two participants had fallen pregnant when they were 14 years while the other 2 became pregnant when they were 15 years old.

The 4 who had been pregnant, at least 3 (10.71%) had an abortion while 1 (3.57%) did not abort. The 3 participants indicated when they had an abortion they were 14 and 15 years old (table 4.6).

Table 4.6
Relationships and behaviors-personal experiences

Sexual behavior	Frequency	Percent	Age first time	Frequency	Percent
Kissing using tongues	36	90.0	12	15	41.67
			13	10	27.78
			14	5	13.89
			16	6	16.67
Touching genitals	30	75.0	14	1	3.33
			15	1	3.33

			13	6	20.0
			16	2	6.67
Sexual intercourse	28	70.0	16	13	46.42
			12	3	10.71
			15	9	32.14
			14	2	7.14
			17	1	3.57
Safe sex	14	50.0	–	–	–
Pregnancy	4	14.28	14	2	7.14
			15	2	7.14
Abortion	3	10.71	14	1	3.57
			15	2	7.14

When asked how many were currently in a sexual relationship, 26 (65%) indicated they were and enjoyed having more physical contact with their partners. However, only 11 (42.30%) of the 26 participants said they talked about protection with their partners before having sexual intercourse; 16 (61.53%) said they practiced safe sex (use condoms) when having sexual intercourse. Some of the sexually active participants 19 (73.07%) had sexual intercourse with at least one person. At the same 1 (3.84%) said she was dating a 34 year old man, 7 (26.92%) were dating 17 year olds, 5 (19.23%) were in relationship with 23 year old men, 3 (11.53%) were dating 15 year old boys, 4 (15.38%) were dating 21 year old men, 3 (11.53%) did not state the age of their boyfriends and the other 3 (11.53%) indicated that they did not know their boyfriends' ages (table 4.7 and table 4.8).

Table 4.7
Relationships and behavior

	Yes	Percent	No	Percent
Are you currently in a sexual relationship?	26	65.0	14	35.0
If yes, would you like to have more physical contact with him/her?	26	100%	N/A	N/A
Do you talk about protecting yourselves with your partner before having sexual intercourse?	11	42.30	15	57.70
Do you use any protection when you have sexual intercourse?	16	61.53	10	38.47
Have you had sexual intercourse with more than one person?	19	73.08	7	26.92

Table 4.8
Partner/boyfriend's age

Boyfriend/Partner's age	Frequency	Percent
34 years	1	3.84
17	7	26.92
23	5	19.23
15	3	11.53
21	4	15.38

4.8 Knowledge and perceptions on sexuality and reproductive health

The participants (40) agreed one can prevent pregnancy by washing the vagina after having sex 18 (45%). At the same time 20 (50%) believed one cannot fall pregnant if they have sex while standing, however, the majority 38(95%) seemed to agree one can become infected with HIV/AIDS if they have sexual intercourse without using protection. As much as they knew about unprotected sex, most of the participants 35(87.5%) disagreed that birth control methods can prevent one from getting infected with HIV. However, 19 (47.5%) supported the statement that the chances of getting infected with HIV and getting pregnant become slim if one has only one

act of unprotected sex. There was disagreement by 18 (45%) that pregnancy should be planned. Only 12 (30%) felt it was not morally wrong to use birth control methods while still young. A number of respondents 18 (45%) felt getting pregnant is a risk one has to take to enjoy sex. The majority 29 (72.5%) did not agree with the notion that people can enjoy each other's bodies without having sexual intercourse. However, all of the participants did agree the only way of preventing pregnancy is by abstaining from sexual intercourse (table 4.9).

Table 4.9
Sexuality and reproductive health knowledge

	Agree	percent	Disagree	percent
Washing the vagina after having sex prevents pregnancy.	18	45%	22	55%
Pregnancy cannot occur if a couple as sex while standing.	20	50%	20	50%
By having unprotected sex, you can get pregnant and HIV at the same time.	38	95%	2	5%
Birth control methods also prevent one from getting infected with HIV.	5	12.5%	35	87.5%
There are very limited chances of getting pregnant and HIV after one act of unprotected sex.	19	47.5%	21	52.5%
Pregnancy is something that should be planned.	22	55%	18	45%
Using birth control while still young is morally wrong.	28	70%	12	30%
Getting pregnant is a risk you have to take to enjoy sex.	18	45%	22	55%
You can enjoy each other's body without sexual intercourse.	11	27.5%	29	72.5%
The only way to completely prevent pregnancy	40	100%	–	–

is by not having sex.				
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4.9 Knowledge of HIV/AIDS

Participants were asked if it was true or false that only people who look sick can spread the HIV/AIDS virus; 6 (15%) indicated it was true, 24 (60%) indicated it was false and the remaining 10 (25%) were not sure.

Participants had to indicate if it was true or false that one can become infected with HIV by having unprotected sexual intercourse. The majority 37 (92.5%) supported the statement while 1 (2.5%) said that it was false and the remaining 2 (5.0%) did not know whether it was true or false.

Participants were also asked to indicate whether there is a cure for AIDS, of which 21 (52.5%) indicated true, 14 (35%) indicated the negative and 5 (12.5%) were not sure whether it was true or false.

A statement requested participants whether it was true or false that young people under the age of 17 need their parents' permission to have an HIV test; 9 (22.5%) said it was true, 8 (20%) indicated it was false while the remaining 23(57.5%) were not sure whether it was true or false.

When asked if having another sexually transmitted disease such as gonorrhoea or herpes increases a person's risk of becoming infected with HIV; 12 (30%) said it was true, 11 (27.5%) indicated it was false and 17 (42.5%) did not know whether it was true or false.

Participants were also asked if it is true or false sharing intravenous needles increases a person's risk of becoming infected with HIV; 17 (42.5%) indicated it was true, 14 (35%) disagreed while the remaining 9 (22.5%) did not know.

The participants were requested to indicate their opinions that only people who have sex with gay (homosexuals) people get HIV/AIDS; 10 (25%) said it was true, 26 (65%) disagreed and 4 (10%) were not sure (table 4.10).

Table 4.10
HIV/AIDS knowledge

	True	Percent	False	Percent	Don't know	Percent
Only people who look sick can spread the HIV/AIDS virus.	6	15.0	24	60.0	10	25.0
You can become infected with HIV by having unprotected oral sex.	37	92.5	1	2.5	2	5.0
There is no cure for AIDS.	21	52.5	14	35.0	5	12.5
Young people under the age of 17 need their parents' permission to get an HIV test.	9	22.5	8	20.0	23	57.5
Haven another sexually transmitted disease like gonorrhoea or herpes increases a person's risk of becoming infected with HIV.	12	30.0	11	27.5	17	42.5
Sharing intravenous needles increase a person's risk of becoming infected with HIV.	17	42.5	14	35.0	9	22.5
Only people who have sex with gay (homosexuals) people get HIV/AIDS.	10	25.0	26	65.0	4	10.0

4.10 Perceptions about education and the future

Respondents indicated their perception about education and about the future, the study found 57.5% felt it was extremely important for them to graduate from high school, 25% said it was

very important, 10% indicated it was important, while the remaining 7.5% said it was somewhat important.

The subject of receiving training and get the job they want; 52.5% said it was extremely important, 27.5% felt it was very important, 12.5% thought it was important while 7.5% indicated it was somewhat important.

The study also sought to establish how important it was for the participants to graduate and get a job before getting pregnant; 65% felt it was extremely important, 22.5% indicated it was very important, 7.5% thought it was important while the remaining 5% said it was somewhat important (table 4.11).

Table 4.11
Education and the future

	Extremely important	%	Important	%	Very important	%	Somewhat important	%
How important is it to you to graduate high school?	23	57.5	4	10.0	10	25.0	3	7.5
How important is it for you to get training and get the kind of job you want?	21	52.5	5	12.5	11	27.5	3	7.5
How important is it to you to graduate, have a job before	26	65.0	3	7.5	9	22.5	2	5.0

getting pregnant?								
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4.11 Summary

This chapter presented the study findings on the participants' age, race, primary spoken language, demographic characteristics, relationships, perceptions on sexuality and pregnancy, knowledge on HIV/AIDS and their perceptions with regards education and the future.

CHAPTER 5

DISCUSSIONS OF RESEARCH FINDINGS

5.1 Introduction

This chapter focuses on the findings of the study while at the same time relating the findings to other studies.

5.2 Problem statement

The problem statement of the study is thus: What factors are responsible for the high rate in teenage pregnancy among high school students in South Africa's former African schools that could lead or increase their vulnerability to HIV infection?

5.3 Discussion of the study findings

Objective one: To assess the perceptions of teenagers that leads them to engage in high risk unsafe sexual behavior and practices.

The study findings revealed only 30% lived with both parents; remaining 70% lived with step mother/step father, one parent only, relatives, friends and siblings.

A study conducted by Nicole Martin in 2000 showed children who come from broken homes are twice as likely to have sex before the age of 16 as compared to those living with both parents. In a study by Martin (2000) 25% of children of divorced parents or separated couples said they had engaged in underage sex compared with only 13 % of teenagers whose parents were married. When there is disturbance in a family, children portray this feeling of rejection and as a result they go out to look for love, companionship and stability elsewhere, many times of which they wrongly believe that they will get these elements from a partner and by having sex. The family is not a stable entity and the addition of a step-parent or step-siblings can affect the amount of attention the teenager receives.

The consequences of unprotected sex affect too many lives for parents not to inform the girls about methods of birth control other than continuous abstinence. At the same time parental guidance and supervision is an integral part and one way of keeping teenage girls from engaging in premarital sex.

Some young girls become sexually active in their teens and many before their 15th birthday (UNAIDS, 2004 p.96). This not only exposes them to the possibility of more partners in their life time but they start having sex at an early age, take away their ability to negotiate for safer sex and therefore increases their vulnerability to teenage pregnancy and HIV vulnerability.

The study also revealed 65% of the participants who were in a relationship by the time of the study; all of them agreed they enjoyed having more physical contact with their partners. The participants were further asked if they talk about protecting themselves before having sex and 42.30% said they did talk about protection while the remain in 57.70% said they did not talk about protection. At the same time 61.53% agreed they did use protection while having sexual intercourse. This means as much as they do not talk about it, somehow for others it just happened they use protection.

The Demographic and Health Survey highlights its findings on sexual and reproductive health status of 15- 19 year old girls in 2000 and 2001 (table 5.1).

Table 5.1
Distribution of sexual and reproductive health status.

	Mali	Uganda	Malawi	Ethiopia	Colombia	Peru
Had sex before 15	26%	14%	17%	14%	10%	5%
Married before 15	18%	7%	6%	14%	4%	3%
Gave birth before 15	5%	3%	2%	2%	2%	2%

Source: Demographic and Healthy Survey. (2001)

A study also conducted by Liederman and Almo (2001) established teenagers saw parenthood as a way to provide a opportunity to create a loving family (often compensating for their own bad experiences of child hood), a new purpose, sense of capability and satisfaction. They indicated many teenagers felt their life would have been worse if they had not become a parent due to continued family disruption and unhappiness, growing sense of worthlessness and lack of direction. Liederman and Almo (2001) in their research on teenage pregnancy also found children from broken and abusive homes are at risk for difficulties stemming from the pervasiveness of violence and abuse in their parents' lives. They are a direct risk as they continue to be raised in abusive and violent settings or if the parents continue to form unhealthy partnerships or have a few safe living alternatives. Teenagers thus are most likely to seek sexual information from their friends than from their parents or guardians. For all their seeming sophistication, adolescents can harbor some astoundingly inaccurate ideas about sex from their fellow teens. Friends and peer pressure is thus a major cause of pre-marital sex as girls do not see the reason not to engage when everyone else.

Kelly, Desmond and Cohen (2002) added HIV/AIDS and poverty are intertwined. The poor are at higher risk of infection and vulnerable. Some young girls may have to sell sex for income as

poor households are likely to have fewer disposable resources for spending on education and immediate basic needs of their children. This means when an individual is being paid in exchange for sex, using protection largely depends on who is paying. In most cases, when monetary issues are involved the relationship normally involves an older partner.

Lead researcher Padian (2004) in a research conducted jointly by California and Zimbabwe Universities found inter-generational sex was as a result of economic and cultural reasons and unless an intervention to support school girls was put in place, most of them would remain victims of unplanned pregnancies and HIV infection. “Though African culture is different from place to place, everywhere...the associated value of semen to procreation renders condom use and is seen as a waste of semen.....Evenly, semen had traditionally another great value. It is an element of converse acceptance between two partners...If a woman or girl refuses to receive in her body, the semen of a man that could mean or be interpreted as lack of love of their partner” (Loosli 2004, p.41). Loosli (2004) in her study established condom use suppresses this psychological mind state which undermines men’s pride and masculinity.

Previous studies by different researchers have also established at some places in Africa and Asia, many people feel condoms reduce enjoyment of sex...and STIs and HIV can be prevented by taking antibiotics before or after sex.Often the young girls especially from poor backgrounds, because they want financial support never negotiate for condom use even if they know they are at great risk of contracting HIV.

Objective two: To identify the needs of teenagers in order to encourage safe sex practices.

The HIV/AIDS and STI Strategic plan for S.A (2002) reports on studies carried out in several regions of South Africa and found the majority of children are not in stable homes and are being cared for by one parent or other family members. As a result these children are vulnerable and are at higher risk for teen pregnancy hence HIV infection as they face numerous materials, emotional and social problems. They also often suffer from malnutrition and ill health and are in danger of exploitation and abuse by relatives and older men.

The study found 40% of the participants lived in shacks; 45% lived in RDP or government sponsored houses; 15 % lived in a flat or house respectively. These results clearly show the majority of people in South Africa are living in poverty and can hardly fend for themselves. Most teenage girls do not plan to get pregnant, but find themselves in a situation because of other things such as poverty and other social reasons. Poverty and financial problems by families is a disturbing issue and cause for concern in South Africa and in the sub-Saharan region.

Many families who live in poverty do not have formal jobs; can barely afford to pay rentals, let alone to put food on the table. Impoverished teens often live in cramped spaces. Dr Lester Coleman at the Trust for the study of adolescents in which they found some teenagers feel their conscious decision to become a parent is a reasonable rational life choice given their past and options available to them. Sharing the same sentiment Van Zyl (2010) believes widespread poverty, high unemployment and low returns from the informal sector in-come generating activities have been associated with high risk sexual behavior hence making the young girls vulnerable to teen pregnancy and HIV infection.

These findings clearly indicate most children grow up in broken homes. Households experience the immediate impact of teen pregnancy and HIV. The problem of orphans and children who grow up in broken homes will persist for years even with the expansion of prevention and treatment programs (Lamprey et al., 2002).

Every child deserves the right and chance to be loved and being taken care of so they can do the same to their own children. Findings from other studies also agree when they observed the more the teenagers are satisfied with the mother-child relationship, the less likely they are to be sexually experienced. Estrangement at home often leads children to look for and establish intimate relationships outside the family, seeking the warmth and support they lack at home

Conversely poor communication with parents about sex and safe sex practices, parental substance abuse and broken homes are also linked with risky sexual behaviors among young girls. In a broken home, there is hardly any communication and the consequences are severe.

Whereas good sexual health is significant across the life span, it is critical in adolescent health. Young people have a need and the right to know about their bodies and to be educated and informed about their sexual health, yet they face many social and community barriers to receiving and gaining access to the right information.

Older men continue to influence teenage girls into having sex with them for financial support. The study showed of the (65%) who were sexually active by the time of the study, 38.48% fell for men far older with even 3.84% being in relationship with someone old enough to be their father.

UNAIDS (2004) compiled over 45 quantitative studies in sub-Saharan Africa on age differences between girls 15-19 year old and their sexual partners and found most of their partners were 6 or more years older. According to UNAIDS (2004) many girls reported that gifts of clothes, jewellery, perfumes and cell phones enhanced their self esteem. Whatever the reasons, the UN secretary-general's Task Force on women, girls, teen pregnancy and HIV/AIDS in Southern Africa has found both transactional and intergenerational sex have become a norm in many countries.

Exploitation by older men who are supposed to be role models to these young girls has contributed greatly to teenage pregnancy. Quite often the girls due to peer pressure and other social reasons come across with many demands which their parents or guardians cannot meet, leading them to fall for older men for financial support. In return these men request sex resulted where the girls become victims of teenage pregnancy.

In South Africa 20% of sexually active girls between the ages of 16 and 18 are infected with HIV (Pisani 2003). These relationships are based on equations of power and economics that leave the girls vulnerable to abuse, violence, teenage pregnancy, HIV and exploitation (Futterman 2003). 'Sugar daddies' take advantage of the girls' vulnerability. Similar to the findings are those by a Abrahams (2004) who also found over one-half of infants born to South African women younger than 18 years were fathered by adult men. Abrahams (2004) also found 40% of the 15 year olds

had partners aged 20 years or older. The study of seventy-one 16 to 19 year olds youths by Abrahams established that 30 to 40 % of girls had dangerously unequal relationships with older partners. The girls reported the men would become violent if they refused sex or suggested condom use.

According to Dr Lester Coleman at the Trust for the study of adolescents, many teenagers whom they interviewed cited early sexual debut with older men as a better option than a prospect of low-paid and dead-end job by their parents so that they can be provided for without compromising their health or the consequences of their actions.

Loosli (2004) established for the young girls under 18, having older partners is a significant risk factor for HIV infection and teen pregnancy as it exposes them to a pool of higher prevalence of infections. Sharing the same view is Lamptey et al (2002) who note the young girls are more likely to shun condom use, thereby being vulnerable to teen pregnancy and HIV infection if they have sexual partners who are 5 or more years older than themselves.

UNICEF,UNAIDS and WHO (2002) jointly agree if the girls tend to have sexual partners that are considerably older and who are more sexually experienced, the young girls have limited power to negotiate sex or the circumstances of sex.

A study sponsored jointly by the University of California and University of Zimbabwe found many teenage girls depend on sugar daddies for school fees, food or for greater-status consumer goods to satisfy their desire. This is referred to as transactional sex which involves the exchange of sex for monetary gain. Transactional sex thus further disempowers the young girls as it reduces their ability to negotiate for safer sex.

Kelly (2000) note due to peer and social pressures the girls feel the need to show to their peers they are in a 'good' relationship. At school the others show off and talk about the gifts and money vouchers their boyfriends provide and as a result the other girls will be forced into the same act so they can fit in the group. Pressures like these can lead to behaviors that carry the risk

of teen pregnancy and or HIV infection. Basically all children need a loving family, clothing, good shelter and enough food if they are to grow as normal children and be responsible citizens.

Objective three: To establish teenagers' perception of the physical, psychological, social and economic implications of teenage pregnancy

Millions of South African girls and elsewhere in the whole continent face unplanned pregnancies every year. Deciding what to do about an unplanned pregnancy can become complicated. It may be made even more difficult by the fake clinics that tend to engage in illegal abortions thereby putting the girls' lives at a higher risk.

According to the South African Medical Research Council (SAMRC) the latest national survey into HIV prevalence recorded 16% of pregnant young adults under the age of 19 tested HIV positive. Some observers have suggested a child support grant by the state was and is an incentive to young girls to fall pregnant. Studies conducted by William (2013) are also a cause for concern as she established 30% of teenagers in South Africa reported ever having been pregnant and the majority was unplanned. The study sought to establish from the participants their true perceptions about the importance of education and the future. More than half of the participants (57.5%) said it was important for them to graduate from school. Combining the results with those who indicated it was important (77.5%) who felt education was indeed important to them.

The participants were further asked about their perception on the importance of getting trained and getting the kind of job they want. It was established 12.5% and 7.5% felt it was important and somewhat very important respectively. The other 52.5% and 27.5% seemed to greatly value the importance of being trained and get their dream job. The study found from the participants what is their perception on the importance of graduating from university or college and get a job before getting pregnant. More than half of the participants 65% felt it was extremely important. Combining with the 22.5% who indicated it was very important shows the majority of the participants really want to achieve the best in their lives.

What is disturbing from these findings there is no relationship about the type of sexual behavior the participants are portraying and the kind of life they wish to live in future. Risky behavior is rife among teenagers and their pregnancy is a problem that cannot be ignored. The issue contributes to higher levels of unemployment considering the girls who drop out of school due to having their babies.

Many girls engage in risky behavior, develop unhealthful habits and experience physical and mental health conditions that can jeopardize their immediate and future health. Many adults are uncomfortable with the idea of teen sexuality and prefer to remain in ignorance and denial. It is critically important for adults to address adolescent sexuality realistically and to recognize many factors including socio-economic status, race, family structure, educational aspirations and life experiences affect young people's behavior (Whitaker et al 2000).

Adolescents who can envision positive futures for themselves are more likely to maintain healthier sexual behaviors and to avoid or reduce sexual risk-taking but there are racial and ethnic disparities that delineate young girls' ability to perceive positive futures (Futterman 2003). Because poverty and lack of access to health services is correlated to the poor, the adolescent population becomes more diverse and the young girls from poor backgrounds are at risk of being unable to access health care and other social services that help to influence adolescent health and well-being. The study showed all of the participants interviewed did not see it as being sensible to get pregnant while still in school and they all cited different reasons from having to drop out of school to look after the baby, having no money to take care of it, facing the risk of being neglected by the family, lack of support from the father of the child and among other things having to face difficulties due to early pregnancy.

The majority of the participants did indicate there are consequences of having unprotected sex as an individual would face the risk of getting infected with STIs and HIV and getting pregnant. The study went further to ask the participants how the consequences would affect their life now and in future. Many responses were given and almost every participant agreed they might get sick and have to drop out of school and having to look after the baby and with no job would be

difficult. Others also cited discrimination from peers and teachers in the event of still attending school while pregnant or decide to attend school later after giving birth. Failure to concentrate in class and thus get poor marks was also seen as another consequence of getting pregnant while at school. There are some participants who thought by getting pregnant one would not be able to do things such as drinking alcohol and smoking which they see as a good thing.

The study also sought to find out from the participants if they knew anyone at their school or community or a friend who had been pregnant before matriculating and the issues they faced. All the participants interviewed were quite aware of someone or many girls in their community who had been pregnant while at school. Others said the person although she was able to matriculate, was, however, unable to go to university to study as she had to take care of the baby and had no money for studying as she had to do odd jobs in order to survive. Others also cited the boyfriends denying responsibility and the person taking the baby for adoption and some girls going for abortion or committing suicide. Some further went on to report some of the girls were working in farms and others were going to night clubs at night to look for boyfriends. Some girls had to take the baby to crèche before coming to school or having to stay at home or at hospital because the baby was ill. Amongst others not coping with the challenges ended up committing suicide and others got sick and eventually died. However, others reported on someone who did not face any issues because apparently the parents were quite rich and did everything for their girl and the baby and the girl had to continue with her education and later went to study at the university.

Objective four: To establish the teenagers' knowledge on pregnancy and HIV/AIDS.

The study showed most of the participants lacked knowledge and the right information with most issues surrounding HIV/AIDS. Interestingly, 92.5% of the participants were quite aware that one can get infected with HIV by having unprotected sex, 95% knew that by having unprotected sex one can get pregnant and HIV at the same time, but surprisingly the majority still thought there is a cure for AIDS.

It can be implied 65% said there is a cure for AIDS they are not getting accurate information and probably assume that ARVs are a cure. ARVs is a treatment for HIV though being available for the management of HIV infections should not be misconceived as being a cure for HIV/AIDS.

The study found most children become sexually active at a young age and yet with limited knowledge on sexuality. As shown by the study, 41.67% had already been involved in kissing with tongues by the age of 12 and by the age of 13 most (20%) had touched each other's genitals. This kind of behavior will lead eventually having sex and in most cases there is no time to talk about protection as it happens when they least expect.

The girls seem to engage in sexual activity at very tender age when they hardly have enough knowledge about sexuality and reproductive health. Adolescents who become sexual activity early are likely to have sex with more partners and with those who have been at risk of HIV exposure; are not likely to use condoms (Who 2000, UNAIDS 2002).

At times, early sexual debut is not always as a result of early sexual maturity but sometimes due to curiosity and the need to experiment. Adolescence is the time of experimentation and curiosity. Sex is often challenging and difficult issue for both youths and adults to discuss. Lack of parental guidance and absence of communication in households and schools is mostly to blame and has seen many young girls engaging in immoral activities. Sometimes as it is the norm of African culture, parents knowingly provide information that is false with regards to this subject as a way to discourage their children from participation and discussion. Some African people, be it at home or at school may find it offensive to talk about sex issues especially to their children as these are not habitually discussed openly and publicly. People who dare approach sexuality are often pointed out as having received the wrong education or have low morals and in most African cultures it is a taboo to talk about the subject.

At the same time, apart from religious and cultural opposition, condom use by the youth is often faced with opposition in such a way that the young girls feel embarrassed and hence too scared to carry on or use the condoms because there is failure of authorization on condom use by the

parents and even teachers who keep on preaching about abstinence. Most relatives, parents, educators and church ministers think talking about condoms and sexuality to teens could actually motivate them to start sexual activity; as a result abstinence is often preached of (www.fao.org 2005).

Many young girls still believe they can determine an individual's health by merely looking at their physical appearance and if they seem healthy outwardly then condom use is not necessary.

The study was able to show that the teenage girls were perceived to be at higher risk for teenage pregnancy and HIV as they seemed not to have enough and accurate information with regards some issues surrounding sexuality and reproductive health. For instance 45% who believed by washing the vagina soon after having sexual intercourse, one cannot fall pregnant and the 50% who thought that pregnancy cannot occur when one has sex while standing clearly shows lack of knowledge among the participants

The study established the majority of the participants were not aware of the legal age to have an HIV test with or without the parents' permission. The majority of the participants were not knowledgeable about other ways of getting infected with HIV besides through sexual intercourse. In trying to establish if participants were knowledgeable about sexuality and reproductive health, they were asked if birth control methods prevent one from letting pregnant and getting infected with HIV, of which 12.5% agreed with the idea. Furthermore 47.5% believed there were very limited chances of getting pregnant and HIV after one act of having unprotected sex.

Unprotected sexual intercourse can lead to an unwanted adolescent pregnancy which is often considered a serious social and public health problem. Teenagers have a high risk of unintended pregnancy. Richter and Mlambo (2005) said teenage pregnancy appears to be encouraged by lack of access to sex education. Some parents are reluctant to make sex education and contraceptives available to their teenagers, as they are afraid that their teenagers might interpret this as permission to engage in sexual activities. They further pointed out teenagers are reluctant to visit

clinics to obtain contraceptives and thus do not make use of available health services. Morake (2011) revealed teenagers appear to be ignorant about issues such as puberty, pregnancy and contraception. Ignorance, aggravated by cultural taboos to discuss sex with one's parents, combined with real or perceived peer group pressure to engage in sexual activities, cause unnecessary heartache for many young women.

When participants were further probed if pregnancy should be planned, 45% strongly believed that it should not be planned. However, this finding does not correlate with findings by the Bill Gates Foundation who believe more than 220 million women and young girls in developing countries who do not want to get pregnant lack access to contraceptives and voluntary family planning information and services. As much as the Bill Gates Foundation is right, significant challenges such as cultural barriers stand in the way especially in an African setting where people generally are socialized to believe that pregnancy is something that should not be planned. As young children, the young girls are thus brought up with the idea and tend to put it into effect in the later years.

Lacking of information and knowledge on many issues such as children's rights, health issues and many cultural ideologies and misconceptions might put the children at risk and in danger of becoming exploited and abused while at the same time getting pregnant and infected with HIV. The basic values of choice, dignity, diversity, equality and respect underlie the concept of Human Rights; these affirm the worth of people.

Objective five: To suggest strategies, interventions and recommendations to various stakeholders and policy makers based on the study findings on streamlining teenage pregnancy among school children.

A study done jointly by UNICEF, UNAIDS and WHO in (2002) established earlier sexual debut is significantly associated with increased risk of low condom use hence teenage pregnancy and HIV infection. The risks of early sexual debut also include higher likelihood of having multiple sexual partners, lower likelihood of condom use at first sex and higher overall numbers of sexual

partners, not to mention higher biological susceptibility to infection and pregnancy of adolescent young girls (UNICEF, UNAIDS, WHO, 2002. p.40).

WHO maintains consistent and correct condom use reduces the risk of teen pregnancy and HIV infection by 90%. Ignorance about condom use is thus a major concern which is often underestimated. Using condom is a preventative method against unwanted pregnancies, STIs and HIV infection.

The study found there were higher levels of lack of condom use among the participants in the study in spite of the knowledge level on reproductive health and HIV transmission. These responses from the participants show how complex sexuality becomes even when one is aware of the risks of HIV transmission. This agrees with the findings by Health Demographic Survey (1996) that showed despite knowledge on HIV/AIDS transmission very few young girls ever actually used condoms to protect themselves from getting infected with STIs, HIV and getting pregnant.(ZDS 1996). National prevalence of condom use was reported to be 45.6% (UN 2011).

Loosli (2004) also believe condom use in Africa is still low and in South Africa the rate is about 10 to 20% of the population although South Africa is a country where condom use is relatively high in sub-Saharan Africa. Loosli (2004, p.5) indicated in a study which was conducted in Cote D'Ivoire and concluded condom use remained very low in the country despite the increasing prevalence of HIV and widespread awareness of how the virus is transmitted. The same study revealed the level of accuracy of AIDS knowledge did not predict the likelihood of recent condom use in this sample. However, several studies found the most powerful determinant of condom usage in Africa is a perceived risk of HIV infection from the partner.

Teenage pregnancy, STIs and HIV/AIDS are all important issues during adolescence. It is important to address these issues because they are intrinsically linked with unsafe behavior practices. It is at this stage when the girls should adopt new behaviors. This can only happen if they are convinced by an idea suggested to them by other members they trust.

Loosli (2004) assert when beneficial beliefs are instilled and widely held within the individual's immediate network, their behavior is more likely to be consistent with the perceived social norms. The theory explains of how a new idea is disseminated throughout communities and institutions and influential people should take the role model in campaigns on teenage pregnancy and HIV/AIDS by showing best practices which contribute to risk reduction in order to be followed by others. Loosli et al., (2004) are certain this method is useful to diffuse safer sex messages within groups or communities which are resistant to condom use. Thus in order to change behaviour, individuals may be educated about avoiding teenage pregnancy and HIV by accepting and adopting key attitudes while at the same time be given appropriate products and services. UNAIDS (2004) in its previous studies in Kisumu in Kenya also established that 33% of the sexually active young girls had not used a condom during their first and subsequent sexual encounters.

In support thus, Kelly (2002) concluded by not using protection, the physiological factors put the young girls at higher risk of HIV infection and unplanned pregnancies. This is so because of the extensive and easily lacerated tissues in their vaginal area and during sexual intercourse they are exposed to a large volume of high risk body fluids and STIs may remain undetected.

A representative of the Ministry of Education in Zimbabwe (2004) agreed they never talk about condoms and the result of such an assertion is clear. The young girls who were interviewed in the country are awarded of HIV infection yet they did not know how to protect themselves apart from abstinence. Program and policy directions thus have been hampered by adult beliefs of what young girls should be permitted to know. A study by UNAIDS and UNICEF (2004) has shown young girls were more likely to delay sexual activity when they are well informed of the sexual issues.

Other misinformation presumes condom use weak and asphyxiates sex since the rubber does not allow it to breath. In the same way both young girls and their sexual partners dislike the idea of rubber between themselves during sexual intercourse. This feeling is reported as diminishing

their pleasure or at worst making them lose their virility. It is the reason that underlines the famous expression in Africa 'skin to skin' (Loosli, 2004. p.52).

As much as the schools do sensitize students about HIV they should be educated more on the issues of peer pressure and sexuality. Sexual health is an essential part of good overall health well-being. Sexuality is a part of human life and human development. Good sexual health implies not only the absence of disease, but the ability to understand and weigh the risks, responsibilities, outcomes and impacts of sexual actions, to be knowledgeable and comfortable with one's body and to be free from exploitation and coercion.

According to IRIN (2007) figures released by the South African provincial education department indicated teenage pregnancies had doubled in the past years, despite a decade of spending on sex education and AIDS awareness. The number of pregnant girls jumped from 1 169 in 2005 to 2 336 in 2007 in Gauteng, the country's economic heartland and most populous province (IRIN 2007). One in three girls has had a baby by the age of 18 (Lovelife, 2007). Previous studies by Linnet et al (2001) found in India and sub-Saharan Africa pre-marital sex and teen pregnancy are more common and generally acknowledged.

The unique South African context of high prevalence rates of HIV with nearly one-third of all sexually young active girls infected requires the promotion of dual protection. In addition to prevent unwanted pregnancies, the young girls also need to protect themselves against HIV infection as they bear the brunt of the disease. This requires barrier protection in form of condoms and other forms of contraceptives as a means of preventing transmission of HIV virus and pregnancy (Pillay and Baron 2013). Family Planning 2020(FP2020) has created global momentum on the issue of access to contraceptives and has spurred collaboration, innovation and greater accountability in family planning efforts.

In an effort towards the reduction of new infections to HIV and teenage pregnancies, South Africa has undertaken to ensure condoms are free and can be accessed easily from the health facilities. The question remains though: Do the young girls have access to these facilities and are

they aware of these facilities? What challenges do they face in trying to access the condoms and information about sexual health?

Previous studies has shown although sex education is part of the school curriculum, some state officials dilute the messages they disagree with and teachers just like parents often avoid topics that make them uncomfortable. When the young girls seek information or services at health facilities, they are often scolded or even face judgmental health providers leaving the girls to seek information that is substandard or illegal services (Pillay and Baron 2013). It is therefore recommended in this era of HIV/AIDS the young girls should face reality and be educated about the dual protection if the world has to minimize the rates of teenage pregnancies hence HIV infection among the young generation; the world will be wiped of its future leaders.

Disturbingly, despite them knowing the consequences of having unprotected sexual intercourse, the girls seemed to continue having unprotected sex and this leaves one to wonder as whether it is mere ignorance or the need to experiment. According to many studies done in South Africa and elsewhere usually young girls ignore the safety precautions required for ‘safe’ sexual behaviour. Often they do not have adequate knowledge to practice safe sex or they want to taste and feel the ‘actual thing’. Unsafe behavior, like sexual intercourse without a condom, can lead to pregnancy, STIs and HIV/AIDS. In spite of the high levels of self-risk perception to teenage pregnancy and HIV, almost 50% of the participants interviewed were not doing anything to protect them. The young girls need to have access to information. They need to be educated that sexual behavior can be safe and unsafe. The trend of teenage pregnancy and HIV infection can be reversed if the young girls are informed and empowered to change their behavior and reduce their risk (The HIV/AIDS and STI Strategic Plan for South Africa 2002, p. 55).

In all interventions there should be a special plan on reaching young people and consciously involving them in activities. However, Bearinger (2007) strongly believes effective approaches are multifaceted and hindered by uncooperative and ignorant health providers. “All adolescents need access to quality-friendly services provided by clinicians trained to work with this population.....Sex education programmes should offer accurate, comprehensive information

while building skills for negotiating sexual behavior.....,girls and boys need equal access to youth development programmes that connect them with supportive adult and with educational and economic opportunities” (Bearinger, 2007, p. 1220).

A 2009 report on teenage pregnancy by the department of Basic Education found over two-thirds of young girls reported their pregnancies were unwanted because it prevented educational aspirations and imposes greater financial hardships in a context of high levels of poverty and unemployment. Despite high levels of knowledge about modern methods of contraception, many young girls do not use it and others use it inconsistently and incorrectly. One intervention that is required is for contraception to be more available to young girls who are sexually active without being discriminated against with judgmental health providers, parents and educators.

There is need therefore to continue educating young girls on sexuality and different modes of HIV/AIDS transmission to dispel some of the misconceptions of its transmission, educate them about sexuality while at the same time raising an awareness that all individuals are worthy regardless of their age, class, orientation, preference, culture and other determinants of the status. The study also established 70% of the participants believed that it is morally wrong to use contraceptives while young. In 1968, Pope Paul VI issued his landmark encyclical letter, *Humanae Vitae* (Human life) which re-emphasized the church’s constant teaching it is always intrinsically wrong to use contraception to prevent new beings from coming into existence. “Contraception is any action which either in anticipation of the conjugal (sexual intercourse) act or in its accomplishment or in the development of its natural consequences, proposes whether as an end or means to render, procreation impossible.....” (*Humane Vitae* 14).

This includes sterilization, condoms, the pill and other barrier methods. Since then most religions have followed suit and have evidence in Biblical sources that contraception is in conflict with God’s laws. Despite the various religious teachings, a new look at family planning especially among teens in South Africa is on the cards. The issue of family planning has been put on the global agenda. Health Minister Motsoaledi strongly believes neglecting family planning directed at teenagers was due to greater emphasis on condom distribution rather than contraception and

family planning. The Minister's view is supported by WHO when they reported the prevalence of contraceptive use in Africa was a mere 20% compared to 63% in Latin America. The provision of appropriate and adequate family planning services in South Africa is critical in a context of high rates of teenage pregnancy, as well as child mortality (Motsoaledi 2013).

In the field of teenage sexuality, contact that does not involve intercourse is referred to tongue-in-cheek as outer course. Outer course may include activities such as kissing, rubbing, masturbation, using sex toys and acting out fantasies. As much as the participants did not agree they can enjoy each other by outer course, research has shown outer course greatly reduces the risk of HIV/AIDS and STIs unless body fluids are exchanged through oral or anal intercourse. At the same time outer course offers nearly 100% protection against unintended pregnancies. Studies done by Norman in 2006 agree with the findings as he concluded the levels of participation in outer course were low across the sample. Outer course should not be promoted as the only option for safer sex relationships but instead in the context of a comprehensive prevention message which also includes protected sexual intercourse for those who choose to engage in penetrative activities.

Dr Donna Futterman, director of adolescent AIDS programme at New York's Montefiore Medical centre, encourages and urges parents and educators to talk to the children about other forms of sexual expression other than the vagina-penis penetration. Futterman (2003) argues children should know they do not need to have sexual intercourse to be fulfilled in their daily lives.

MEC for social development in Gauteng, Mayathula reported on a study conducted as part of a national survey at schools of which more than 500 pupils between the ages of 13-18 participated and 19 focus groups consisting of 10 -12 pupils were formed. The Department of Basic Education estimated 94 000 school girls became pregnant during 2011, with Mpumalanga reporting over 1600 pregnancies in 2012 and a total of 51 306 gave births in the same year, meaning that the other 42 694 unaccounted for went for abortions.

The National department of Health (2012) found 28% of school girls country wide was HIV positive whereas only about 4% of the boys were infected. The DA's Gauteng education spokesman, Khume Ramulifho attributed the prevalence of teenage pregnancies to a lack of practical education. She argued Life Orientation is taught at schools and children pass with flying colors, yet the problem does not seem to disappear. Experimentation with sex and factors such as having multiple sexual partners and older partners has to be discouraged (Ramulifho 2012).

5.4 Recommendations

The factors driving teenage pregnancy are complex and varied and therefore require multifaceted intervention strategies. There is a wide variety of strategies aimed at preventing adolescent pregnancy including education programmes, family planning services, school-based health centres, youth-friendly clinics and youth development programmes.

Findings presented throughout this study indicate many adolescents who become pregnant are from poor socio-economic backgrounds thereby engaging early in sex or get involved with older men as they try to search for a better life. While some victims will thrive without special supports, most will experience consequences that can affect multiple aspects of their lives. Their ability to succeed in school, be self-sufficient, form healthy relationships and avoid early pregnancies and to parent children well may all be compromised because of psychological and material after-effects of untreated exposure to violence.

The results from the study also showed early sexual debut, exploitation by older men, poverty, low condom use, ignorance and lack of accurate information and knowledge have also played a pivotal role in teenage pregnancies.

While there are promising practices that could better support adolescents through these challenges, they are neither widely known nor typically incorporated in programmes aimed at adolescent pregnancy, parenting or prevention. The following pregnancy prevention strategies are recommended based on the results of this study.

There is need to create awareness among the general public by creating messages that reframe public understanding of why and under what circumstances many young girls become pregnant and the need for policies and programmes that fit their actual situations and needs.

Messages that reframe men who exploit young girls should be communicated nationwide. There are laws in place in South Africa that make it a criminal offence to have sexual intercourse with under aged individuals.

Advocacy on sharing materials should be emphasized for instance through websites, journals and conferences aimed at practitioners in other fields like people working on men reproductive health and violence prevention, educators who work with adolescents or sexuality educators. Policies in multiple areas should be reviewed to see whether they promote relevant cross-disciplinary work, exploit opportunities and or reduce barriers to working with pregnant girls or adolescents at high risk of getting pregnancy who are also victims of violence, broken homes and poverty.

Pregnant prevention education should start early in the lives of young children because victims of poor socio-economic backgrounds tend to begin sexual activity earlier than non-victims, either through coercion to meet previously unmet needs and or because of early sexual involvement. At the same time, not ignoring the importance of allowing the adolescents to control the content and process activities designed to affect them, giving them leadership roles in the governance of these efforts and treating them as resources not merely recipients of services.

5.5 Summary

In this chapter, the researcher gave an outline of the problem statement, discussion of findings and recommendations.

5.6 Limitations of the study

The study results were limited to one school in the Northern suburbs of Cape Town and will not be generalized to all teenagers in the district, province or country. It is suggested the same study

be conducted in other districts in order to determine the factors which contribute to teenage pregnancies amongst the teenagers.

5.7 Conclusion

The study concluded participants from poor socio-economic backgrounds are mostly the victims of teenage pregnancies. Broken homes, poverty, early sexual debut, exploitation by older men, low condom use, multiple sexual partners, transactional sex, and ignorance and in some cases lack of knowledge were seen as contributory factors leading to teenage pregnancy. The socio-economic factors, including their lack of access to personal income by their family, perpetuate the girls' lower status and create even greater vulnerability to teenage pregnancy and HIV infection.

Preventing teenage pregnancies among adolescents is critical as a way of slowing the HIV/AIDS epidemic because first sexual intercourse commonly occurs during adolescents' years.

The education sector is committed to the prevention of teenage pregnancy and HIV through the teaching of Life Orientation as a subject. There are suggestions, however, that implementation capacity for specific activities within the sector is inadequate.

There is need to promote social change and cohesion in society. The moral regeneration and values promotion in schools and the community at large should be enhanced to support sustainable behavioral change among teenage girls. To change behavior, the individuals thus may need to be educated about avoiding pregnancy, accept and adopt key attitudes and need to be given appropriate products and services. The increase in the number of teenage pregnancies is causing great concern and is becoming a critical issue. This situation requires the urgent attention of every section of society in order to prevent family life from disintegrating completely.

References

- Abrahams, N. (2004).Violent against intimate partners in Cape Town: Prevalence and risk factors reported by men. *Bulletin of the World Health organization* 82(5):330-333.
- Babbie, E. (1998).*The practice of social research*. Boston: Wadsworth publishing company.
- Bearinger, L. (2007).*Adolescent condom use consistency over time: Global versus partner specific measures*. New York: NIH Publishers.
- Brink, H.I. (2006) *Fundamentals of Research Methodology for Health Care Professionals*, 2nd edition. Cape Town:Juta
- Christensen, L.B, Johnson, R.B and Turner, L.A (2011). *Research methods, design and analysis*. Boston: Allyn and Bacon.
- De Vos, A.S. (2000).*Research at grassroots*.Pretoria:J.L.Van Shaik.
- Futterman, J. (2003).*Adolescent girls and young women and HIV/AIDS: HRSA*.
- Hepburn, A. (2001).*Primary education in Eastern and Southern Africa. Increasing_access for orphans and vulnerable children in AIDS affected areas*. New York: Duke University.
- Holborn, L and Gail, E. (2011) .*First steps to healing South Africa*. Johannesburg: South African Institute of Race Relations.
- Kanku, T. (2010) .*Attitudes, perceptions and understanding amongst teenagers regarding teenage pregnancy, sexuality and contraception*.
- Kail, M and Cavanaugh, C. (2004).*Treatment for sexuality abused children and adolescents*. *American Psychologist*, 55(1), 206-210.
- Kazdin, A.E. (1992).*Methodological issues and strategies in clinical research*. Washington, D.C: American psychological association.
- Kelly, J.*Changing HIV risk behavior: Practical Strategies*. New York: The Guilford Press.
- Kelly.M.J, Desmond, C and Cohen.D (2002).*The Impact of HIV/AIDS on Development*. New York: The Guilford Press.
- Kirby, D. (2001).*Emerging answers: Research findings on programmes to reduce_teen pregnancy*. Washington DC: A Journal for Health Education.

- Macleod G. (1999). Adolescent mothers in later life and responsible teenage sexuality. Cambridge: Cambridge University Press.
- Lamptey, P, Wigley, M, Carr D and Colleymore, Y (2002). Facing the HIV/AIDS Epidemic. Population Bulletin Vol 57, Number 3.
- Leedy, D.P and Ormrod, J.E. (2001). Practical research: Planning and design. New Jersey: Merrill prentice hall.
- Loosli, B.C. (2004). Traditional Practices and HIV Prevention in sub-Saharan Africa.
- Morake, A. (2011). Factors associated with teenage pregnancy in Limpopo Province. Polokwane: Government printers.
- Motsoaledi (2013). Minister of Health. South Africa.
- Msimangana, S (2007) Education for All: Country Report. Pretoria: Department of Education.
- Norman. (2006). Sexual behavior and attitude towards HIV testing among non-HIV testers in developing nation: A public health concern. New Jersey: North American Journal of Medical Sciences.
- O'Dinoghue, T and Punch (2003). Qualitative educational research in action: Doing and reflecting. London: Routledge Farmer.
- Panday, S. Makiwane, Ranchod, C and Letsoalo, T. (2009). Teenage pregnancy in South Africa.-With specific focus on school going learners. Pretoria: Department of Education.
- Patton. (1990). Evaluation and Research Methods. California: Sage Publications.
- Richter, M.S and Mlambo, G.T (2005). Perceptions of rural teenagers on teenage pregnancy. Health South Africa Gesondheid 61-69
- Tiendrebeogo, G, Meijer, S and Engleberg, G. (2003). Life Skills and HIV Education Curricula in Africa: Methods and Evaluations. USAID: ABIC.
- Pope Paul VI. (1968). Humanae Vitae (Human Life) of the supreme pontiff.
- Whitaker, D.J, Miller.K.S and Clark, L.f (2000). Reconceptualizing adolescent sexual behavior: Beyond Did they or didn't they. NY. Guttmacher institute.
- White. (2000). Study designs in outcome research. New York: Taylor and Francis Group.

- William, S. (2013).A Review of teenage pregnancy in South Africa-Experiences of Schooling and Knowledge and Access to sexual and reproductive health services.Pretoria: PSH.
- UNAIDS, (2004).Report on the Global AIDS Epidemic/Focus,"HIV and Young People". The threat for today's youth.
- UNICEF UNAIDS and WHO (2002): Young people and HIV/AIDS: Opportunity in Crisis.
- Van Zyl, G. (2010).The basics of HIV and HIV epidemiology. Cape Town: NHLS and Stellenbosch University.
- Youth and Condoms:Knowledge,Attitudes and Practice.(2005).www.fao.org/docrep/t2942e03.htm
- Zimbabwe "In denial" over teen AIDS, pregnancy risks (2004):www.cyc-net.org/features/ft-denial.html.

APPENDIX 1: Survey Questionnaire for Teenage Girls

INSTRUCTIONS

1. It is important to mark all answers carefully so that we are able to know the circle or box you choose. Do not mark between circles.
2. If you do not find an answer that fits exactly, choose the one that comes closest.
3. There are some state/questions which will require you to choose more than one answer.
4. There might be questions that you do not to give answers to, but try to answer as many questions as possible.
5. You have the right not to answer questions that you feel uncomfortable with.
6. By answering the questions truthfully, you will help us to learn and understand what other teenagers do, know and think with regards teenage pregnancy and HIV/AIDS.
7. Your answers will be put together with those of other teens and all the answers you give will be kept private.
8. If there is a question/statement that you do not understand, please do not hesitate to raise up your hand for assistance.
9. Use a pencil to mark your answers.
10. If you make an error, erase it completely and choose another box.

IMPORTANT: PLEASE DO NOT WRITE YOUR NAME ANYWHERE ON THIS SURVEY.

Section A (Please tick the appropriate box/es)

1. Gender

Female	
3.Male	

2. Age

15 years	
16 years	
17 years	

3. Race

Black	
White	
Indian	
Colored	
Other	

4. What is your primary spoken language?

Xhosa	
Afrikaans	
English	
Indian	
Other (Specify).....	

5. With whom do you live?

Mother	
Father	
Step mother	
Step father	
Relatives	
Siblings	
Friends	
Other (Specify).....	

6. Describe where you live.

Shack	
RDP House	
Flat	
House	
Shelter	
Other (specify)	

Section 2: Relationships and Behaviors. (Some of you might have had sexual intercourse but others might not have. We would like to know about your own experiences.

Read the instructions carefully before answering.

By sex or sexual activity, we mean a situation where two partners get sexually excited or aroused by touching each other all over the body. A sexual partner is someone with whom you have sex with. Safe sex means that sex is protected by using a condom.

Have you experienced any of the following with another person?

		Yes	No	Age first time if you answered yes
1.	Kissing with tongues			
2.	Touching each other's genitals			
3.	Sexual intercourse			
4.	Practiced safe sex			
5.	Ever been pregnant			
6.	Ever had an abortion			

Please answer by Yes, No or N/A

		Yes	No	N/A
1.	Are you currently in a sexual relationship?			
2.	If yes, would you like to have more physical contact with him/her?			
3.	Do you talk about protecting yourselves with your partner before having sex?			
4.	Do you use any protection when you have sexual intercourse?			
5.	Have you had sexual intercourse with more than one person?			

6. State the age of your boyfriend.....

Section 3: Pregnancy Knowledge and Behaviors. Please indicate if you agree or disagree with the following statements.

		Agree	Disagree
1.	Washing the vagina after sex can prevent pregnancy.		
2.	Pregnancy cannot occur if a couple has sex while standing.		
3.	By having unprotected sex, you can get pregnant and HIV at the same time.		
4.	Birth control methods also prevent one from getting infected with HIV.		
5.	There are very limited chances of getting pregnant and HIV after one act of unprotected sex.		

6.	Pregnancy is something that should be planned.		
7.	Using birth control while still young is morally wrong.		
8.	Getting pregnant is a risk that you have to take to enjoy sex.		
9.	You can enjoy each other's body without sexual intercourse.		
10.	The only way to completely prevent pregnancy is by not having sex.		

Section 4.HIV/AIDS. Please indicate whether you think each of the following statements is true or false, or if you do not know.

		True	False	Don't Know
1.	Only people who look sick can spread the HIV/AIDS virus.			
2.	You can become infected with HIV by having unprotected oral sex.			
3.	There is no cure for AIDS.			
4.	Young people under the age of 17 need their parents' permission to get an HIV test.			
5.	Having another sexually transmitted disease like gonorrhoea or herpes increases a person's risk of becoming infected with HIV.			
6.	Sharing intravenous needles increases a person's risk of becoming infected with HIV.			

7.	Only people who have sex with gay (homosexual) people get HIV/AIDS.			
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Section 5.

About the future: Think about the future and answer the following questions.

		Extremely important	Important	Very important	Somewhat important
1.	How important is it to you to graduate high school?				
2.	How important is it for you to get training to get the kind of job you want?				
3.	How important is it to you to graduate, have a job before getting pregnant?				

Section 6: Answer the following using your own words.

1. Do you think it is sensible to fall pregnant while still at school? Give reasons for your answer.....

2. What do you think are the consequences of having unprotected sex?

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3. How will the consequences affect your life now and in future?

.....

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.....

4. Have you had anyone at your school/ community or friend who has been pregnant before matriculating?

YES	NO
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What issues did this person face?

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