

# **A qualitative study of early childbearing: Experiences of black women in a South African Township**

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## **ABSTRACT**

For more than 30 years the topic has increasingly received global attention in developed and developing countries. The findings of teenage pregnancy statistics have highlighted a concern for young women entering puberty. Negative outcomes associated with early sexual debut threaten the reproductive health outcomes of young girls. In South Africa, early childbearing has been identified as a challenge facing the country. Studies globally have shown a higher fertility rate amongst teenagers compared to other age groups. The aim of this study is to shed more insights into the factors influencing early childbearing among young Black women aged 18 to 24 years in a South African township. For this study, data was obtained from face to face in-depth interviews. The in-depth interviews were held with 10 black females from Mpumalanga Township, Hammarsdale, KwaZulu Natal. The findings of the study indicate that limited information on pregnancy prevention methods plays a role in influencing early childbearing. In addition, young women complained about the poor interpersonal relations with healthcare providers. Despite participants' emphasis on education, stigma and discrimination continue to pose a challenge in society. Lack of knowledge of prevention methods contribute to early pregnancy. The study suggests the need for youth-friendly interventions to increase family planning use among young people. The study recommends that schools and community plays a significant role in assisting young women with children. The involvement of schools and community is essential to curb early childbearing and this is also likely to influence individual's sexual and reproductive health decision-making.

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## **ACROYNMS AND ABBREVIATIONS**

AIDS –	Acquired Immune Deficiency Syndrome
ASFR-	Age Specific Fertility Rate
CSG –	Child Support Grant
FET -	Further Education and Training
HIV –	Human Immune-deficiency Virus
HSRC -	Human Science Resource Council
IUCD -	Intrauterine Contraceptive Device
KZN -	KwaZulu-Natal
LO –	Life Orientation
MAP –	Morning after Pill
SADHS –	South African Demographic Health Survey
SRH -	Sexual and Reproductive Health
STDs –	Sexual Transmitted Diseases
STIs –	Sexual Transmitted Infections
SES –	Socio-economic status
Stats SA -	Statistics South Africa
TFR -	Total Fertility Rate
UNPF-	United Nations
UNPF-	United Nations Population Fund
WHO –	World Health Organization

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# **Chapter 1**

## **Introduction**

### **1.1 Background of the study**

Teenage pregnancy has received substantial attention over the past few decades. This interest has been partly prompted by the wide range of health and social outcomes associated with teenage pregnancy. Globally, the interest in teenage pregnancy has been influenced by the increase in fertility levels among young women. Fertility can be viewed as either a life-course phenomenon of women over their reproductive careers or as behaviour within a specific interval (Hirschman, 1994:205).

In the 1990s, the total fertility rate (TFR) ranged from 2,5 to 5,5 births per woman in all parts of the world and has been steadily declining in all major regions of the world (Casterline, 2001:18). However, the fertility decline is much slower in Africa. In other parts of the world like England, Finland, Norway and Denmark the fertility transition began earlier than in Africa (Hirschman, 1994). Childbearing in these countries is low, which is evident in the TFR. TFR refers to the total fertility rate, and is equal to the number of births a woman would have at the end of her reproductive years if she were to bear children (Bongaarts, 1978). Bongaarts (2002) notes that in the late 1950s and early 1960s, European TFRs were an average of 2,8 children per woman. A decade later, rapid fertility declines occurred and the fertility rate had fallen below the replacement level of 1,91 children per woman. In the late 1990s, TFR decreased by 44% from 2,8 to 1,5 children per woman (Bongaarts, 2002). European fertility trends are low and if they remain constant, the population of European countries will decrease (Hirschman, 1994). In many parts of the world, fertility is declining, but early childbearing remains common.

Teenage pregnancy is a global social phenomenon, affecting both developing and developed countries (Beainger et al., 2007). For the past 20 years, teenage pregnancy in the United States has been a serious problem and about 10% of 15- to 19-year-old females become pregnant each year; and 40% become pregnant before they turn 20 (Kirby, 1999). During the past two decades fertility in developing countries has been observed to be declining (Kaufman et al., 2001).

Between the early 1970s and 1980s, fertility declined significantly in the developing world. In some sub-Saharan African countries, the number of adolescents giving birth has declined but remains relatively high (Ogana, 2006). Studies suggest that in the past three decades, sub-Saharan African countries have the highest level of adolescent childbearing, with more than 52% of young women having given birth (WHO, 2007). Statistics indicate that about one-fifth of young women in Namibia have given birth by the age of 20 (WHO, 2007). WHO (2007) indicates that similar trends are shown in countries like the Democratic Republic of the Congo (DRC), Niger and Somalia. In South Africa, more than half of women have given birth before the age of 20, and studies have shown that fertility rates increase among teenage girls aged 15 to 19 years and young women aged 20 to 24 years (Kaufman et al., 2001).

There is increasing evidence that in developing countries childbearing begins during the adolescent years. Globally, from 1995 to 2000 women between the ages of 15 to 19 years are estimated to have given birth each year, with most of these births occurring in developing countries (WHO, 2007). From 2010 to 2030, the number of countries with more than 5 million adolescent girls who gave birth are projected to increase from 16 to 18 (WHO, 2007; Panday et al., 2009:27). The number of sub-Saharan African countries with more than 5 million will double from 3 to 6 (Loaiza and Liang, 2013). The number of countries with more than 2,5 million will increase from 32 to 44. In percentage terms, 8 of the 9 countries to see an increase of over 70% of the adolescent girl population are in sub-Saharan Africa: Niger (101%), Zambia (99%), Malawi (93%), United Republic of Tanzania (90%), Rwanda (78%), Mali (75%), Uganda (75%) and Burkina Faso (74%) (Loaiza and Liang, 2013:9).

While studies have shown that in some developing countries the average age at first birth is 20 years, WHO (2007) indicates that in the Eastern Mediterranean region, for example in Bahrain, approximately 20% of young women have given birth by the age of 15 years of age. In the context of Southern African countries, in countries like South Africa, Lesotho and Zimbabwe there has been a steady fertility decline (Chimere-Dan, 1996). South Africa's fertility rate is considered to be the lowest in sub-Saharan Africa. According to SADHS 1999 report, , more than 40% of young South African women had given birth before reaching the age of 20 years . Kaufman et al. (2001) argue that early childbearing levels do not appear to be changing and

remain high. Moreover, early childbearing among teenagers has been the subject of substantial debate in social sciences research (Panday et al., 2009: 21).

Blanc and Way (1998) observe that girls are increasingly having children outside of marriage. In Kenya, Rwanda, Senegal, and Zambia, the proportion of women aged 40 to 44 engaging in sexual activities is at least 30% lower compared to women aged 20 to 24 years and younger (Nour, 2006). At a global level, more than 9 out of 10 adolescents are currently not married. Many more young girls are engaging in premarital sexual intercourse and having children, accounting for 16% in the developing countries and 3% in developed countries (Loaiza & Liang, 2013). According to Loaiza and Liang (2013), this distribution is even more extreme in South Asia, where 25% of female adolescents versus 5% of male adolescents are already married and West and Central Africa, where the figures are 28% and 2% respectively. Percentages shrink in East Asia and the Pacific to 5% and 2% respectively.

In sub-Saharan Africa, for example, a study conducted by Haruna and Ibrahim (2014) indicates that 11 countries – Cote D’Ivoire, Ghana, Kenya, Madagascar, Mali, Mozambique, Senegal, Tanzania, Uganda, Zambia, and Zimbabwe – showed that at least half the young women have had premarital sex before age 18 (Haruna, and Ibrahim, 2014). Country-specific data indicates that in countries like Senegal and Zimbabwe less than 10% of single women have had premarital sexual intercourse. In ‘Cote D’Ivoire 45% are sexually experienced; while in Zambia 31% of young women aged 15 to 19 years are single and sexually experienced’ (Haruna, and Ibrahim, 2014:71). According to Haruna and Ibrahim (2014), in Kenya and Zambia for example, boys are more likely than girls to report having had sex before age 15. In another study in Bangladesh, only 3 girls and 17 boys from a sample of 2 600 unmarried adolescents reported that they had sex (Nour, 2006).

Teenage fertility rates seem to be significantly higher in developing regions such as Latin America, Asia and sub-Saharan Africa. However, statistics from the United States of America and the United Kingdom suggest their teenage fertility rates are similar to those of developing countries (MacLoed, 1999; Seamark and Lings, 2004). WHO (2007) suggests that teenage childbearing occurs in every society. In some

societies young girls are forced into marriage and expected to begin childbearing during their adolescence (WHO, 2007:7). Childbearing is seen and considered the norm in marriage; a woman has to prove her fertility (WHO, 2007; Kaufman et al., 2001). Manzini (2001) suggests that worldwide, women are increasingly becoming sexually active at an early age and many are engaging in unprotected sexual activity. Unsafe sexual behaviours carry the risk not only of HIV and sexually transmitted infections (STIs), but also of pregnancy for females (Hallman, 2004). Despite widespread social changes regarding women's fertility that have occurred over the past three decades, levels of pregnancy among young people have remained relatively high in developing countries (Hockaday et al., 2000).

Rates of teenage pregnancy vary widely and are the highest in more deprived areas. There are also variations between outcomes of the pregnancies, with more 'women in poorer socio-economic situations continuing with the pregnancy' (Seamark and Lings, 2004:813). South Africa is confronted with an escalating epidemic of teenage pregnancies (Kirby, 2009; Panday et al., 2009). Progress has been made in reducing teenage pregnancy rates since the democratic government came into power, but it still remains high.

South Africa's fertility varies substantially by province and is shown to be significantly different according to each province (Chimere-Dan, 2008). Teenage fertility rates among 15 to 19-year-olds are higher in KwaZulu-Natal, Mpumalanga, the Northern Cape, Limpopo and the Eastern Cape and lower in the Free State, Gauteng and North West (Panday et al., 2009; SADHS, 1998). Fertility is lower in Gauteng than in KwaZulu-Natal. In less developed provinces, teenage pregnancy rates are higher compared to more developed provinces. According to Panday et al. (2009), the lower fertility rate is associated with the higher levels of economic development, better access to education as well as greater contraceptive use. In South Africa and other developing countries, research has been undertaken to identify causes of teenage pregnancy and suggest possible solutions to this problem (Jewell et al., 2000). Furthermore, studies have contributed immensely in understanding this challenge facing the country.

South Africa's history of racial classification was accompanied by gross inequalities in access to education and economic opportunities as well as health services. This is also reflected in the high teenage fertility rates (Panday et al., 2009). Between 1996 to 2001 teenage pregnancy rates among 15 to 19-year-olds decreased in all population groups. Among the white population the teenage pregnancy rate declined by 28,8%, followed by a decline of 16,8% among blacks, 12,7% among Coloureds and 7,8% among Indians (Panday et al., 2009).

It is important to note that although the teenage pregnancy rate among the black population has declined, the fertility rate among this racial group is still high. Studies suggest that the black population has a high rate of young people falling pregnant at an early age (Manzini, 2001; Makiwane, 1998). Some studies suggest that the low socio-economic status and poor social environment the young black female comes from contribute to early childbearing (Hallman, 2004; Grant & Hallman, 2006). Although it has been established that early childbearing occurs among all four races, Panday et al. (2009) found that females aged between 17 and 19 years have higher pregnancy rates than other age groups. This accounts for 71 births per 1 000 among Blacks, 60 births per 1 000 among Coloureds, 14 per 1 000 births among whites and 22 births per 1 000 among Indians.

To date little attention has focused on the implications of the pregnancy for the young mothers. Women who become pregnant during their teenage years may well experience an interruption of their education. In addition, early pregnancy may cause health risks, which prevent girls from continuing with their education. Consequently, these young women face a bleak future (Manzini, 2001). Biologically, a young woman's body at the age of 15 years is still physiologically immature to carry a child (WHO, 2007).

Early childbearing is likely to have negative implications for the mother and the child. It has becoming increasingly clear that a young mother faces challenges not only because of being a mother, but also as a result of her age at first pregnancy. According to Seamarks and Lings (2004), negative outcomes such as poverty and deprivation attributed to the mother's age are as much causes and correlates of teenage pregnancy as effects. In the case of South Africa, for example, teenagers living in townships,

which refer to African communities that the apartheid government forcefully removed from state-owned areas to the periphery of the city, experience the effects of poverty and deprivation (Ndimande, 2012).

The focus on teenage pregnancy leads to an understanding of the underlying dynamics of the effects of early childbearing on women. In their study using focus group discussions in a peri-urban setting, Kaufman et al. (2001) found that teenage parents and their children face economic and social uncertainty. Many of the children are born into conditions of limited resources. According to Makiwane (1998) & Jewkes et al., (2001), pre-marital childbearing has become socially accepted; and 35% of teenagers have been pregnant or have a child by the age of 20. Kaufman et al. (2001) and Makiwane (1998) suggest that although early childbearing is not embraced socially, it is accepted.

Early childbearing poses numerous challenges and requires many compromises (Kaufman et al., 2001:158). Teenage pregnancy often occurs in females who are still at school, which is viewed as a major problem. An early pregnancy can alter the entire future of a young woman. In some instances, those who are still in school often experience poor scholastic performance. The consequences of young women having their first child during their teenage years are detrimental. Moreover, high rates of early childbearing among teenagers may in turn have drastic impacts on their socio-economic status.

## **1.2 Early childbearing**

The term *adolescence* is rooted in the Latin word *adolescere*, which means to grow to maturity (Everaerd, Hindley, Bot, & Van der Werff, 1983; Hurlock, 1973). In this study, the terms adolescents and teenagers are used interchangeably. Adolescence is a period of transition between childhood and adulthood. The terms ‘youth’ and ‘young adult’ cannot be divorced from the dynamic concept of adolescence. The concept refers to the ages of 15 to 24 years and encompasses different experiences (Dehne & Rieder, 2001:11). According to WHO (1995) and Dehne and Riedner (2001:11), adolescence is commonly associated with the physiological changes occurring with the progression from puberty to sexual and reproductive maturity.

In most societies childbearing is problematic. Nonetheless, early adolescence childbearing is a great concern for all societies. The adolescent years of a child commence from the ages of 10 till 19 years (Phipps & Sowers, 2002; Manzini 2001). Meanwhile WHO (2007) and Manzini (2001) suggest that early childbearing appears to start among girls aged 15 to 19 years. This age group is more vulnerable to 'risky sexual behaviours that often co-exist with other problem behaviours such as delinquent behaviour during adolescence' (Kotchick, Shaffer & Forehan, 2001: 503).

Studies show that there are risks associated with early childbearing. For the purpose of this study the focus is on young black African women aged 18 to 24 years who fell pregnant in their adolescence. A young person is a person who faces a range of life events and makes decisions that can impact on their immediate and longer-term health and wellbeing (WHO, 2012 & Hopkins et al., 2014). Some of these include decisions on schooling and career paths, relationships with families and peers, sexual behaviours, employment, financial decisions and contact with drugs, alcohol or the justice system (Hopkins et al., 2014:26).

Despite the high prevalence of early childbearing in South Africa and other developing countries, a large number of young women on average have had their first child by age 20 (Kaufman, 1997). Marteleto, Lam and Ranchood (2006) assert that early childbearing among young girls while still at school does not predict an end to their education. Young girls giving birth while in school are just as likely to finish school as those who do not. However, Black and Coloured girls are less likely to return to school after giving birth than White girls. Nonetheless, girls are more likely to enter and finish school than boys. In South Africa girls return to complete their schooling after giving birth, and it is a function of support from the girl's family and paternal recognition (Kaufman et al., 2001; Marteleto, Lam & Ranchood, 2006).

### **1.3 Rationale for the study**

The alarming teenage pregnancy rate among young black women in South Africa is the main reason for this research (Kotchick, Shaffer and Forehand, 2001). The total fertility rate is the highest among black women compared with other racial groups. Young people experience socio-economic pressures that ultimately result in an early pregnancy. Studies suggest that young women who are in their reproductive years and



who come from disadvantaged social environments are more likely to experience early childbearing (Panday et al., 2009: 71). Since the apartheid era, the fertility of the black population has remained higher than that of other racial groups. The survey also found that the TFR for black women is 2,27 children per woman, 2,33 for Coloureds, 1,4 for Indian or Asians and 1,45 for whites (Statistics South Africa, 2007). According to Chimere-Dan (1994), apartheid policies caused racial segregation prior to the early 1990s; hence they had an impact on socio-economic factors which resulted in sub-group differences in fertility. This study will therefore focus on one group that has a high fertility rate.

The overall aim of this study is to shed more light on the factors influencing early childbearing among young black women. The specific objectives of the study are to:

- ascertain attitudes to early childbearing
- determine the factors that contribute to early pregnancy
- investigate the opportunities and challenges in preventing early childbearing

The study used qualitative data from in-depth interviews with young mothers in Mpumalanga Township, Hammarsdale. The sample population consists of 10 black mothers who live in Mpumalanga Township, Hammarsdale. The findings draw from the one-on-one interviews to gain insight into the experiences of early pregnancies.

#### **1.4 Theoretical framework**

South Africa's fertility rate has remained relatively high among teenagers, which is a matter of great concern. The study will make use of the framework developed by Hallman (2004). The conceptual framework was developed on the basis of an extensive review of literature from a variety of disciplines that examine risky sexual behaviour among young women and men. These 'disciplines include sociology, demography, economics, political economy, epidemiology, psychology, and anthropology, both globally and from South Africa' (Hallman, 2004:8).

The perspective explains the socio-economic factors that influence early childbearing. Hallman (2004) also considers exogenous factors, namely the society, the community and the household, which often influence individual's behaviour and outcomes. Societal factors include the social, economic and political structure, culture and policies. Community factors include peer influences, school environment and health services. Household factors include household assets and structure and other models that view sexual behaviour as determined by individual health beliefs and perceptions (Hallman, 2004).

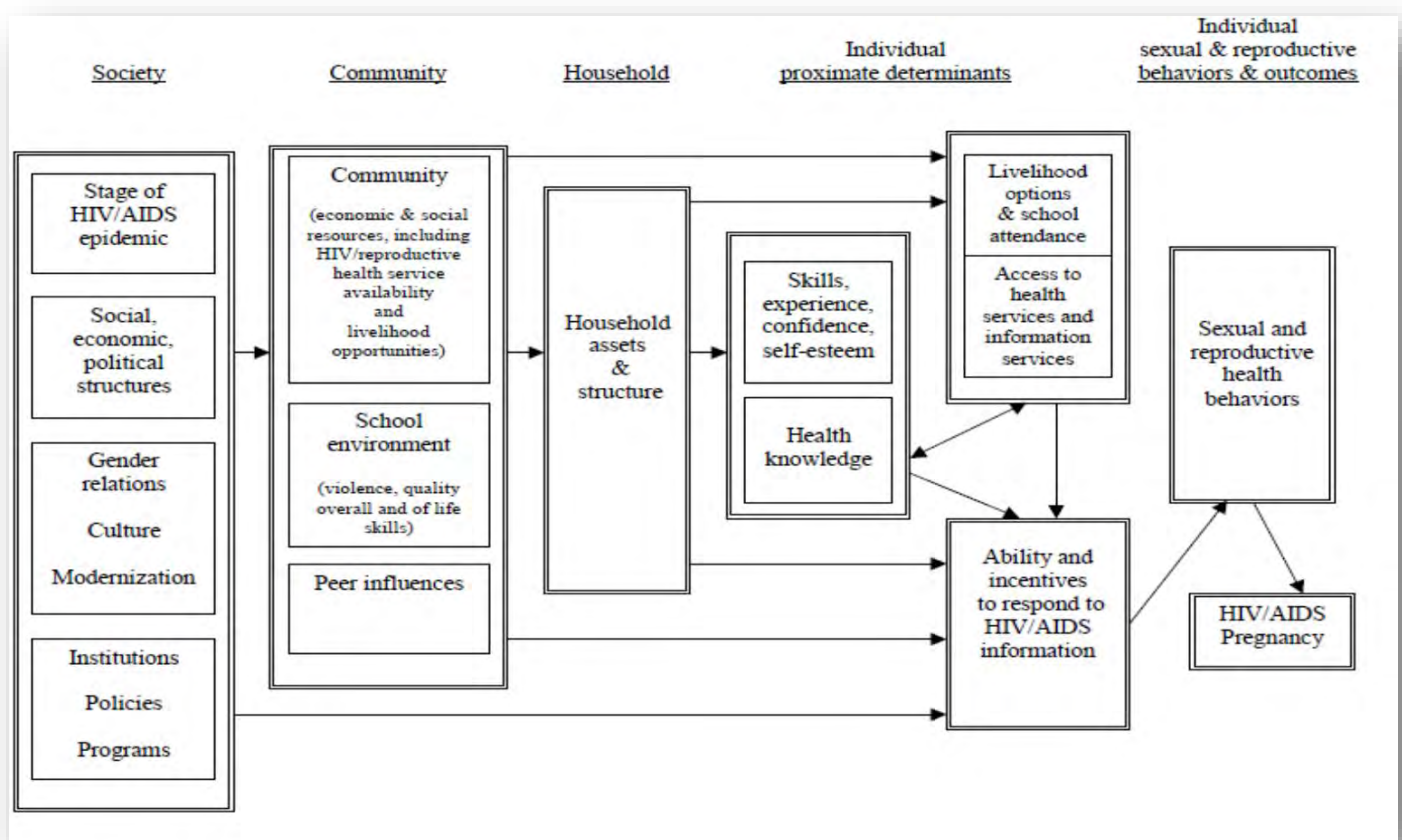
The framework looks at the 'individual proximate determinants, which include their experiences, attitudes, self-efficacy, skills and enrolment in school, which affect sexual and reproductive behaviour and access to health services' (Hallman, 2004:9). Moreover, the perspective recognises the relationship between individual's proximate determinants that influences the exogenous factors mentioned above. Hallman (2004) notes that livelihood activities may raise skills and experience, while school enrolment may increase health knowledge about sexual behaviours. Some studies suggest that young people are not aware of the importance of preventative measures of pregnancy. However, Hallman (2004) postulates that even if young women and men know about risks of HIV, STI and unplanned pregnancy, they still engage in risky sexual behaviour. Often females are from impoverished areas, characterised by low levels of education and poor living conditions. According to Hallman (2004), there is an association between an individual's proximate determinants and the environment, i.e. exogenous factors.

Hallman's holistic conceptual framework is of interest to the study because it explains on how socio-economic factors influence decisions in engaging risky sexual behaviour. Unlike other frameworks' that view socio-economic factors as determinant of early childbearing; Hallman's framework recognises influences of society, community and household. In addition, the framework observes that sexual and reproductive behaviour is influenced by an individual's self-esteem, skills, experience, confidence and school attendance. Moreover, an individual's behaviour is influenced by the environment in which they live. The decisions, knowledge and skills of the individual are influenced by the environment. These factors influence the risky sexual behaviour of young women and men that results in childbearing at a

young age. Young people from impoverished backgrounds are more prone to risky sexual engagement and behaviour.

Nonetheless, Hallman's (2004) conceptual framework provides a multidimensional explanation of high pregnancy and early childbearing rates among the disadvantaged individuals. Therefore Hallman's explanation gives a clear reasoning as to factors associated with early childbearing in young girls.

**Figure 1.1: Hallman's conceptual framework**



Source: Hallman (2004).

## 1.5 Organisation of chapters

This dissertation is divided into five chapters. Chapter one provides a background and rationale of the study in great detail and also outlines the conceptual framework. It discusses the global fertility transition and levels of fertility in the South African context. Chapter two reviews relevant national and international literature and

outlines factors and consequences of early childbearing. Chapter three discusses the study methodology, which includes the study location, research methodology and instruments used for data collection, and analysis. It also looks at ethical considerations and limitations of the study. Chapter four summarises the main findings of the interviews that were conducted with the women. The final chapter provides a discussion of the main findings and looks at the implications of the findings of the study, and also makes recommendations.

## **Chapter 2**

### **Literature review**

#### **2.1 Introduction**

Teenage pregnancy has been the focus of much research in developed and developing countries. In developed countries such as the United States of America, the United Kingdom and Ireland, this social phenomenon is also seen a huge problem given the high rate of teenage pregnancies (Maseko, 2003). This chapter reviews previous studies on the cause of teenage or early pregnancies, their main determinants and consequences.

#### **2.2 Trends of fertility in South Africa**

In the past five decades 'South Africa's fertility rates have been steadily declining compared to other sub-Saharan African countries' (Panday et al., 2009:11). According to the South African Demographic and Health Survey (SADHS), in 1999 the TFR for girls aged 15 to 19 years was 2,9, in 2003 it declined to 2,0. Studies suggest that it is evident that fertility rates among young women in their teenage years are decreasing slightly (Kaufman et al., 2001; Panday et al., 2009). Part of the slow decline in South Africa's fertility rates among teenage girls is the interruption of schooling during the struggle years, which was associated with the rise in teenage fertility (Panday et al., 2009)

Despite the decreasing fertility trends in South Africa, there are variations in fertility rates across the different population groups (Chimere-Dan, 2008). In the early 1990s the white population experienced a decline in fertility in the TFR from 3,3 to 1,9 (Makiwane, Palamuleni & Kalule-Sabiti, 2007). The Asian population also experienced a fertility decline from TFR of 6 to 2,7. Fertility for the Coloured population also decreased from TFR of 6,5 to 3. In the mid-1990s, the African population was estimated to be 75% of the total population (Chimere-Dan, 2008). The TFR for this population declined from 6,6 to 4,5 since the 1960s (Makiwane, Palamuleni & Kalule-Sabiti, 2007).

The fertility of the African population seems to be decreasing more slowly than for the other population groups. This is probably a direct result of the socio-economic conditions in which they find themselves (Makiwane, Palamuleni & Kalule-Sabiti, 2007:113). Apartheid policies favoured the minority white population, which enjoyed better living conditions and opportunities compared to other racial groups (Hirschman, 1994). Studies suggest that globally, differences in fertility rates between populations groups are a persistent social concern (Makiwane, Palamuleni & Kalule-Sabiti, 2007; Seamark & Lings, 2004). On the other hand, research indicates that the differences in fertility rates among population groups is influenced by the wide variation in the social conditions under which young people grow up, related to disruptions of family structure, inequitable access to education and health services, as well as the concentration of poverty and unemployment in black and Coloured communities (Panday et al., 2009; Hallman, 2004).

### **2.3 Age at first sexual debut**

Many studies in South Africa and elsewhere in Africa are finding that young people are increasingly engaging in sexual activity at an early age (Maharaj & Munthre, 2007:231). Age at first sexual encounter is important because it usually signals the beginning of exposure to the risk of pregnancy and STIs, including HIV and AIDS (Maharaj & Munthre, 2007; Manzini, 2001). In addition, studies globally have shown that young people are engaging in risky sexual behaviour (Biglan et al., 2001; Gage, 1998). Risky sexual behaviour appears at younger ages among teenagers, where sexual debut is often unprotected.

Risky sexual behaviour refers to any sexual activity that brings a person into contact with semen, blood, or vaginal secretions of a person infected with HIV, and that puts that person at risk of HIV infection (Manzini 2001; Biglan et al., 2001; Jewkes et al., 2001). In most cases, it is usually associated with lack of adequate knowledge, with the teenager being uninformed about the consequences of unprotected sexual behaviour. Studies have also shown that the first sexual debut starts in the mid-teen years, with girls engaging in sexual intercourse with older partners (Manzini, 2001; Brown et al., 2005; Wood & Jewkes, 1997). Scholars emphasise that the average age in South Africa for a first sexual debut is 15 years for boys and 14 years for girls

(Jewkes et al., 2001; MacLoed, 1999; Manzini, 2001). However, age at sexual debut differs from society to society.

Hallman (2004) asserts that around the world one-fifth of young women's sexual debut is forced. Young girls having sex with older partners are at higher risk of unplanned pregnancies and it usually signals the beginning of exposure to the risk of pregnancy and STIs, including HIV and AIDS (Manzini, 2001; Maharaj & Munthre, 2007). According to Heise et al. (1995), cited in Maharaj and Munthre (2007), sexual coercion refers to a range of experiences, all of which compel a person to have sex against their will. Moreover, studies suggest that the age differences between teenage girls and their partners inhibit girls' ability to negotiate safer sex (Manzini, 2001:49). An estimated 30% of teenage girls between the ages 15 to 19 years engage in non-consensual sexual intercourse (Hallman, 2004). Often the partners of teenage girls are older, and such a sexual dynamic reinforces unequal gender relations and result in unplanned early childbearing (Hallman 2004; Manzini 2001; Varga, 2003). Some studies suggest that age at sexual debut for teenagers is the same for both pregnant and non-pregnant girls (Hockaday et al., 2000:425).

Manzini (2001) asserts that sexual activity starts at an early age in South Africa and when sexual encounters begin at an early age it generally continues. Therefore, when an unprotected first sexual encounter begins, it carries the risk of early childbearing and an unplanned pregnancy (Marteleto, Lam & Ranchhood, 2008).

## **2.4 Role of education in delaying early childbearing**

Education plays a vital role in child development and can be positively associated with delays in childbearing. Numerous studies suggest that educated women delay childbirth (Kaufman et al., 2001; Caldwell, Orubuloye & Caldwell, 1992). This is supported by Bongaarts, Frank and Lesthaeghe (1984), who emphasise that women with at least primary education generally have reduced levels of fertility, compared to those with lower levels or no education. Women who have at least some schooling (primary, secondary, and tertiary) have more access to information compared to those with no education. Moreover, the authors suggest that educated women have more access to family-planning and health services (Bongaarts, Frank & Lesthaeghe 1984).

Most young women know about contraception, yet they lack sufficient information about how to use them effectively (Manzini, 2001). Research indicates that women with no or low educational attainment are less likely to know and use contraceptives than other women (Bongaarts, Frank & Lesthaghe, 1984:535). Education is fundamental for a young person, as it equips them for the future when facing challenges in their social lives (Govender, 2011). In addition, it provides them with the awareness of the risks associated with unprotected sexual behaviour, which is essential information in combating unplanned teenage pregnancies (Martelelto, Lam & Ranchhood, 2008).

Manzini (2001) points out that sex education is important in schools to delay an early sexual debut which contributes to early pregnancy among young people. Teenage girls who complete their schooling are able to make rational decisions about their sexual behaviour and delay pregnancy (Manzini, 2001; Govender, 2011; Panday et al., 2009). In addition, girls who have been in school make decisions to not only delay pregnancy but to delay their sexual debut. As such, sexually active girls take precautions and thus are able to protect themselves (Panday et al., 2009). In the case of South Africa, a girl can attend school while pregnant and continue schooling after having given birth.

Studies have indicated that sex education is imperative in the curriculum as it introduces the topic of sexuality, delays an early sexual debut and promotes safer sex. However, an early pregnancy may result in interruption of education, absenteeism from school and time spent on antenatal care visits. The burden of motherhood are intensive and teenage girls are less likely to return to school during pregnancy and/or after childbirth.

Education incorporates schooling, sex education and future aspirations. According to Basch (2011), collectively the studies provide compelling evidence that comprehensive sex education (i.e. including education about both abstinence and contraception) results in delayed initiation of and frequency of sex, reduced number of partners and increased contraceptive use.



## **2.5 Attitudes to early childbearing**

Teenagers often hold positive attitudes towards early childbearing. They tend to perceive children as a demonstration of love, maturity and womanhood (Wood & Jewkes, 1997; Panday et al., 2009). Some teenage girls often assume the child will build a stronger relationship with the father of the child. Research has shown that some teenagers fall pregnant intentionally to gain the respect of their partner and father of their child (Panday et al., 2009).

In a study on attitudes towards early childbearing, Groat et al. (1997) found that among young women, there is a significant difference between the white and black population regarding childbearing. Black teenagers who were 18 years and younger felt regret at having a child at an early age. The authors observed that there were few who felt their first child was a blessing compared to the majority who felt regret at having a child at a young age (Groat et al., 1997; Dlamini & van der Merwe, 2002). This study observed that the white population found children to be more rewarding than the black population.

A study conducted by Preston-Whyte et al. (1990) found that black teenagers experience more severe repercussions of pregnancy compared to other races. Parents get angry and emotional pressure is experienced by the young mother. During the course of the pregnancy she would be neglected and parents would show no interest in her due to her behaviour. She might be scolded and thrown out of her home, which are some of the reasons why teenage mothers opt for abortion. As Groat et al. (1997) indicate, for many black teenagers pregnancy is often a mistake and not intended.

Furthermore the authors indicate that 'children outside marriage are a common place occurrence in black families' (Preston-Whyte, 1988:14). Preston-Whyte et al. (1990) also argue that teenage pregnancy is a fairly typical stage in the domestic cycle of most families. The pregnancy often leads to the breakdown of the family. Pregnancy is an event that parents dread, but cope with when it occurs (Preston-Whyte et al., 1990; Wood & Jewkes, 1998). As Preston-Whyte, Zondi and others have observed, in the black community it is not condemned. Black families cope with the repercussions of teenage pregnancies. Young mothers are likely to return to school and even aspire

to get married if they find a potential man to marry them (Preston-Whyte, 1988; Preston-Whyte et al., 1990).

## **2.6 Determinants of early childbearing**

### **2.6.1 Culture**

Little research has been done globally to review the relationship between culture and early childbearing. Culture is a complex concept to define, as it refers to beliefs, values, logic and decision-making from learned behaviour acquired through socialisation (Gong, Li & Stump, 2007). Culture can be defined as social habits and behaviours that are passed on from generation to generation (Gangadharan & Maitra, 2001). Culture dictates how women and men should behave, the timing of pregnancy and the number of children they should have. These views ignore some of the factors contributing to early childbearing and the consequences for the mothers.

Studies conducted in sub-Saharan Africa suggest that culture plays a role in early childbearing. In some cultures young girls are reared at a young age to fall pregnant in order to demonstrate their womanhood (Nour, 2006; Gong, Li & Stump 2007). It has been indicated that early pregnancies among teenagers is influenced by the socio-economic context of an individual. Mkhwanazi (2010) and Preston-Whyte (1988) suggest that early childbearing presents a route of upward mobility, which influences culture. This is because of the high cultural value placed on childbearing. Childbearing is a major component of femininity and is a way for a teenage girl to show that she is fertile and to demonstrate her womanhood (Mkhwanazi, 2010:348). In some societies, cultural dimensions and values are deeply embedded in community values (Dlamini & Van der Merwe, 2002).

### **2.6.2 Parent-child-communication**

Communication about sex as a means of promoting safer sex is especially important for teenagers (Whitaker et al., 1999). Parent-child sexuality communication has been identified as a protective factor against negative reproductive health outcomes (Bastien, Kajula & Muhwezi, 2011:1). However, the topic of sex is not discussed openly. This creates a general reluctance among girls and boys to address certain issues with parents.

Research has indicated that among African families issues such as sexuality, human reproduction and unmarried teenage motherhood are usually viewed as sensitive issues 'belonging to the private domain' (Dlamini & Van der Merwe, 2002:53). A study in Nigeria conducted by Bastien, Kajula and Muhwezi (2011) indicates that 30% of teenagers reported seeking information about sexual matters from their parents. The study also found there was significant relationship between the source of information and sexual experience; a greater portion of teenagers received sex information from peers than from parents (Bastien, Kajula & Muhwezi, 2011:8). In other parts of Africa, research shows that in Burkina Faso, Ghana, Malawi and Uganda, while the proportion of adolescents reporting having discussed sex-related matters with their parents was low (between 8% and 38%), the proportion reporting communication about contraceptives was even lower (10%) (Nour, 2006; Bearinger et al. 2007; Bastien, Kajula & Muhwezi, 2011).

At home, sex education remains a taboo subject, as parents perceive it as promoting sexual activity at an early age (Biglan et al., 2001). Although parents are very supportive of sexual abstinence to prevent pregnancies, it is evident that young women are engaging in pre-marital sex. The previous generations were supportive of childbearing within marital relationships. Childbearing usually followed after marriage; and these values were prevalent and of importance to family values (Kaufman et al., 2001; Groat et al., 1997). In issues relating to sex, the [mis]conception that discussions of sex should be avoided between parents and children has an effect on the teenager's sexual behaviour. Children receive very basic information about puberty and about how to prevent pregnancy from their parents (Mkhwanazi, 2010).

In South Africa, pre-marital fertility and childbearing are high among black teenagers and young women. Panday et al. (2009) assert that pre-marital childbearing is not widely accepted in the black population group and remains stigmatised. However, studies suggest that the cultural value placed on childbearing has contributed to the 'non-use' of contraception, and as a result, high fertility levels among the youth of South Africa (Varga, 2003).

Parents may have negative attitudes about discussing sexual matters with their children. On the other hand, studies found that teenagers are not against parent-child communication on sexual matters. In fact, 'young people prefer communication to take place with the parent of the same sex' (Varga, 2003; Mkhize, 2007; Bastien, Kajula & Muhwezi, 2011:9). In South Africa, findings show that teenage girls prefer 'discussing sexuality issues with their mothers rather than their fathers; (Bastien, Kajula & Muhwezi, 2011: 9).

Issues of sexuality in some communities remain in the private domain. Adults are 'entitled' to talk about 'sex' but not to young women and men. Biglan et al. (1998) declare that issues of sexuality are a taboo subject in communities and young people who raise the topic are subject to stigma and discrimination. Therefore, young people are not being provided with adequate information on sexuality, which places them at risk.

A risk factor also identified by Biglan et al. (1998) is that young people experience risky behaviours. The authors indicate that there are still young people in South Africa who do not know how pregnancy occurs, which could explain the high levels of unwanted pregnancies (Biglan et al., 1998). Besides early parenthood, what also has been a concern among black parents is no communication or limited communication about sex. Even though some teenagers would appreciate more discussion about sex with their parents, parents avoid parent-to-child communication regarding sexual matters. It signifies lack of respect to parents and a challenge to parental authority. Fearing punitive responses, young people would rather not discuss sex with their parents (Mkhize, 2007). Research shows that 'parents upholding the ideal of not talking to children create fertile ground for a teenage pregnancy to occur' (Mkhwanazi, 2010:365). One study suggests that some parents seem to 'turn a blind eye to the probability that their children are having full sexual relations before marriage and at school' (Preston-Whyte et al., 1998: 19).

### **2.6.3 Marital status**

The United Nations (UN) declares that 'any country that allows child marriage is committing a violation of human rights' (Nour, 2006: 1644). Child marriage refers to marriage of a child below 18 years of age (Nour, 2006: 1644). According to Nour

(2006), globally in 2002, an estimated 25 000 persons younger than 18 years were married each day. The author also indicates that almost half the young people (especially girls) aged 15 to 24 years in South Asia are married before reaching the age of 24, and the percentage of girls married before 20 in Niger is 77%, in Chad 71%, and in Cameroon 61% (Nour, 2006). In many other countries, marriages are arranged between families without the consent of the young woman (Nour, 2006:1646). Nour (2006) points out that parents want financial security for their daughters. In some parts of the world, daughters are considered an economic burden.

The institution of marriage allows women to prove their womanhood to their husbands and in-laws by demonstrating their fertility and marriage is one of the proximate determinants of fertility (Bongaarts, 1982). According to Kaufman et al., (2001) marriage and pregnancy are closely related. In most African countries (including South Africa), payment of bride wealth is common. Bride wealth is the transfer of rights over the labour and potential childbearing capacity of a woman (Kaufman, et al., 2001:153; Nour, 2006:1645). Lobola in South Africa is an old marriage custom, a way of showing the girl's family respect, and is seen as joining two families.

In the African context, marriage that takes place at an early age often is a consequence of high fertility among women (Makiwane et al., 2007). Furthermore, women who marry late have on average shorter exposure to the chance of becoming pregnant. Although women can bear children within their reproductive ages from 15 to 49 years, marriage is associated with exposure to sexual activity (Manzini, 2001; Bongaarts, 1982). Bongaarts (1978) asserts that it is likely for women who are married to bear more children, compared to those who are not married. Age at first marriage for young women is on average similar to the age at first sexual intercourse.

WHO (2007), Bongaarts, Frank and Lesthaeghe (1984) and Kaufman et al. (2001) assert that young girls who marry on average below the age of 20 years are most vulnerable and are more likely to face the hardships of parenthood. Moreover, marriage signals the onset of women's exposure to childbearing (Makiwane, Palamuleni and Kalule-Sabiti 2007:125). Studies have shown that these young girls

have consequently missed the opportunity to experience childhood; to play, develop friendship bonds, become educated and build social skills (Nour, 2006: 1645).

In the context of South Africa, early marriage is often forced marriage, with a young girl often being forced to marry an older man. In the Zulu culture, forced marriage is called '*ukuthwala*'. The word *ukuthwala* means 'to carry'. This is a practice involving a culturally legitimate abduction of a woman before a customary marriage, with a young man forcibly taking a girl to his home (Mwambene & Sloth-Nielsen, 2010). This practice among the Nguni tribes (amaZulu and amaXhosa) has influenced early marriage among young girls. The young girl is too young to make conscious decisions about marriage and as a result she is exposed to sexual intercourse and childbearing at a young age. Early marriage and/or forced marriage increase the risk of girls engaging in sex at a young age with older and/or sexually experienced partners. Often, they are exposed to relationships with older men and other multiple partners and this increases the risk of HIV/AIDS and other infections (Mwambene & Sloth-Nielsen, 2010).

#### **2.6.4 Place of residence**

Research has found that women in rural areas, more especially black women, value tradition. Groat et al. (1997) articulate that rural women's total fertility rates are much higher than those of urban women's. Apart from that, studies have shown that a high teenage fertility rate is prevalent in both rural and urban settings (Skatrud, 1996; Hallman, 2004; Seamark & Lings, 2004). Kaufman and others have found that early childbearing is increasing in both areas (Kaufman et al., 2001). Traditionally, rural areas experienced high levels of teenagers falling pregnant because of rigid socio-cultural sex roles such as virginity testing for young girls to prevent girls falling pregnant (Scorgie, 2002). Panday et al. (2009) suggest that social change may have influenced views of women's fertility. However, Hallman (2004) also indicates that there is a relationship between social environment, traditional roles and women's fertility. Some scholars argue that fertility in rural areas is higher than in urban areas due to the health service provision (MacLoed, 2001). In rural areas, young, sexually active women have to travel long distances to clinics to access health services. On the other hand, urban girls avoid seeking health services even if it is provided (Kaufman et al., 2001; Panday et al., 2009; Nkwanyana, 2011). Studies have therefore shown

that there is no significant difference in teenage pregnancy rates in urban and rural settings.

#### **2.6.5 Socio-economic status**

Early childbearing is not uncommon among young women living in disadvantaged communities. Although risky sexual behaviour occurs among all age groups, young women from advantaged communities are more likely to have greater access to health services (Jewell, Tacchi & Donovan, 2000: 527). Young women from a disadvantaged background experience difficulties in accessing health services such as contraception and therefore opt for abortion to prevent early pregnancy (Maseko, 2003).

In South Africa, Craig and Richter-Strydom (1983), Hallman (2004) and Nkwanyana (2011) postulate that teenagers and young women who are from impoverished families and households are often exposed to risky sexual behaviour. Children from those circumstances also engage in risky sexual behaviour as soon as they enter adolescence (Dickson, 2004). Research also suggests that young people from impoverished societies have higher total fertility rates than those from less impoverished backgrounds (Hallman, 2004). Socio-economic status plays a vital role in contributing to early childbearing. Lack of opportunity has been the driving force of high fertility rates among young girls (Nkwanyana, 2011:15; Mchunu et al., 2012).

Sexual debut among women of all ages commence during teenage years, and high rates of fertility peak in their 20s after young people have experienced their sexual debut (Chimere-Dan, 2008). These rates are higher among the poor and disadvantaged – an important risk factor of early childbearing is low socio-economic status and poverty (Panday et al., 2009; Nkwanyana, 2011). Hallman (2004) declares that in South Africa, socio-economic status and poverty should not be divorced from each other. These issues are intertwined, which increases the risk of particularly females engaging in unsafe risky sexual behaviour. Poverty also raises young women's chances of experiencing coerced sex, both at sexual debut and during their lifetime. They also engage in transactional sex (Panday et al., 2009:27; Hallman, 2004: 23; Mchunu et al., 2012). Young women's low socio-economic status increases the lack of communication with their partner about safe-sex precautions and family-planning

alternatives. Low socio-economic status impacts the young woman in a number of ways such as access to family planning, information on sexual and reproductive issues and the range of contraceptive services. The notion of poverty is intriguing and has a great impact on the sexuality of young women.

#### **2.6.5.1 Lack of edutainment in townships**

Looking at the dynamics that young people experience in townships, the lack of recreational activities contributes to teenage pregnancies, especially unplanned pregnancies. In communities with high pregnancy levels, often pregnancy is seen as a negative event and girls are subject to stigma and discrimination. Being stigmatised and discriminated against during and after pregnancy impacts the women. As a result, they suffer from anxiety, fear, loneliness, which affects their academic performance and future aspirations. In the townships, early childbearing is rooted in the context where young people grew up – their family, partners, peers and community (Panday et al., 2009:80), as well as the social context of high levels of poverty, low-income households, and widespread unemployment.

A study conducted by Panday and others (2009) found that learners in KwaZulu-Natal's low-resourced schools were less likely to receive life-skills education than more resourced schools. As a result, they do not have access to information from a young age, especially at the crucial age of adolescence. Even with information and good communication skills, young people living in underprivileged settings may still be more likely to find themselves in situations that are conducive to high-risk behaviour (Hallman, 2004:25). Young people from poverty-stricken households and communities have less or limited access to information and services to prevent early pregnancy. Furthermore, early childbearing limits the opportunity of these young adolescents to escape the intergenerational cycle of poverty which has the tendency of perpetuating itself from generation to generation (Govender, 2011).

#### **2.6.7 Family structure**

Family structure has also been identified as a factor contributing to early pregnancies among teenagers. Family structure in this context refers to children living in households with one parent or no parents (Anderson, 2003:4). Thomas and McLanahan (2012) indicate that family structure was classically identified as married



parents with children. However, family settings have evolved over the years and more diverse types of family structure now occur, for instance stepparents, cohabitating parents, divorced-mother and never-married parent families.

McWhirter et al. (2003) and Hallman (2004) indicate that it is often seen as important for a young female to have strong communication with her mother, particularly during the period of adolescence. Miller (2010:25) argues that this delays sexual debut because there is the 'parent-child connectedness' – parental support, closeness and warmth, which are related to a lower pregnancy risk. Hallman (2004) argues that young girls who do not reside with their mothers have a reduced likelihood of discussing sexual topics with them.

Teenagers from one-parent-headed families and low income groups are more likely to suffer from deprivations that may lead them to seek affection, security and a sense of significance elsewhere (Maseko, 2003:17). This is particularly true for females. Early childbearing is associated with single-parent-headed households, often female, urban black, poor and uneducated (Grant & Hallman, 2006). Children from single-parent families and an unstable family environment, such as divorced parents and victims of domestic violence, are more likely to experience the repercussions of early pregnancy and parenting (Hallman, 2004).

In black communities more children are born to unmarried women and the majority of households are female-headed (Maseko, 2003:19). Family structure, especially single-parent and child-headed homes in which parents are less available, is associated with early childbearing and more sexual risk taking among sexually active teenagers (Biglan et al., 1998; Hallman, 2004; Panday et al., 2009). The absenteeism of parents is associated with teenage pregnancies, more especially in child-headed households (Miller, 2010). Moreover, studies on family structure suggest that older, sexually active siblings also influence teenagers to engage in early sexual debut and therefore risk pregnancy (Miller, 2010; Hallman, 2004; Gage, 1998). Although family structure and organisation may influence early childbearing, it cannot determine whether or not the teenagers have sex, use contraceptives and become pregnant (Miller, 2010: 25).

### **2.6.8 Gender roles**

Substantial evidence shown in a study by Groat and others (1997) indicates that young women from impoverished households have sexual relationships with older men. The authors also show that often the male partners are married and much older than the women. Hallman (2004) postulates that there are unequal gender roles among young women and their male partners. As argued by Groat et al. (1997), traditional gender roles give men the power to make decisions for their female partners. When young girls engage in sexual relationships with older men, it is therefore difficult to negotiate safer sex. Teenage girls are also financially dependent on men and the economic power that older men have over them. This suggests that teenage girls in sexual relationships with men for financial gain have a greatly reduced power to refuse sex or negotiate the conditions under which sexual intercourse occurs (Gupta, 2000; Maharaj & Muthree, 2006: 239).

The unequal gender relations influence males' power over females and also the conditions under which sex takes place (Gupta, 2000:2; Wood & Jewkes, 1997). There is unequal decision-making between partners, with poor or no communication about sexual matters, which is important to prevent unplanned pregnancy (Maharaj & Munthree, 2006: 239). However, it increases the vulnerability of the woman to risky sexual behaviour and early childbearing. Maharaj and Munthree (2006) assert that age differences between partners impact women's ability to negotiate decision-making and safer sexual practices.

In South Africa, particularly in the townships, older men are referred to as 'sugar daddies' (Manzini, 2001). Young girls from poverty-stricken communities have sex with these older men in exchange for material goods such as money, clothes etc. Transactional sex is more prominent in informal settlements (Hunter, 2002:101). Hallman (2004) found that young women from impoverished homes begin relationships with older men for social status and economic benefits. However, accepting financial or material assistance from a man means accepting sex on his terms, which often translates into sex without condoms (Mchunu et al., 2012:433). Having sex with high-risk groups, for example married men (with several previous sexual partners and longer exposure to the risk of STIs), also puts women at risk of

HIV infection and unplanned pregnancy (Biglan et al., 1998; Maharaj & Munthre, 2006:240).

#### **2.6.9 Peer influence**

Peers have a strong influence over the sexual behaviour of young people. Peer influence refers to the attitudes and beliefs of peers who have an influential role on other members of the peer group (MacPhail & Campbell, 2001). Parents spend more time at work trying to provide food, education and shelter. During this time, young people spend time with their peers in school and in the community (Nkwanyana, 2011:28). Young people have inadequate sexual knowledge as a result of wrong information or misconceptions about sexual relations (Varga, 2003). Peer influence and pressure are often cited as one of the most influential factors affecting adolescents' sexual decisions (Nkwanyana, 2011:28).

Information shared about sex and sexual relations among teenagers is not always accurate. Moreover, the transfer of inadequate knowledge could lead to inaccurate information, which is a contributing factor to early childbearing. As Nkwanyana (2011) and Panday et al. (2009) note, as a child reaches their adolescence, their source of information shifts from parents and siblings to peers. Research suggests that their perceptions of their peers have a significant and consistent impact on young people's sexual behaviour (Panday et al., 2009: 66; Biglan et al., 1998: 247; Mkhize 2007: 28). Therefore, when teenagers start to experience sex, their friends and peers are more likely to do so.

A study by Jewkes et al. (2001) in Cape Town (Khayelitsha Township) found that young people reported sexual encounters because people in their age group were sexually active. Similar reports were found in KwaZulu-Natal among teenage girls (Jewkes et al., 2001; Panday et al., 2009). Kaufman et al. (2001) assert that peer influence is more common among girls than boys to also maintain multiple sexual partnerships to gain respect from friends. In addition, those who are sexually inexperienced are excluded from a circle of friends in a group, and peers often determine new relationships and also the course of the relationships (Ndimande, 2012). There is pressure to lose their virginity in order to be included and accepted by friends. In fact, early sexual experience leads to risky sexual behaviour. A study in

KwaZulu-Natal found that 74% of females felt pressured by their friends to have sex (Panday et al., 2009:67).

#### **2.6.10 Child support grant**

Often women from impoverished social backgrounds who bear children need financial support in raising a child. Often older male partners tend to run away from the responsibility of raising a child, regardless of whether it is their biological child. For some, the child support grant is a means of getting an income from the government (Panday, et al., 2009). However, studies have shown that the child support grant (CSG) does not contribute to early childbearing. Mchunu et al. (2012) argue that the findings of the Department of Health confirm that the CSG does not increase childbearing rates. In a study in the UMkhanyakude District of KwaZulu-Natal, Lund (2008) found a relationship between the child support grant and an increase in school attendance. However, lack of employment and job opportunities is associated with childbearing. Therefore, receiving the child support grant is not seen as necessary for early childbearing for young girls.

More studies suggest that there is no relationship between the CSG and teenage fertility. Moreover, the studies indicate that since teenage pregnancy increased during the 1980s and stabilised when the CSG was introduced, teenage fertility has been declining (Makiwane, 2010; Makiwane, Desmond, Richter & Udjo, 2006:2). The authors also indicate that the beneficiaries of the CSG who are young mothers are less than 20%. Overall, although the CSG is means tested, even young mothers who do not qualify to be beneficiaries for the social grant experience high rates of pregnancies. However, the CSG is not seen to be increasing teenage pregnancy rates, and young girls are not deliberately having children for the benefit of the social grant (Makiwane et al., 2006).

According to Chimere-Dan (2008) and Makiwane (2010), teenage-specific fertility in the 1980s was 103 per 1 000, and in 2009 it was 53 per 1 000. From 1998 to 2003, South Africa's teenage-specific fertility decreased by 30% across all population groups (Makiwane, 2010). There have been controversies regarding the relationship between the CSG and teenage childbearing (Lund, 2008). Looking at the studies and statistics shown, there is no positive relationship between the introduction of the CSG

and the trend in teenage childbearing (Makiwane, 2010:202). Teenage fertility has been on a declining trend, before and after the introduction of the social grant (Makiwane, 2010; Panday et al., 2009).

#### **2.6.11 Sexually risky behaviour**

Sexually risky behaviour would co-occur with other problem behaviours such as delinquent activities or substance use during adolescence (Kotchick, Shaffer, Forehand & Miller, 2001:503). Sexually risky behaviour is defined as negative health consequences associated with early and unsafe sexual activity, including HIV/AIDS, other sexually transmitted diseases, and unintended pregnancy (Kotchick et al., 2001: 495). Sexual behaviour is influenced by positive motivations for sex, which may be physical (the desire for the feeling of excitement or pleasure), social (the desire for peer approval or respect) or individual (the desire to gain a sense of competency and learn more about oneself) (Ott, Millstein, Ofner & Halpern-Felsher, 2006:84).

#### **2.6.12 Planned pregnancy**

For some girls, premarital pregnancy seems to be the norm. The notion among young people is that when they are in the relationship, they get pregnant deliberately to trap the boy and keep him from dating other girls and also to force him to marry her. However, some young women get pregnant to prove their maturity and identity as women (Hancock, 1982; Singh, 2005; Mchunu et al., 2012). A number of authors suggest that that women use motherhood to prove their maturity, identity and feelings of love by her partner (Nkwanyana, 2011; Hancock, 1982; Singh, 2005; Mchunu et al., 2012). Girls fall pregnant out of wedlock because of the desire to have someone to love who will love them back (Hancock, 1982: 130).

Being neglected by society impacts young girls' relationships with their partners during and after pregnancy. Young girls want to feel a sense of security and they engage in sexual relations with their partners in the hope that they will eventually get married to their partner. Some studies suggest that young people engage in such behaviours for the wrong reasons and think about the present moment and not the future (Rutenberg et al., 2003; Manzini, 2001). Rutenberg et al. (2003) note that a study on early childbearing found that teenagers between 15 and 19 years old reported having a child deliberately to prove their fertility.

## **2.7 Barriers to accessing contraceptives**

### **2.7.1 Attitude towards contraceptive use**

Adolescents entering puberty often do not have sufficient information on contraceptive methods. Their attitudes towards contraception are influenced by highly prevalent myths and misconceptions regarding contraceptives (Miller, 2010). Studies suggest that some girls do not want to use contraceptives because of low self-esteem and the fear that their partner might abandon them. As a result, they are less spontaneous in the relationship (Nkwanyana, 2011:22; Blanc & Way, 1998).

Besides unequal gender relations and the inability of women to negotiate safer sex, the use of contraceptives is still a stigmatised practice that has negative connotations of being promiscuous (Panday et al., 2009:55). In general, men with inadequate knowledge of contraceptives in particular hold negative perceptions of women using any method of contraception (Bearinger et al., 2007). Some men perceive women to be promiscuous if they suggest condom use. Parents are also reluctant to discuss contraceptives with their children because they perceive it as promoting promiscuity and encouraging them to have sex (Bastien, Kajula & Muhwezi, 2011). This also relies on the culture of parents not talking about sex and sexuality to their children. On the other hand, the reality is that young girls are already having sex without their parents' knowledge, which may lead to pregnancy.

### **2.7.2 Inconsistent contraceptive use**

A study by Blanc and Way (1998) found that in more than 37 countries from sub-Saharan Africa, North Africa and Latin America women know at least one contraceptive method. Studies suggest that most of the women aged between 20 to 24 years from these regions have had sex by age 18, and their first sexual activity was reported between the ages of 10 and 15 years (Nour, 2006; Bearinger et al., 2007). Furthermore, in sub-Saharan African countries women are most likely to know about a contraceptive method. Uganda accounts for 70,3% and Niger for 81,2% of women who have had sex by the age of 18 and who know about a contraceptive method (Bearinger et al., 2007).

Condom usage as a method of contraception in developing countries has increased since the 1990s (Panday et al., 2009:55). Bearinger et al. (2007) also indicate that condoms are commonly used in preventing negative reproductive health outcomes. These authors also indicate that there has been significant progress in increasing condom use for preventing pregnancy, STIs and HIV/AIDS worldwide (Bearinger et al., 2007; Panday et al., 2009). However, inconsistent use of condoms among both young men and women remains highly prevalent. According to Bearinger et al. (2007), Gage (1998), Blanc and Way (1998), contraceptive use shows an increase from 19% to 28% between 1993 and 2001 in 19 African countries. While teenage girls and young women used condoms during their most recent sex encounters, discontinuing, not adhering and switching contraceptive methods place them at risk and may lead to negative health consequences. Reports have shown that in most sub-Saharan African countries, including Uganda and Niger, less than a third of sexually experienced teenagers use a condom at most recent sex. The proportion is more than a half in Romania, the Ukraine, Latin America and the developed world (Bearinger et al., 2007:1221). While condom usage has increased over time, the inconsistent use of contraceptives among sexually active teenagers increases the risks of unplanned pregnancy, STIs and HIV/AIDS (Panday et al., 2009; Blanc & Way, 1998).

Bearinger et al. (2007) indicate that contraceptive methods are key in preventing negative reproductive health outcomes. In a study of the sexual and reproductive health of teenagers, the authors found that sexually experienced girls in the United States of America (42%) report less use of modern contraceptives, namely the contraceptive pill, injections, implants, and the intrauterine contraceptive device (known as IUCD or 'loop') at recent sexual encounters than sexually experienced girls from Canada (64%), France (50%), and the UK (69%) (Bearinger et al., 2007). The use of modern contraceptives by teenage girls from the developing world is substantially lower than among adult women (Kirby, 1999; Gage 1998; Biglan et al., 1998; Bearinger et al., 2007). Studies on contraceptives indicate that modern contraceptive methods are increasingly being used by young sexually active and experienced unmarried girls (Nour, 2006; Blanc & Way, 1998; Gage, 1998).

Literature suggests that teenagers start using contraceptives at least six months after their sexual debut (Nkwanyana, 2011:21). The reason for this is that young girls

entering puberty have limited information about contraceptive methods. Family planning services target older women who have a child rather than sexually active girls who have not had a child (MacLoed, 1999; Bearinger et al., 2007). The purpose of family planning services, especially with regard to the use of contraceptives, is to prevent unwanted pregnancies. Studies indicate that in some countries like South Africa health services are available, yet teenagers face obstacles when seeking medical contraceptive methods including stigma, discrimination, negative attitudes of healthcare providers, insufficient knowledge about modern contraceptives and limited access to services in some parts of the world (Bearinger et al., 2007).

Nkwanyana (2011) and Blanc and Way (1998) indicate that there is a lack of community support for young girls accessing contraceptives to prevent unwanted pregnancy. Lack of support in the community contributes to girls not seeking contraceptives and leads to unwanted pregnancies. In the case of South Africa, Panday et al. (2009) found that in 2006 about 66% of young women were pregnant due to a lack of consistency in contraceptive use.

### **2.7.3 Problems with health services**

Research suggests that young people are socially constrained at health facilities compared to other people in a community. It is generally acknowledged that ‘teenagers do not use health services because of the fear of being judged by healthcare providers at the health facility (WHO, 2007:31). Healthcare providers serve as a barrier to teenagers and unmarried sexually active women accessing contraceptives. Also, women delay antenatal care visits to the clinic. Young people do not visit clinics because of the fear of being judged by the elderly clients at health facilities (Wood, Maepa & Jewkes, 1998:27). A study by Wood and others (1998) in the Northern Province (now called Limpopo Province) found that their anxiety was related to the fear of being the subject of gossip and ridicule by the older community members. The perceived lack of support affects the attitude and behaviours of teenagers (Phafoli, Alberts & Aswegen, 2007). Some women would not like to be in clinics with their daughters because they feel that they are too young to know about sex (Wood et al., 1998).



Lack of anonymity at health facilities remains a challenge for young people seeking information and services. Young people using contraceptives may want to keep it a secret from their parents and partners; they are particularly worried that people from the community would find out that they are using contraceptives and it would lead to gossip and rumours (Grant & Hallman, 2006). Young women are worried that they may be perceived as ‘sleeping around with many boys’ and that is why they are trying to access contraception.

Furthermore, the age gap between young women and nurses contributes to the anxiety that they face because they fear being mistreated, judged, harassed and marginalised. By far the most important and commonly reported problems encountered by teenagers were the ‘attitudes of nursing staff towards them’ (Wood et al., 1998:26). Many young women report being mistreated by nurses in clinics. Some rely on their friends for information and they fear the negative reaction of health workers. As a result, many teenagers are reluctant to visit their local clinics. Wood et al. (1998) found that young girls found nurses to be rude and arrogant and would ask them if they had boyfriends and why they were having sex at a young age. Some nurses are uncomfortable providing contraceptives to them because they are too young and they are engaging in adult activities (Wood et al., 1998; Nkwanyana, 2011).

## **2.8 Abortion**

Abortion in South Africa was legalised in 1996 by the Choice on Termination of Pregnancy Act, No. 92 of 1996. Various socio-economic factors influence the decision to terminate a pregnancy (WHO, 2007; Govender 2000). An estimated 46 million abortions are performed worldwide each year, especially in Africa, Southern Asia and Latin America (WHO, 2001; Bearinger et al., 2007). Among those 46 million terminated pregnancies, 27 million are performed legally and 19 million illegally, mostly under unsafe conditions. In sub-Saharan Africa, East and Central Africa, 20% of maternal deaths result from complications from unsafe abortion practices (WHO, 2007).

In other parts of the world, statistics show that abortion rates are high among women younger than 20 years, accounting for 29 to 44 abortions per 1 000 girls between the ages of 15 and 19 years. Termination of pregnancy has increasingly attracted research

from a public health perspective. Apart from the lack of contraceptive use, unplanned teenage pregnancies have other health implications, including induced pregnancies.

Social pressures influence teenage girls to opt for abortion. According to Bongaarts (1978) and Bongaarts (1984), abortion refers to any practice that deliberately interrupts the normal course of gestation. In some countries, abortion services are restricted (Bearinger et al., 2007:1223). In South Africa, abortion is legal if performed in a designated healthcare facility. Moreover, this act allows women to terminate their pregnancy if they see fit.. Legal abortion services are provided to be used by those in need of them. However, in some communities, abortion is associated with being immoral and self-centred (Maseko, 2003:25; Panday et al., 2009:106).

Young girls often opt for an abortion because the pregnancy is not planned or wanted. When the decision is made to terminate the pregnancy, it is often done by a ‘non-medical provider or attempting self-induced abortion, e.g. by drinking herbal medicine’ (WHO, 2007:35; Maseko, 2003, Govender 2011; Gresh 2010). Studies show that teenagers opt for a quick, easy and cheap way of inducing a pregnancy.

Studies report that the attitudes of providers make pregnant girls reluctant to use legal abortion services (Gresh, 2010:28). The decision to have an abortion is influenced by the economic, legal, moral and religious contexts (Bearinger et al., 2007:1223). Young women choose to abort because they have fears of disappointing their parents, being judged and stigmatised. It is worth noting that teenage girls who have had their first abortion are more cautious in seeking family planning and using contraceptives than those who have not (WHO, 2007). Healthcare providers and healthcare systems should emphasise preventing pregnancies (contraceptive methods) before young girls opt for abortion. Girls fall pregnant because they know that seeking illegal abortion services is much cheaper, and if they fall pregnant again they would terminate their pregnancy (Evans, Selstad & Welcher 1976; Caldwell & Caldwell, 1993).

## **2.9 Consequences of early childbearing**

### **2.9.1 Health**

Some health risks regarding pregnancy are more common among young women (WHO, 2007:19). Young women are likely to suffer psychological and physiological

health consequences as a result of early childbearing (Maseko, 2003). A woman carrying a child before the age of 20 has more health risks than an older woman (Panday et al., 2009; WHO, 2007). UNFPA (2007) suggests that girls between 15 and 19 years old are more likely to die after pregnancy than those aged 20 to 24 years. Young women who engage in risky sexual behaviour with multiple sexual partners are not only at risk of pregnancy but also of infections. Studies suggest that girls with limited information about the risks associated with unprotected sexual activity only found out that they were HIV positive during their antenatal care visits (WHO, 2007; Du Plessis, 2003).

### **2.9.2 Educational**

Pregnancy can have a profound impact upon young girls, especially those who are still at school. It can impact education attainment and performance. Often girls who fall pregnant before the age of 20 have less education than those who are not pregnant or fall pregnant after the age of 20. Often research shows that early childbearing is associated with low educational attainment. The negative impact of early childbearing on a woman's educational attainment is probably due to the difficulty and cost of arranging child care and running a household, to the necessity of earning a living, and, not least, to the pressures she may encounter from family and friends to devote herself to child care (Moore & Waite, 1977:225). Time devoted and spent on child care increases the chances of the teenagers dropping out of school, grades declining and, as a result, poor education attainment.

### **2.10 Youth culture**

The youth of South Africa have been identified as independent and energetic, hence the socialisation of township youth influences behaviour and decision-making (Manzini, 2001). Youth culture is high paced, with the media and technology having an influence. It refers to the wide range of belief systems (and sub-cultures) within that age group of young people (Brown et al., 2005). Youth culture has been conceived of as a set of understandings, behaviours, and artefacts used by particular groups, i.e. young people, and diffused through an interlocking group network and interactional negotiation in group settings (Fine & Kleinman, 1979:18). Misconceptions relating to sexuality and sexual matters are common among youngsters. Adolescent years are characterised by physical changes and social

changes affecting them (Maseko, 2003). Ogana (2006) points out that teenagers from townships have misconceptions about their sexuality, including equating love with sex; seeing sex as the only way of expressing love; the 'assumption that a girl cannot get pregnant the first time she has sex; boys engaging in sex as proof of manhood; boys having sex with multiple partners, or saying no to sex is not an option' (Ogana, 2006:14).

In township cultures sexually active girls turn to their friends for advice on sex; once conception occurs, inaccurate information is also shared (Mkhwanazi, 2010). Seeking advice from friends suggests that there is limited trust of nurses and the girls fear to tell their parents once they started having sex. Those who have fallen pregnant often feel that they have disappointed their parents and have broken their trust. Manzini (2001) notes that in township jargon, there is the perception among teenage boys' that when a girl says 'no' to sex, she actually means 'yes'. As a result of this, many girls end up having non-consensual, coercive sexual encounters (Maharaj & Munthre, 2006). However, boys are socialised into thinking that sex is necessary and impregnating a girl is seen as enhancing a boy's status by demonstrating his manhood (Ogana, 2006:19).

Sexual behaviour in townships is mostly prompted by peer influence, proving manhood and womanhood among young people. Studies have indicated that sexual behaviour is seen to be the cornerstone of early childbearing in townships (Manzini, 2001; Mkhwanazi, 2010; Wood & Jewkes, 2001). Townships in South Africa are similar to other communities in developing countries with respect to young people engaging in risky sexual behaviours. Risky sexual behaviours in townships include unplanned pregnancy, alcohol and substance abuse and multiple sexual partners, which are also some of the issues contributing to teenage pregnancies (Kotchick, Shaffer & Forehan, 2001).

### **2.11 Role of fathers**

Most studies focus on young women and their pregnancy experiences, yet there is little focus on fathers. Studies suggest that fathers often do not take responsibility for their children, especially if they have uncertainties about the child's paternity. The father often denies paternity, especially if the mothers are perceived as promiscuous (Panday et al., 2009; Kaufman et al., 2001).

In African societies, particularly the Zulu culture, ‘when a man impregnates a girl it implies social and financial commitment to the child’ (Varga, 2003:166). The role of the father does not necessarily mean impregnation, however, as Varga (2003) argues, it entails support of the child. The father’s family determines whether damages for impregnating the girl, called ‘*inhlawulo*’, have to be paid. To some African families *inhlawulo* is a way of acknowledging and respecting the girl’s family (Preston-Whyte et al., 1990). Payment of damages symbolically states that the newborn is a child of the boy in question (Kaufman et al., 2001:158).

When the man has impregnated a girl there are cultural expectations that he will pay damages. This may frighten the father of the child, as he may not be employed and finds it difficult to make payment to the mother of his child, which is a constraint as he is perceived as ‘not good enough’ (Swatz et al., 2013). ‘A poor relationship with the child’s mother also reduces a young father’s ability and desire to play a fathering role. When young parents live with their own parents, and these (grand) parents play a major role in providing and caring for the children, the young persons’ actions are guided (and limited) by the desires and wishes of the grandparents’ (Swartz et al., 2013:2).

The father’s role becomes limited as the primary caregivers are the mother’s family. They have much power in the decisions regarding the child and that undermines his ability to play a role as a father (Swartz et al., 2013:2). Studies suggest that most men are encouraged by their own mothers to take an active role in their child’s life despite the limitations they face (Swartz et al., 2003; Varga, 2003).

On the other hand, some boys and men refuse and deny paternity (Kaufman et al., 2010). The obligations that accompany paternity and paternity damages give them a reason to deny impregnating the woman (Preston-Whyte et al., 1990). Paternity denial also demonstrates that boys and their families have total decision-making power with respect to paternity (Varga, 2003:167).

It is important to note that sexual behaviour has consequences not only for the young mother or father, but also for the grandparents. This means that the burden of

childrearing often falls on the elders, mostly the grandparents. They have to adjust their lives to accommodate the new member. In some communities, to avoid the embarrassment of early childbearing by the young girl, the grandparents raise the child as their own.

## **2.12 Summary**

This chapter has provided a summary of the main findings from the literature review. The literature suggests that teenage pregnancy globally, including developing and developed countries, has continued to be an area of concern. The health, educational and life implications of early childbearing alter a young person's life. Although there are family planning services to prevent such implications, studies have shown that an early pregnancy is likely to create disruptions in the young person's life. It is evident that various factors contribute to early childbearing among young girls, including poverty, unemployment, individual's place of residence, and barriers to accessing contraceptives. This chapter argues that early childbearing among young women continues to persist and increases the fertility rate among this cohort group.

## Chapter 3

### Research methodology

#### 3.1 Introduction

Over the past several decades there has been increased research on the fertility of young people in developing countries. The overall objective of this study, as was explained in the first chapter, was to provide more insight into the factors influencing early childbearing among young black women. The study draws on qualitative data from in-depth interviews to understand the impact of early fertility on young women. This chapter gives explanations for the type of research design and methods used throughout the study. The chapter starts by providing an overview of the research setting and study area. It then examines the data collection process and considers the sampling procedures used for the study. Thereafter, it describes the techniques of analysis to make sense of the data. Lastly, it highlights the main ethical considerations as well as limitations of the study.

#### 3.2 Study area

##### *Mpumalanga Township, Hammarsdale*

The study was conducted in Mpumalanga Township, Hammarsdale. It is situated 18 kilometres from the city of Durban in the Camperdown district in the province of KwaZulu-Natal (see Figure 3.1). The township was initially known for its history of political conflict between ruling chiefs in the 1960s. It was during this time that the Mpumalanga Township, Hammarsdale was established and built on mission land. It was initially called Hammarsdale. The whole of Hammarsdale was then, separated into sections in the late 1980s, including Georgedale, Woody Glen, Mophela, Sankontshe and Mpumalanga, meaning ‘*sunrise*’ (Moesetsa, 2005). It was later recognised as an industrial area where products such as cotton and fibre weave were produced. Today, it is called Mpumalanga Township, Hammarsdale a densely populated area in the province of KwaZulu-Natal. The township is separated into sections and units consisting mainly of four-bedroomed houses (see Figures 3.2 and 3.3), surrounded by communities still ruled by the traditional *Induna* and other traditional leaders. Moesetsa (2005) asserts that there are high levels of poverty, youth unemployment and crime in Mpumalanga Township, Hammarsdale. The township is

predominately African and constitutes mainly isiZulu speakers. There are approximately 172 503 people residing in Mpumalanga Township, Hammarsdale, which includes informal dwellers from the surrounding areas (Oyeka, 2011:35).

**Figure 3.1: Location of Mpumalanga Township, Hammarsdale**



Source: Moesetsa (2005)

Townships were initially created during apartheid when the government forcefully removed inner-city African communities and relocated them to the state-controlled township on the periphery of the city to uphold the apartheid ideology of racial segregation (Ndimande, 2012:3). The township consists mainly of low-cost houses (see Figure 3.2). The location of these houses is considered to be bad from a transport point of view. There is little employment in the area, and previous surveys have indicated that only 17% of the community will find employment in the area (Aucamp & Moodley, 2003).

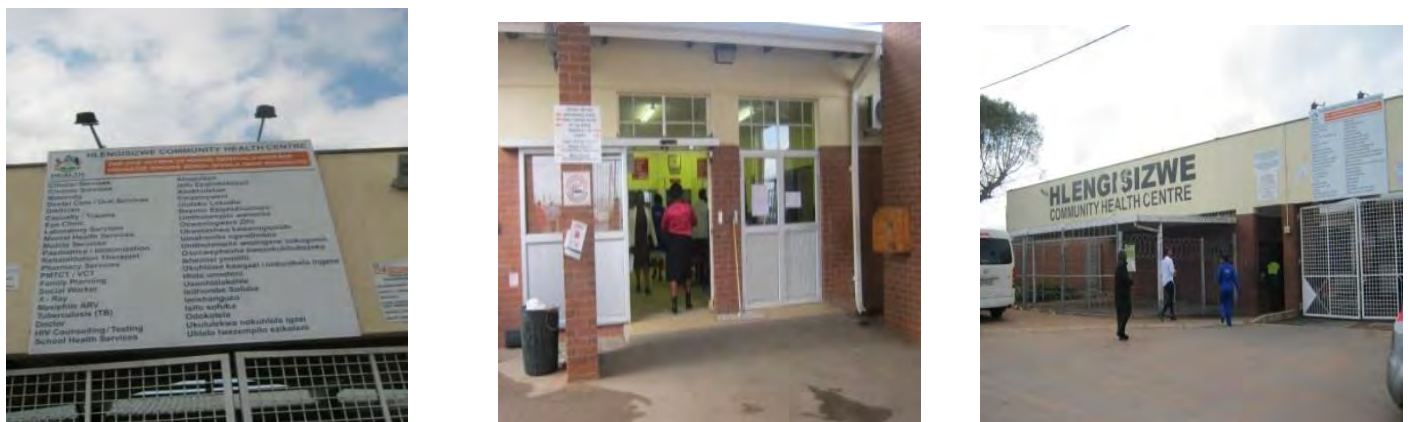
In 2013, the new shopping mall, called Hammarsdale Junction, was opened. This infrastructural development has created employment opportunities for some of the youngsters in the community. The township also contains schools, a library, a local municipality office and the local Hlengisizwe Community Health Centre (see Figure 3.3). Healthcare services are easy to access because of the availability of public transport, which is not very expensive.



**Figure 3.2: Four-roomed houses in Mpumalanga Township, Hammarsdale**



**Figure 3.3: Social services in Mpumalanga Township, Hammarsdale**



Despite the availability of some basic social services for the residents, living conditions in the townships are overall unfavourable (Govender, 2011). Moesetsa (2005) maintains that high levels of poverty, high levels of youth unemployment, population density, poor education and rampant crime are some of the challenges faced by the youth of the township. As a means of securing a livelihood, residents earn an income within the township through business enterprises such as local spaza shops and shebeens (including pubs and beer halls).

### **3.3 Research design**

The study used qualitative research methods. Qualitative research uses an interpretative approach for understanding human experience (Patton 1988). The method is more flexible and interactive to gain insight into the participant's experiences (Babbie & Johann, 2001). Qualitative research methods are endlessly creative and interpretive (Creswell, 2009). Moreover, qualitative research methods are used for a wide range of interconnected, interpretive practices to get an understanding of the subject matter at hand (Denzin & Lincoln, 1998). The main strength of qualitative research is its ability to study phenomena that are simply unavailable elsewhere (Silverman, 2006). Qualitative methods include different techniques such as face-to-face in-depth interviews, focus groups, case studies and life histories. For the purposes of this study, qualitative methods are therefore seen as most appropriate for shedding light on young women's experiences of early childbearing.

Qualitative research methods have been criticised by scholars for their subjectivity (Denzin & Lincoln, 1998:8). Moreover, results are more easily influenced by the researcher's personal biases and dependent on the researcher's skill, training, intellect, discipline, and creativity (Patton, 1988). Some critics argue that qualitative methods tend to generate large amounts of detailed information about a small number of settings (Mays & Pope, 1995). This is one of the reasons for using this method – the ability of qualitative methods to provide detailed information.

The focus of this study was on understanding the perspectives and experiences of young mothers. This study used the qualitative methodology to understand young women's perspectives and experiences of early childbearing. Qualitative methods most often offer the best approach in getting such knowledge and meaning that is not easily quantified (Oyeka, 2011:33). This type of methods allows people's experiences to be examined in detail, and for the purpose of this study in-depth interviews were used. Hennick, Hutter and Bailey (2011) declare that qualitative methods enable the researcher to identify with issues from the perspective of the participants. The study was conducted with young mothers living in the township of Mpumalanga, Hammarsdale. A total of 10 in-depth face-to-face interviews were conducted with women aged 18 to 24 years who had had a child.

All the interviews were face-to-face interviews conducted at the home of the young mother. This setting presented an advantage for the participants in the comfort of their own home. The interviews were done in a private room in order to ensure maximum privacy. The sampling method used was non-probability, purposive sampling, which sought to gain insight into the participant's experiences of early childbearing.

All participants were invited to a meeting to introduce the study. At the meeting, the researcher outlined the purpose of the study and also addressed any concerns with the study. Those women who were interested in participating in the study made appointments with the researcher to be interviewed. The selected participants were young women – pregnant women and young women who had at least one child. The selected participants were aged 18 to 24 years. Women who agreed to participate in the study were asked to sign an informed consent form. They were also asked if the interviews could be recorded. The one-on-one in-depth semi-structured interviews were recorded with the permission of the women.

The consent form was signed by participants to indicate their understanding of the purpose of the study and their willingness to participate in the study. They were also asked to give their consent to the interview being tape recorded. Participants were assured of confidentiality. Each interview lasted approximately 45 minutes. All the participants were assured of anonymity and pseudonyms were used in the reporting of findings. The interview consisted of a list of questions relating to the study. The interview schedule involved open-ended questions. The open-ended questions covered themes of relevance to the study.

The questions were divided into sections. Firstly, the participants were asked about their socio-economic and demographic characteristics, followed by their experiences while pregnant, the support systems, their perceptions of contraception, their use of contraceptives, sources of supply, future aspirations, their family structure and finances (Appendix I). Most of the interviews were in the local language. Only two were in English. Prior to the commencement of the study, the researcher asked the participants to choose to be interviewed either in English or in isiZulu. All the interviews were recorded, but the researcher also took notes during the interviews.

### **3.4 Data analysis**

The purpose of data analysis in qualitative research is to manually organise and arrange information and it is a fundamental and the most critical aspect of the qualitative research process (Govender, 2011:38). However, qualitative research is time consuming and costly. The researcher interviewed the participants and the interviews were recorded, written down manually and transcribed. Transcriptions were used as they were useful in analysing data and findings; however transcribing was time consuming and extensive work, especially translating from isiZulu and transcribing in English.

Once data had been gathered from the in-depth interviews, thematic analysis was then applied to the study. The thematic analysis approach is suitable for the study of qualitative research. It focuses on examining themes within the data and organising data sets (Boyatzis, 1998). The researcher listened to all 10 of the interviews and also reflected on the written notes when analysing the data. The researcher identified initial themes after the data had been sorted. In using thematic analysis, the researcher did not look beyond what the participant said. However, some themes could have been predetermined prior to the interviews (Govender, 2011:39).

The process of thematic analysis entails reading and reflecting on the written transcripts and recorded tapes. Once the transcription had been completed, codes were generated. Codes identify predominant themes from the raw data (Boyatzis, 1998:63). The process of coding involves organising data into meaningful groups, tags and labels. The data was then sorted by themes. According to Boyatzis (1998), themes are developed from the generated codes and during the process of coding themes are developed. Boyatzis (1998) also notes that some initial codes form main themes and some form sub-themes. Themes are then reviewed and defined.

### **3.5 Ethical considerations**

Ethical considerations are important when using qualitative research methods. Ethical clearance to proceed with the study was obtained from the Human and Social Sciences Research Ethic Committee of the University of KwaZulu-Natal (Appendix

II). Once ethics approval for the study had been obtained, the researcher met with the participants and explained the purpose of the study.

The researcher first introduced herself and then explained the purpose of the study and also answered any questions from the participants. The participants were informed that their participation in the study was voluntary and that they could withdraw from the study at any point if they wished to do so. Furthermore, participants were also informed that once the report had been completed the researcher would destroy the transcripts and audiotapes. In the event that the interview had provoked distressing emotions or memories, participants were briefed prior the interview about being referred to the local clinic, Hlengisizwe Health Centre, for counselling.

### **3.6 Limitations of the study**

The purpose of qualitative research is to gain insight into the experiences of participants. However, with qualitative research, the sample does not represent the whole population. In addition, the participants selected from Mpumalanga Township, Hammarsdale were only a portion of the whole township's population. It was a limited representation of the whole population of women who had experiences of early childbearing. It covered a small geographical space in just one of KwaZulu-Natal's peri-urban areas, i.e. townships. It would have been ideal to have interviewed more participants to gather more information, but it is important to consider that qualitative technique methods require time and resources to gather data. Transcribing and coding (labelling, mapping and coding) are time consuming and require resources; participants interpret questions in their own way. Most of the interviews (8 out of 10) were conducted in isiZulu and later transcribed to English. Pregnancy is a sensitive issue globally, and qualitative methods for the study required one-on-one interviews, which might have influenced participants to not disclose some information. In addition, some participants may have not answered some questions honestly.

### **3.7 Summary**

This chapter has provided an overview of the methods used to collect the data for the study. The study employed qualitative methods and this method was deemed suitable

for exploring the perspectives and experiences of young mothers. Ethical considerations were explained and the sensitivity of the study and the importance of not compromising the individual's identity were highlighted. Limitations of the study were also stated, as were overall observations of the study.

## **Chapter 4**

### **Results**

#### **4.1 Introduction**

The aim of this study was to shed more light on the factors influencing early childbearing among young black women. The study draws on qualitative data from ten face-to-face, individual in-depth interviews. To enable understanding of the significance of early pregnancy, the study aimed to unravel issues of early pregnancy from the perspective of participants and obtain a deep understanding of the factors influencing early childbearing among black women. This chapter describes the characteristics of the women. It then outlines the findings from the in-depth interviews in which the women narrated their experiences of early pregnancy.

#### **4.2 Demographic profile of the participants**

It is important to have an understanding of the demographic characteristics of the sample of young women. Table 4.1 presents the characteristics of the participants of the study. In total ten participants were interviewed for the study. The ages of the women in the sample ranged from 18 to 24 years. The sample included one woman who was pregnant at the time of the interview. All the participants indicated that they had been born and grew up, and were still living in Mpumalanga Township, Hammarsdale. The average age of the sample was 21 years and all the women were black and unmarried. All the women had fallen pregnant while still in school. Of the sample, nine had completed their secondary education and one was still in secondary school. The study indicated that some participants from the study were not able to continue with their tertiary education due to lack of finances. As a result, some had to seek employment in order to financially support their child, and this put an end to their aspirations of furthering their education. The majority of the participants resided at home with their parents. Most had had their first child while they were still in school. They reported that the pregnancy had a negative impact on their school performance.

**Table 4.1: Distribution of participants aged 18–24 years according to their demographic profile**

Interview	Pseudonym	Age at interview	Period out of school/missed	Marital status of participant's parents'	Occupation
1	Zanele*	23 years	+/- 2 months	Married	Unemployed
2	Sphindile*	24 years	-	Mother married, stepfather	Waiter
3	Zama*	24 years	One week	Single mother	Unemployed
4	Gugu*	21 years	+/-4 months	Single mother	Unemployed
5	Mbali*	18 years	-	Single mother	Cashier
6	Nonku*	19 years	-	Mother married, father passed	Unemployed
7	Smangele*	20 years	-	Not married, living with aunt	Unemployed
8	Tholakele*	20 years	-	Single mother	Cashier
9	Samke*	22 years	One week	Married	Student
10	Amanda*	23 years	-	Married	Student

\* not their real names

Some of the respondents reported that they had been sexually active before conceiving. They were also anxious not to fall pregnant again. One participant had been forced to drop out of school because of the stigma associated with pregnancy – the women reported that girls who fell pregnant often acquired a bad reputation at school. Nine of the girls, however, did not drop out of school, because they were



determined to complete their education. They wanted to complete their education for the sake of their unborn child. One of the participants was still in the process of completing her schooling.

None of the participants were married at the time of the interview. This was not surprising, given that marriage is not the norm in South Africa. Only three of the women were employed full-time; some had secured temporary jobs as cashiers but were still seeking more permanent employment. Six out of ten participants had had sexual intercourse before the age of 17 years old.

### **4.3 Experiences of pregnancy: a disruption of life**

Young women who experience pregnancy experience a disruption of their lives. Groat et al. (1997) and Panday et al. (2009) indicate that often when a pregnancy is unplanned, teenage girls experience challenges that are a result of early childbearing and childrearing. All participants indicated that they had encountered challenges because of early childbearing. In this study, most of the participants reported that they had had to cease pursuing their dreams and had found it difficult to handle the obstacles of motherhood at a young age. Furthermore, all the participants had still been in school and had had to make drastic changes to their lifestyle. The participants claimed that the pregnancy had brought about many changes to their lives. The women reported that they had experienced ostracism and criticism from their community. Some felt that they had been victims of stigmatisation and discrimination. The comments below illustrate some of the challenges the young women had faced during the pregnancy:

*“people were gossiping in the community. They were saying things about the father of my child. They were saying that he loved girls, and why would I fall pregnant by him or even date him out of all people, because I was an innocent girl” (Sphindile, 24 years)*

She added:

*“and I had to drop out of school ... I had to drop out the following year because I had to take care of the baby. I did not submit some of my assignments. My baby*

*was a sickly baby, he had pneumonia. I was so stressed during the few months I had him. He passed on after seven months. I could have at least finished two years of my modules if I didn't have a child. It was challenging because I didn't know anything about raising a child, firstly, and secondly I had to take care of an ill child" (Sphindile, 24 years).*

This participant had lost her child almost two years after giving birth and for most of the time the child had been sick. This placed a great deal of pressure on the young woman because she had had to take on a number of responsibilities. She had had to take care of a sick child and at the same time she had had to try and complete her studies.

Early childbearing is associated with a number of challenges. For one woman, the pregnancy had been fraught with difficulties. She reported that she had been constantly sick during her pregnancy and at the same time she had also been trying to complete her education. Others reported that they had had to make changes to their lifestyle. One reported that she had missed out on key social activities and as a result, she felt that she had been denied opportunities.

*"The time I was pregnant, I got sick, because during that time we were writing our final matriculation trial examinations at school (March 2007) so I didn't write some examinations due to being sick. Those are the challenges I can recall" (Zanele, 23 years)*

*"I missed out on my matric dance because I was heavily pregnant and it is something I will never have again. My mother as a single parent, she had to raise 3 children, my brother and I and my child" (Zama, 24 years).*

*"I fell pregnant when I was in my final year of school and we were forced to drop out (me and some other pregnant girls at the time), as we were left with no option'. 'I missed a lot of work; maybe my grade would have been good if I attended school full time like other pupils. It really disrupted my education" (Gugu, 21 years).*

One woman who had fallen pregnant in her final year of secondary schooling had her studies disrupted. She noted that girls who are pregnant at school acquire a 'bad reputation'. The school had been concerned that they might have a negative influence on other girls. For this woman, attending school full time would have improved her grades. She had missed a lot of work that was done by other pupils, which had impacted negatively on her final results. For this woman, early childbearing had led to a disruption of her schooling and her chances in life.

All the participants revealed that they had had to take on the responsibilities of early motherhood. They had to mature at a young age. In this study, young mothers claimed that they had many regrets and reported that they were very disappointed in themselves because they missed out on their childhood.

#### **4.4 Onset of sexual activity**

In order to understand how young people make decisions about whether or not to engage in sexual activity, their perceptions on sexual matters should be considered (Gage, 1998:158). Studies suggest that early onset of sexual activities increases the risks of pregnancy. Hence, if sexual debut is delayed, it is expected that pregnancy is also delayed (Bongaarts & Potter, 1983). Studies have shown that once sexual activity begins among young people it generally continues (Manzini, 2001:48). Early sexual debut not only impacts the social lives of young people but also poses a threat to their reproductive health (Manzini, 2001).

Most of the participants in the study claimed that they were aware of the methods of preventing pregnancy. The condom was widely acknowledged by all the participants for protecting them from getting pregnant. Some women had engaged in sex for the first time as early as 13 years old. By age 17, many of the women had sexual intercourse. Most participants revealed that they had not thought of the risk of pregnancy during sexual intercourse. For them, pregnancy was not even a matter of consideration. They had never thought they would fall pregnant. Some had felt protected because the first time they had had sexual relations they did not fall pregnant so they did not use any protection.

Their partners had exerted a great deal of pressure on them. Most participants indicated that their sexual partners had influenced them into having sex. Peer pressure had also played a role in influencing their decision. Some said they had engaged in sexual intercourse because their friends had been having sexual relations and they also wanted to experience it.

Exposure to unprotected sex increases the risk of unplanned pregnancy (Biglan et al., 1998). The study indicated that for many women the pregnancy had not been planned and in most cases it had been unwanted.

*“I was only 13 years old when I started to have sex, I had no idea that few years later I was going to fall pregnant, because the first time I had sex I didn’t fall pregnant” (Zama, 24 years).*

*“I thought I was the youngest to have sex and fall pregnant; when I went for pre-natal care visits in the clinic, they were even younger girls than me in the clinic who were pregnant” (Mbali, 18 years).*

This study indicated that most participants had inadequate information and knowledge regarding sexual matters during their teenage years. They had previously engaged in unprotected sexual intercourse and therefore felt that they were not at risk of pregnancy.

The risk of engaging in unprotected sex also increases exposure to infections. Often women use contraceptives after their first child and are cautious about using them because they fear another pregnancy (Blanc & Way, 1998). In the study it was found that nine women were using contraceptives at the time of the study because they were afraid to fall pregnant again. They revealed that they were using contraceptives to prevent a second pregnancy.

#### **4.5 Consequences of early pregnancy**

The study revealed that most participants felt regret at having a child at a young age. They were asked how they felt about the pregnancy. Most participants indicated that they had wanted to reverse time and would have preferred not to have a child. They

felt that they had not been ready to become parents. In addition, they had to take on so many responsibilities, often without the support of their male partners.

The participants indicated that adequate knowledge of contraceptives could have prevented an early, unwanted pregnancy. Most participants pointed out that delaying sexual intercourse would have prevented early childbearing. Literature reports that the consistent use of contraceptives by younger women delays fertility (Chimere-Dan, 1994; Bongaarts, Frank & Lesthaeghe, 1984). Most participants felt that they did not have adequate knowledge of contraceptives and as a result they should have delayed sexual intercourse until they were better informed about the risks associated with early sexual intercourse. The comments below illustrate the consequences for women who had not used contraceptives and engaged in early sexual debut.

*“I regretted falling pregnant; I don’t want to lie. If maybe I waited till I was older to have sex, maybe I would not have fallen pregnant and become a young mother” (Mbali, 18 years).*

*“I was disappointed in myself. There was so much I wanted to accomplish; pregnancy and a baby was not an option, I kept asking myself why I had a child at such a young age” (Sphindile, 24 years).*

*“It was hurtful and sad, because I was scared of my parents and what they will say to me. If I was given another chance I would have abstained because I saw how stressful and strenuous it was to be a single mother; to have a child and her father being not supportive and always relying and depending on my parents” (Gugu, 21 years).*

*“I did not feel right. At that moment life stopped for me, I had to juggle school and pregnancy. I did not know what to do in the circumstances. Pregnancy is bad because it is better if one is married. If you are pregnant at a young age outside of wedlock, and still staying at home, it is a burden. It is better once you are married to get pregnant because it is the responsibility of both parents to raise a child. Child out of wedlock is not good” (Tholakele, 20 years).*

*“I was shocked because I did not have a job, and I was worried I will not complete my secondary schooling. I was worried what is going happen to me, and then I realised whatever happens will happen. If I had a job I would have supported the baby. It is important to have a job and sufficient finances” (Zama, 24 years).*

From the comments it was clear that having a child is a huge responsibility for a young person. It is especially difficult if the young woman is not currently employed. Many of the women were ashamed of their behaviour and they felt disappointed in themselves. The study indicated that participants viewed the pregnancy as a burden and felt that it had ruined their lives. They felt that their life prospects were bleak as a result of the pregnancy.

#### **4.6 Education**

Most participants felt that education was the key to success and they were struggling to further their education in order to secure employment. Studies suggest that women who have an education are more likely to delay fertility than less educated women (Hirschman, 1994; Moore & Waite, 1977). Most of the participants reported that they often did not go to school while they were pregnant. It was revealed that only one of the ten had completed their tertiary education. However, four of the ten women were pursuing their tertiary education. Three of the ten women were still living with both their parents and siblings, while seven of the ten participants were living with only their mother or father or extended family members.

The participants felt that if they had focused on their secondary schooling they would have delayed sexual intercourse and pregnancy and they could have enjoyed better opportunities. Participants also indicated that having a child when financially stable is not problematic, but having a child at a young age while relying on parents was a challenge. According to Manzini (2001), childbearing does not always result in the end of a girl's school-going life. Evidently, most of the participants in the study continued their education when the means permitted. The following quotation highlights the importance of education as viewed by the young people:

*“I should not have fallen pregnant. I should have focused more on my studies, so that I could continue with a career. Boys will always be there, even after I have my*

*education. I would have progressed far in life by now if I didn't have a baby"* (Sphindile, 24 years).

Pregnancy prevented this woman from furthering her education. Even though she completed secondary school, she felt remorseful about falling pregnant and it resulted in her failure to pursue further education.

*"If I had a choice I wouldn't have been pregnant and become a mother; I would have used condoms and prevented being pregnant. I would have achieved a lot of things like my education if I didn't get pregnant"* (Mbali, 18 years).

*"I should have focused on the positive things that would have not set me back, and not led me to have a child. I should have got involved in other things. As a person growing up, even if you don't study, but you should have something positive to focus on and keep busy even if distractions come along, but your focus remains on achieving your goals"* (Tholakele, 20 years).

The young women put a great deal of emphasis on education. For some it was seen as a way of lifting themselves out of their socio-economic situation. In the study, early childbearing was viewed as a major social problem among the youth. Sexual decisions and behaviour in the study seemed to have an impact on education among young people.

#### **4.7 Highest grade completed by participants**

Women who engage in an early sexual debut whilst still at school are more likely to fall pregnant than those delaying sex (Moore & Waite, 1977). Most of the participants were sexually active while still at school. The one woman who was pregnant at the time of interview indicated how difficult and challenging it was to complete her schooling while pregnant. Most participants reported that they had continued with schooling during and after pregnancy. The women reported that they had experienced stigma and discrimination in school from peers, teachers and the community. However, they had been determined to continue their schooling, regardless of the obstacles they had encountered.

*“I attended school from the time I found out I was pregnant till I delivered. I delivered during the school holidays, so I was lucky to return to school after giving birth” (Amanda, 23 years).*

*“When I found out I was pregnant I studied hard, because I wanted to complete my secondary schooling which I completed. My marks dropped on only one subject and the rest of my marks were consistent. The day when I was supposed to write my exams I went to the hospital to deliver my baby which resulted in me not passing the subject well” (Zanele, 23 years).*

*“Some pupils were judgemental at school during the time I was pregnant in secondary school; they think there is something wrong with you having a child at a young age. Some would be judgmental and label me as ‘I am a bitch or I am a loose gir’. My grades went down; I had a C-section [Caesarean Section] because I was pushing to write my final exams and complete secondary school” (Zama, 24 years).*

One participant continued schooling, but pressure from school professionals (school teachers and the principal) made her discontinue with her schooling. She emphasised that the biggest challenge had been when she had to drop out of school due to the negative attitudes towards pregnant girls in school.

*“I had to stop schooling and stayed at home for months. At my school you had to drop out of school. Firstly, the biggest challenge for me was when I had to drop out of school. Secondly, the teachers were very negative towards pregnant girls at school. The teachers would often go class to class and point to the pregnant girls saying that ‘we are loose girls and what example are we setting since we are in secondary school and pregnant’. Pupils felt that the school’s reputation was at stake. We weren’t given any formal letter. They didn’t directly tell us to drop out, but we just saw it was useless coming back to such negativity. There were nine of us pregnant in the same grade. Pregnant girls are not allowed to be chased out of school. I stayed out of school from May to September. I then went back to write my September trial exams and the November final exams. I did not go to school for a total of four months. I did not want to force matters as well by going back to school in an environment where people were negative towards pregnant people” (Gugu, 21 years).*



Despite South Africa's education policy that enables girls to continue with schooling during pregnancy and after giving birth, challenges of stigma and discrimination hamper girls from continuing with their schooling and some opt to drop out (Panday et al., 2009). However, evidence from the interviews showed that participants did not opt to discontinue schooling but due to the social stigmatisation some participants were forced to interrupt their schooling. The women found themselves under extreme pressure and they felt that they could not face going to school under these circumstances.

#### **4.8 Aspirations for the future**

As was previously mentioned, the young women valued and prioritised education. Education represented the key to a successful career and also a form of protection against life's challenges. Financial support was also a concern; raising and rearing a child were mentioned as some of the challenges. The following quotes indicate that they had great aspirations for their future. Even though life for some was bleak, they tried and remained positive for the sake of their child. Their aspirations for the future are aptly captured below.

*"I wish to complete my honours degree this year, probably next year work in the municipality or any other NGO" (Samke, 22 years).*

*"So far so good, I went back to school last year to study teaching, I am passing. My secondary school results were not good so I had to do a bridging course before going into mainstream, so after that I registered at UNISA. I see myself as a teacher, looking after my parents, my family and living the good life" (Sphindile, 24 years).*

*"I wish a good future for my child more especially; accomplish a lot of things myself" (Smangele, 20 years).*

*"My plans are going slowly but I plan to finish my studies, slowly but surely. If I did not have a child I would have been far with my future by now, it is difficult but I am planning for my future" (Tholakele, 20 years).*

*"I am actually studying right now; I did beauty therapy. I am thinking of starting my own cosmetics business. Maybe in five years I see business booming and basically running smoothly" (Zama, 24 years).*

*"What I aspire towards is that I wish one day to get married to someone that is understanding and would love my child. I would rather not marry him if he did not love my child. I would love his children if he has any. Marriage is important for me because even my mother had a child out of wedlock [she never got married] and I also got a child out of wedlock. I want to break the cycle of falling pregnancy while still living at home. I want to get my own family with a husband" (Nonku, 19 years).*

Judging from the comments from the participants, all of them aspired for a better future. However they were not completely sure how to go about achieving it. Six out of ten participants had a clear idea about their future, and four out of ten were not sure about their future. Interestingly, those women living in a household with no employed members were most determined to pursue their careers and study further.

#### **4.9 Awareness of contraception**

The most commonly known contraceptives were the injection, followed by the oral pill, and intrauterine contraceptive device (ICUD). Two of the participants had heard of the ICUD. While contraceptives were seen as a method of protection against pregnancy among participants, there was a lack of adequate information on contraceptives.

Correct and consistent use of condoms and other contraceptives is an integral component of the combination of HIV prevention strategies that young people can choose at any time in their lives to reduce their sexual exposure to HIV and other STIs, or as a dual protective method used for also preventing pregnancy among women (Shisana et al., 2014: 73). Condoms provide dual protection against unplanned pregnancies and sexually transmitted infections (including HIV/AIDS).

All participants had heard about the condom prior to their pregnancies. However, for most, their sexual encounters had been unprotected and had exposed them to unplanned pregnancy. Six participants reported having used the condom at their last sexual exposure. On the other hand, four reported that they had not used the method

consistently. For most participants, after pregnancy they had used both the condom and other contraceptive methods to prevent pregnancy. In the study it was found that the majority of the participants had not been aware of the effectiveness of family planning until they had had their first child.

Most of the women had adequate information about the importance of family planning after their first pregnancies. For the young mothers the most common contraceptive accessible at the local clinic was the injection after they had had their first child. They were only exposed to contraceptive methods after having had their first child.

One participant noted that she did not feel that contraceptives were important for her. She felt that they were methods that were used by adults, rather than by young people. The participants indicated that they accessed their contraceptives from the local clinic. The facility as indicated by most participants was used during their pre-natal care visits. Their attitudes towards types of contraceptive methods available and accessed in clinic for the young mothers are illustrated below:

*“The nurses told me after I have given birth and other mothers to use contraceptives, so we won’t have other children” (Mbali, 18 years).*

*“They are good, because after I got the baby I used them and I didn’t get another child. They helped me. They do not have side effects as people say they have to me. I heard about them from home, since I had the baby, they advised me to use them and go to the clinic and get an injection” (Sphindile, 24 years).*

*“I knew about contraceptives but never used them before I had my baby, now I use them so I won’t have them again, they prevent you from getting pregnant” (Nonku, 19 years).*

*“Those things [contraceptives] should be used by older people but since the nurse at the clinic told me to use them, I do use them so I won’t have a child” (Zanele, 23 years).*

It is evident that the women had inadequate information on contraceptives prior to falling pregnant. They had only become aware of different types of contraceptives after their pregnancy – by then it had been too late. There were some misconceptions about contraceptives. In the study, they had learnt more about contraceptive methods after the first birth. It was noted that clinic nurses advised young women to use contraceptives after giving birth. Contraceptives were seen as preventing further pregnancies. From these comments, it was clear that young people had some awareness of contraceptives and its purpose. Table 4.2 represents the findings on available contraceptives in the local clinic. The condom and injection were the two contraceptive methods that are most commonly known, used and accessed among the ten participants.

**Table 4.2: Participants' knowledge of the accessibility of contraceptive methods**

<b>Rank</b>	<b>Type of contraceptive</b>	<b>Number (max 10)</b>
1	Using any method currently	9
2	Injectable contraceptives	9
3	Condom	8
4	Emergency Contraception	2
5	Oral contraceptives, the pill	7
6	Intrauterine Contraceptive device (ICUD)	2
7	Abstinence	1
8	Spermicide	0
9	Contraceptive patch	0
10	Sterilisation	0

#### **4.9.1 Perceptions of contraceptives**

Participants held both negative and positive attitudes towards contraceptives. The usage of contraceptives among participants to prevent another pregnancy was initially not an individual's decision. Other young mothers also pointed out how family planning methods could have assisted them in not falling pregnant. Some indicated that the inconsistent usage of the condom led to them falling pregnant. According to Gage (1998), the reluctance to use contraceptive methods stemmed from a fear that use might cause infertility, that the contraceptive pill might produce harmful side effects, and that forgetting to take the pill was a serious risk. The women complained about their fear of side effects, which acted as a deterrent to use. They were

particularly worried about gaining weight. However, others acknowledged it had benefitted them as they had not fallen pregnant again. Sometimes health providers may adopt judgmental attitudes to young women having sex and this may discourage them from visiting health facilities. The following perceptions by participants indicate that contraceptives are perceived differently by each participant:

*“I seriously do not like the injection because they make your body jiggle. I am lucky because I am thin. So far they have not revealed any side effects” (Nonku, 19 years).*

*“After I had my baby I used the three-months Depo-Provera. It made me fat. I hated it, I never gained weight during my pregnancy, but I only gained once I used the injection. I went back to the clinic and told them I hated it, and they gave me a two-months injection, after all I can’t get pregnant anymore, but it is difficult to lose the weight I put on when I was on the three-months injection” (Zama, 24 years).*

*“I am not really fond of the injection because when time goes by, your body will be filled with fluids and that is not good especially if I am still young. The pills are a risk because once you forget using them, you get pregnant” (Zanele, 23 years).*

*“Using contraceptives is good so that I won’t get pregnant again with a second child. The nurse at the clinic told me to come back after three months for my next injection, since it is the first time I am using contraceptives [the injection] since I just delivered my baby” (Smangele 20 years).*

*“Contraceptives are good, I only used them after I delivered, they are helpful and they did not have side effects as many girls claim. Even at home they warned me and told me to use them” (Sphindile, 24 years).*

*“They (contraceptives) do work and help. It is about being responsible, how not to fall pregnant, and it is not something I will take every day like the pill because I am scared of the side effects. I do not use them, because I abstain. The nurses at the clinic judge me when I go to request them. I did use contraceptives, but I had the flu and I was on antibiotics, and I had sexual intercourse. As soon as you take antibiotics while*

*you are on contraceptives your system is vulnerable and that is how I got pregnant”*  
(Samke, 22 years).

One participant had an idea as to the function of the injectable contraceptive method. She explains:

*“What I know about contraceptives, especially the injectable contraceptive, is that they make you not go on your monthly period when time goes by. A woman does not ovulate, so the eggs do not get fertilised by the sperm entering. Condoms prevent sperm to enter you and other disease such as HIV, STIs and pregnancy as well”*  
(Tholakele, 20 years).

Two participants pointed out that hormonal contraception should not be used by people who do not have children. However, they suggested that young people should use condoms:

*“In my opinion young people should condomise and always protect themselves from pregnancy and HIV/AIDS”* (Mbali, 18 years).

*“In my opinion, using contraceptives is good to be used by those who have children so that you won’t have any children especially out of wedlock. But with no child it is not good because they have a lot of negative effects. These side effects are going to affect someone that doesn’t have a child, they are only good for those who had a child...they can prevent pregnancy”* (Amanda, 23 years).

It is clear from the interviews that there are still much negativity towards condoms. The women report that men perceive a girl as promiscuous if she initiates condom usage. Some of the contributing reasons for inconsistent use of the condom are their partners’ influence in not wanting them to use the dual protection method. It makes it difficult for some of the young mothers to negotiate safe sex. One participant highlighted that women are weak and men know that women are easily influenced when it comes to safe sex.

*“Men are negligent and when a woman suggests use they will ask why would we want to use a condom because I am dating you only and there is no one else, and you’ll also agree so that’s why it won’t work” (Sphindile, 24 years).*

All the participants indicated that the injectable contraceptive method works ‘well’ or ‘good’ to prevent pregnancy. The participants indicated that they had a preference for the injectable contraceptive. Some of the participants distinguish between the two types of injectable contraceptives: one that is taken every two months and the one that is taken every three months (Depo-Provera).

*“I know that the loop is placed inside you, but how I have no idea. I know with pills you drink them and mustn’t forget them, but the pills are risky because if you forget them there is the risk you might get pregnant. The injection stops your periods. What I know is that they make you sick as time goes by because periods are part of nature, so with regard to contraceptives I am not clear what they do in the body when one takes them, so we are not sure if there is something the nurses are not telling us or not clarifying” (Gugu, 21 years).*

*“There is depovera which I am using, the three-month one, and there is a two-month one (injection) as well as pills” (Sphindile, 24 years).*

From the comments it is clear that participants have knowledge of more than one contraceptive method. They can distinguish between different types of contraceptives. However, they only began to use a method of contraception after the birth of their first child. Participants did not use a method for a number of reasons, including fear of being found out by adults. However, there are problems associated with contraceptive use. Some perceived them as risky, leading to negative side effects, while others were supportive of them but did not use them consistently.

Studies globally have shown that among teenagers and young people, contraceptive methods are perceived negatively. However, there is an increase in the number of young people using contraceptives after the birth of their first child (Miller, 2010; Nkwanyana, 2011; Nour, 2006; Gage, 1998; Blanc & Way, 1998). The contraceptive injection, condoms and oral contraceptives seem to be the most common contraceptives known and used. One participant used the emergency contraceptive

known as ‘morning after pill or MAP’ to prevent falling pregnant after an unprotected sexual encounter. The same participant revealed that at the time she was not using any contraceptive because she was in a long-distance relationship with the father of the child. It is not known if the other contraceptives methods presented in Table 4.2 are available or accessible to women of Mpumalanga Township, Hammarsdale.

#### **4.10 Sex for financial gain**

Young women sometimes engage in relationships with older partners for financial gain (Panday et al., 2009). Due to lack of finances and financial support from family and partners, young women opt to have sexual intercourse with older married men for financial benefit (Govender, 2011; Panday et al., 2009; Hallman, 2004). Often young fathers of children provide no or minimal financial support for the mother of the child and their child. Some participants pointed out that the father of the child was not working. In some cases, the father did not earn enough to support them financially. Those were some of the reasons why young women engaged in multiple relationships with older men for financial gain.

In this study, it was clear that young women engaged in sexual relationships with men not only for financial reasons. Some of the women were very disapproving of girls who had sexual relationships with older men for financial gains. They felt that the young women were using these older men. However, they also acknowledged that the older men had more resources that they could use to entice the women.

*“I think the girls want older, mature men, rather than young boys. These old men might give them what the boys don’t. That is the sad thing” (Amanda, 23 years).*

*“How I see it is that the old men almost all of them are married with children. I doubt they will leave or divorce their wives for some young girl who wants a lousy R500. They value their wives a lot” (Nonku, 19 years).*

*“Obviously due to financial constraints, coming from a poor family, you will date a sugar daddy even if you don’t love him, just to get money” (Samke, 22 years).*



*“I despise these old sugar daddy-dating girls. Perhaps for some girls they are desperate and see the need to date him for money, but the men themselves are old enough to be their fathers, someone needs to talk some sense to these old predators” (Amanda, 23 years).*

*“Some girls are just “mosquitoes”, they suck all the money from the men to buy expensive clothes, cell phones, etc “(Smangele, 19 years).*

Evidently, the participants pointed out that having multiple sexual partners was a choice that was made by some girls. They emphasised that the reasons for some young women engaging in multiple sexual relationships with older men, ‘sugar daddies’, was to financially support themselves and their child.

#### **4.11 Family reaction**

The young mothers in the township experienced pregnancy while they were still in school and most of them received support from their families. Looking at the responses from the participants, when family members found out that they were pregnant, they were angry and disappointed. One participant was chased out of her home and was only allowed to return once an extended family member had intervened on her behalf.

*“I was scared and fearful. I was scared of them finding out about the pregnancy. I am not sure what my parents thought about me; but my mother cried when she found out about my pregnancy. She was very, very hurt” (Zanele, 23 years).*

*“My dad shouted at me, my mother was the calm one, he was angry with me for a long time. I thought he will never forgive me” (Amanda, 23 years).*

*“My father kicked me out of the house when they found out that I was pregnant, at that point, I didn’t know where to go. My aunt came to talk to my dad, by then he was still furious with me” (Nonku, 19 years).*

*“There was no support at all. I was very independent till delivery day. It seemed as if nothing happened, they didn’t really care. They helped me only when they wanted to, even when the baby arrived they didn’t care. It showed me that I was really in the wrong and that they were angry at me” (Tholakele, 20 years).*

*“Mum got angry after she found out that I was pregnant. My brother was also angry and hurt” (Mbali, 18 years).*

The young women described their families as hurt and angry at them. They felt that they had let their family down. One woman felt that her family was not very supportive and she had to take responsibility for her actions. However, not all family members were unsupportive. Some women reported that they could rely on their families.

*“For now they are supportive, but I hope things won’t change once the baby is born” (Smangele, 19 years).*

*“They were angry for that time being but it passed because my father said to me it’s not good for my pregnancy” (Mbali, 18 years).*

*“My mother’s reaction when she found out was to cry. My aunt told me that she said how could I have fallen pregnant because she does everything for me” (Sphindile, 24 years).*

Most of the women were still living with their parents. However, they were aware that a single mother, bringing up a child out of wedlock, places a burden upon the family. Those girls whose parents were not employed were in a more vulnerable situation. They were aware that they were placing more pressure on their parents. Six participants explained that their parents loved them and that was why they were so disappointed in them.

*“It was good, even my dad when he went to work, he asked me every day if I needed anything. They were supportive, even the rest of the family” (Zanele, 23 years).*

*“They were fine at home, just that my mother was unemployed. I had to look for a job in a restaurant at Steers. She had to take care of my baby from three months after the birth” (Gugu, 21 years).*

*“The time they found out about my pregnancy they didn’t have a problem, they were angry for that time being but it passed and now they don’t have a problem and they are very supportive” (Samke, 22 years).*

*“The support system was actually great; they did their best at home. They were always there for me, they showed me how to deal with the pregnancy issue and what you should do when you have a child. They taught me after pregnancy; to take care of a child before and after pregnancy and preparing for the baby. Even preparing for hospital and the necessities needed to carry to the hospital. It wasn’t something you would think about when you’re 13 years old. Because my grandmother would say I should have a back pack ready, when I was almost due” (Zama, 24 years).*

Some of the women admitted that while their parents had been disappointed they still continued to support them throughout the pregnancy. They also felt that they could not have gone through the pregnancy without their support.

#### **4.12 Delayed pre-natal care visit**

Young people are often negligent with regard to sexual and reproductive health matters (WHO, 2007). The young mothers delayed their pre-natal visits to the clinic due to fear of detection. Their parents did not know they were pregnant and as a result they did not go for their first visit to the clinic. Also, there was a great deal of stigma and discrimination within the community and this also delayed their first visit. Some participants initially started pre-natal care without the knowledge of their families when they found out that they were pregnant. For some, pre-natal care started after their parents and family members found out about the pregnancy. According to the WHO (2007), delays in accessing pre-natal care can result in health consequences for the foetus and mother. Often the mother has inadequate knowledge of the importance of pre-natal care. Most participants delayed pre-natal care visits because they feared that their pregnancy would be exposed to the community. Pre-natal care visits to

clinics were the most feared among the participants because they were worried people they knew might see that they were pregnant.

*“I only went for my pre-natal care after 5 months because I was scared. I went by myself to the clinic” (Smangele, 20 years).*

*“When I was pregnant, I don’t remember much, I was young. I didn’t know that I was pregnant until I was 6–7 months pregnant. I confirmed I was pregnant and then I started my pre-natal visits, but before then no one could tell I was pregnant until I was 6 months and started gaining weight because I was small and skinny” (Zama, 24 years).*

*“What happened, at home they found out when I was 7 months pregnant [they didn’t see me]. I was scared to go to the clinic, so I eventually went to clinic for my check up, just the last 2 months of my pregnancy, which meant that I only started pre-natal care after my 7th month of pregnancy” (Zanele, 23 years).*

Looking at the comments above, delayed pre-natal care was due to fear. Most of the participants started their pre-natal visit after their families found out about their pregnancies. The young women were afraid to reveal their pregnancy because they were worried about the negative reaction of their families and communities. Initially, only two out of ten started pre-natal care immediately after they had missed their menstruation period, but they did this without their parents’ knowledge. Participants revealed that they were scared of reporting their pregnancy because of fear of disappointment.

#### **4.13 Partner communication**

Due to a lack of adequate and accurate knowledge about sexual matters among young people, pregnancy is often unplanned. It is essential for partners to discuss sexual matters to limit the negative consequences of pregnancy (Panday et al., 2009). One participant revealed that the pregnancy was unwanted and unplanned. She fell pregnant soon after engaging in unprotected sex.

*“After we had sex, he told me that I was pregnant. He intentionally impregnated me. He said “you are pregnant” but after that I got my periods. I told him and he was sad. The following month my periods didn’t come, he was happy. He said he wanted a child from me. I did not plan to have a child, at least until I was 24 or 25 years. It was important for us to talk about these things so that he should have known that I did not want a child and I could have protected myself by using contraceptives” (Smangele, 20 years).*

*“It is important to talk especially about responsibility when it comes to sex and when the baby arrives. It is something he should stand for as well. Even when the baby arrived, unplanned pregnancy sometimes spoils and tests your relationship” (Tholakele, 20 years).*

*“It is a good idea, because there is a lot we can learn. We can teach each other, wrong and right. It is important for women and men to talk about sex because I should also know his HIV status, so I can take precautions so that I do not get infected” (Sphindile, 24 years).*

*“Emphasis on prevention for both males and females; it is important for partners to talk to avoid the consequences of pregnancy and HIV infection. For instance if as a girl you tell a guy you don’t want to have a child and use protection he will know that you never wanted and intended to get pregnant” (Gugu, 21 years).*

*“It is important for girls and boys to talk about sexual matters but it is up to that person to use protection [condom] during sex” (Nonku, 19 years.)*

The women all felt that it was important for partners to discuss sexual matters as it would prevent misunderstandings. Participants revealed that it was important to communicate honestly with partners to avoid the negative consequences of unprotected sexual intercourse. The participants felt that they would have liked to be given a platform to communicate such issues to their male partners. Communication could have prevented them from falling pregnant when they were not ready to have a child.

#### 4.13.1 Support of the father of the child

A young woman's pregnancy is not only her sole responsibility. The father of the child also plays a role and contributes to the actual pregnancy (Swatz et al., 2013). Some participants were not in any ongoing relationship with the father, yet they still communicated with them for the sake of the child. Communication among partners is essential, especially with regard to the child's financial support. Besides men wanting to prove to their male and female peers that they are fertile, childbearing has financial consequences for the father (Panday et al., 2009). Childrearing should be the responsibility of both parents. However, there is often poor financial contribution from the father of the child. Panday et al., (2009) suggested that this is likely if the father is not employed. For many young mothers, the fathers' role is of the utmost importance; however sometimes the father is not able to financially support his children. Support from the father of the child during and after pregnancy is also vital. These statements from the young women indicate that there was limited support from the father of the child:

*"At first he did provide support but once the baby turned one year, he changed. He did not even bother to bring baby clothes" (Gugu, 21 years).*

*"We are not in a relationship; his parents support the child because he does not have a job to support us financially. I do not care about me, but he should support his own child. His parents give me money to buy baby clothes because he is too lazy to look for a job. I understand you don't get a job overnight, but he doesn't take the initiative to look for one because he has a responsibility. I would look for a job myself if I had anyone to take care of my baby. He is a useless father, but I don't blame him. His parents do everything for him, they spoon feed him and obviously he won't even try to look for a job because his parents do everything for him. He is just not a goal driven person as well, so I would not say he supports the child because the money I get is from his parents, not him" (Nonku, 19 years).*

The women reported that the men rarely provide financial support. One woman reported that her partner initially provided support but this stopped as time went by. Another stated that initially her male partner was reluctant to provide support for the child but he eventually gave in to the demands.

*“He was good and he was supporting me. Hopefully he will support the child, even his family. He is currently not working but during the pregnancy he got a job, prior to that his family supported me” (Mbali, 18 years).*

*“at first he was stalling to buy baby clothes as he said he was not working, however I got what I wanted from him. My mum hated my boyfriend. She even said why would I get pregnant by him. According to her, my baby got the wrong father even if she loved my baby” (Sphindile, 24 years).*

Women also received financial support from the parents of their male partner. They felt it was difficult to get financial support from the father of their child. In many cases, this was also because he was not employed. Not all parents were supportive of the pregnancy. One woman noted her male partners’ family were very unhappy with the pregnancy and they accused her of witchcraft.

*“He was good and, he tried as best as he could. He only started working just after I delivered. From his family side there was a great deal of drama and stories. They felt that I had done witchcraft on him I got pregnant to trap him. His mother and sisters were jealous” (Tholakele, 20 years).*

Young fathers, like the young mothers, often are not ready for parenting. The fathers were often not in a financially stable situation. They were most often unemployed and they found it difficult to take responsibility for the child. Most participants were not satisfied with their child’s father’s role and seemed to view them as incompetent. Often the father of the child would accept the paternity of the child during the pregnancy but once the child was born there was a reluctance to take responsibility for the child.

#### **4.14 Perception of marriage**

The women did not seem to aspire to marriage. However, if it did occur it would depend on the male partner. They argued that if the marriage was to work, then the male partner needed to be faithful. Some felt that marriage depended on both partners working closely together. They regretted having children out of wedlock because they felt a child should be raised by both parents.

*“The youth of today party too much, they cheat on each other. They develop relationships based on lies” (Smangele, 19 years).*

*“Young people live together before getting married which is not good. Marriage can limit cohabitation and marriage is better than cohabitation. Young people are most likely to cohabit and less likely to marry. When a woman cohabitates, men don’t think so highly of her because she does everything for him. He does not see the need to marry her” (Samke, 22 years).*

*“It is not good to be pregnant before you get married. Young people are still not mature for marriage. And if they get married, they think they have everything in the world even if they married at a young age. When you get pregnant, the baby daddy will promise to marry you if you have his baby but he will leave you and never keep his promise. When the baby arrives he neglects and ignores you. Putting your trust in a man is the biggest challenge. For instance in the townships, they assume that since you are pregnant you will get married but that is not true. A child should only follow after marriage” (Sphindile, 24 years).*

*“Right now I do not want to get married, because I do not have a potential husband. The relationships I have with men is not good. I find they disappoint me. They are often not trustworthy and they do not fulfil their promises, so that is why I say I am not ready right now to get married. My perception is that young people should behave [not have a child] until after marriage. It is difficult to raise a child as a single parent especially if you are still living with parents. It is better to have a child when you are married” (Zanele, 23 years)*

It is clear from these comments that women seem to have a tainted view of men. They feel they cannot trust men. They are likely to cheat on the female partners especially if they are not married. It is clear that their experiences of early childbearing have also shaped their attitudes to marriage. The women feel that it is important to have children with their married partners. In marital relationship both partners are likely to contribute to childrearing. This is unlikely to happen if the woman is not married to her male partner. From the participants’ responses it is evident that their perceptions of marriage are viewed more negatively than positively. All participants would like to



get married, however, for the benefit of the child. They felt that there were many problems with having a child out of wedlock therefore they felt it would be better to have child with a married partner.

#### **4.15 Communication on sexual and reproductive health matters**

Information for sexual matters initially is obtained from peers (MacPhail & Campbell, 2001). Participants noted that they often spoke about sexual matters with their peers rather than their partners. In fact, one woman noted it was an endless topic of discussion. Two participants revealed that they felt peer pressure to engage in early sexual intercourse because their friends were already sexually active. One woman revealed that she did discuss sexual matters with her partner. Many of the young women reveal that boys feel great pressure to have sexual relations with their partners. These quotations reveal that peers influence early sexual debut:

*“Among friends it is an endless topic of discussion even before I got pregnant we used to talk about sex and condoms all the time. At home we don’t talk about it. It is something that was never discussed but we only see it on television. Now I talk to my younger siblings about falling into the trap of pregnancy and the risk of HIV infection. Among friends we don’t talk about HIV because it is a touchy topic and maybe talking to someone who has the disease will cause them pain. One of my friends is HIV positive but she has never told me; other people have told me” (Zama, 24 years)*

Women rarely talk to family about sexual matters. If the topic does arise it is usually in the form of lecture, warning young people about the dangers associated with sexual intercourse. This is not surprising given that sex is a taboo topic in many cultures.

*“At home we don’t talk about sexual matters because they warn us about having sex. They tell us that if you sleep around you will get pregnant, but they never go deeper” (Tholakele, 20 years)*

*“If you ask friends who have already had sex they tell you to experience it yourself. And they will say why don’t you do it with your boyfriend, they’ll never give you direction as to what really happens and how sex is experienced” (Sphindile, 24 years)*

*“Among friends, we get information from boys as well; sexually experienced boys talk to us about sex, even girls, when they want to boast about it to those who have not had experienced sex. At school teachers do talk about it, even parents warning us not to have sex, because you won’t like the consequences of having sex” (Gugu, 21 years)*

Sexual matters are often discussed among peers and participants pointed out the knowledge of sexual practices they gained from those discussions. Moreover, looking at the responses, it is clear that the young women did not have a true picture of the likely ramifications of early sexual debut. It is apparent that the participants’ early sexual experience was strongly influenced by their peers. The young women felt that they wanted to have the same experiences as their peers but they did not have adequate information about the consequences of unprotected sexual intercourse.

#### **4.16 Parent-child-communication**

The participant’s responses indicate that parents do not discuss sexual matters with their children. For all the participants, the reactions of their parents to their pregnancy were unfavourable. They emphasize that communication on sexual matters is of absolute importance. It can avoid the negative consequences of early sexual intercourse. They also suggested that it could lower the rates of teenage pregnancy if parents could communicate to their children about sex. It was found in the interviews that advice from the mothers is valued as they are experienced in having children. They would have liked their mothers in particular to offer them some guidance but this was not forthcoming and it resulted in dire, long-term impacts.

Nevertheless, some participants wished they had both parents living in the same household so that they could receive guidance and advice. While they acknowledge that mothers have a crucial role to play they also feel that fathers are just as important. One participant revealed that living with an aunt was not the same as living with her biological mother; even though the aunt assumes the motherly responsibilities. There are communication barriers between young women and their parents which often results in them engaging in risky sexual behaviours and activities. In communities such as Mpumalanga Township, Hammarsdale, young women often grow up without their parents. They live with their extended family members and as a result, they do not receive guidance from their parents. Parental communication with children

regarding sexual matters remains taboo within such communities (Dlamini & van der Merwe, 2002). Authority figures in the communities were mothers and older women. It is seen as being disrespectful to have communication between older women and younger women. Many of the girls revealed that if their parents showed more concern in their lives, they would not be in a situation of being pregnant at a young age. They felt that things would have turned out differently. The findings indicate that many of the young women found it difficult to communicate about sexual matters with their parents; they are not comfortable talking about sex if initiated by them. These illustrations demonstrate a communication barrier between young women and mothers in particular:

*“If I knew about pregnancy I would have prevented it. I only knew I was pregnant when I was 6 months into the pregnancy. We were told not to date because once you date you will get pregnant if you don’t use protection. It is good to talk to your child about sexual matters when they have reached a certain age but that is not the case. What actually happens is that when you go out and come back, they will scold you and hit you and ask you where you have been. They do not clarify what happens even if you start your periods... Few black parents talk to their children about sex; they live in the olden days. They will say: ‘my child if you see a man or boy run away’ and that is why black young people get pregnant because education starts at home. Children, especially young girls should be taught these things” (Sphindile, 24 years)*

*“It is important to have a relation with your mother as a girl child especially when you start your periods and start developing physically; because a mother is like a friend and easy to talk to and whatever I tell her she gives me advice. Children should be raised by both parents because, as much as a girl child might be close to the mother, but a male figure [father] is needed” (Gugu, 21 years)*

*“Children should stay with both parents and develop a relationship with both parents because what if the mother dies or vice versa.” (Zama, 24 years)*

*“My mother would say I should not sleep with a boy or I will bear the consequences and nothing further than that” (Smangele, 20 years).*

#### 4.17 Attitudes of healthcare providers

Family planning services are provided to young people with the purpose of making available reproductive health services, providing contraception, including condoms, and improving their knowledge and skill to use them (Panday et al., 2009: 87). Nevertheless, many young people reported problems at health facilities. Young people are able to access family planning services, however many are reluctant to use them due to the attitudes of nurses in clinics, which caused them delays in accessing pre-natal care visits. During the interviews many young women complained about clinic staff. They felt that there was poor interpersonal relationship between providers and clients. Often nurses in clinics are older women and as a result, were associated with a 'mother' figure.

The young women complained that during their pre-natal care visits, nurses would often express their disgust and disappointment with young, unmarried women falling pregnant. They felt that the clinic nurses were unprofessional and lacked proper skills and training on how to handle young clients. Some of the concerns raised are that the nurses were stricter to young girls than to elderly women and married women. All the women experienced stigmatization during the pre-natal visits at the local clinic during their pregnancy. One revealed that she did not use the local clinic but instead went to another facility because she was afraid of being scolded by clinic nurses for falling pregnant.

*"I did not use the Hlengisizwe Clinic because I heard those nurses are very rude to you, knowing that you want help from them" (Smangele, 20 years)*

*"I would not say much about clinic staff; I was left with two months to go to the clinic. But in those 2 months they were supportive, when I started pre-natal care after my 7<sup>th</sup> month of pregnancy. But the little time I went there, the one lady scolded me for coming so late for my pre-natal visit. She was judgemental; she didn't know my situation for her to be like that" (Zanele, 23 years)*

*"The nurses used to ask me why did I get pregnant at such a young age. She said there are condoms available so why don't we protect ourselves, before she started inspecting me and the baby" (Mbali, 18 years)*

*“I don’t like going to the clinic, I am forced to because I don’t have medical aid but it is not easy having to wake up early in the morning by 6 am and only leave at 2 pm knowing a stranger is going to shout at you. They are not supposed to ask us why we are having sex; it is not their business” (Nonku, 19 years)*

*“I dreaded going to the clinic, when I was pregnant. They used to say to many of us who came for pre-natal care that ‘the young pregnant ones on this side and the rest on the other side’. They would separate us because we were young and the other married pregnant women on the other side; it really was not fair at all.” (Amanda, 23 years)*

They felt that the nurses were judging them because they wanted to know why they fell pregnant. They wanted the clinic staff to treat them in a professional way and to reserve judgements. They did not feel they could discuss sensitive issues with the clinic staff because they lacked sensitivity. If the staff were not judgemental they could have provided the young women with useful information that not only prevents further pregnancies but also HIV infections. Clinic staff should be more empathetic and friendly to young women.

#### **4.18 HIV/AIDS and other STDs**

Women are at risk of HIV infection not only because of their behaviour but also because of their partner’s sexual behaviour. One woman had more than one sexual partner and therefore was at risk of HIV infection. Other women were unaware or suspected their partners of having other partners. Even though the women were tested for HIV/AIDS, only one participant talked about her experience of having an HIV positive friend due to multiple sexual partners. Their knowledge of HIV/AIDS was pointed out in passing, while being taught about protecting oneself against pregnancy and disease; education was not specifically on AIDS but on protecting themselves from another pregnancy. The topic of HIV/AIDS was avoided among participants, however, one participant revealed that she had two sexual partners at the same time and one participant revealed that the father of the child had impregnated her had a relationship with another girl. This illustrated that the participants were prone to the

HIV/AIDS and other sexually transmitted infections. The comments below illustrate this:

*“Initially our relationship was fine until I heard he impregnated another girl, we fought, until he changed a bit. I was angry at him. I never knew the girl, only when I heard he impregnated her. ...we are not in a relationship currently because he impregnated the other girl. He cheated on me even though I thought he will change, but a cheat is always a cheat. I hate him totally, he ruined my life. I was bitter and didn't want to even see him, but gradually I learned to calm down and forgave him for the sake of the child, we needed to have a relationship based on the child, not a dating relationship” (Gugu, 21 years)*

*“At that time I had two boyfriends. The first boyfriend I had I thought was my baby's daddy, but people were telling him that it is not his child. When the baby was born I found out that the man I thought was my baby's daddy was not him because my baby looked like my second boyfriend. They both thought the baby was theirs. Even my first boyfriend still thinks it is his baby because the baby also looks like his family members, because even now he still calls me and say the baby is his because he does not want to accept that it is not his” (Zanele, 23 years)*

These quotations indicate that both of the participants were directly exposed to STIs, HIV and AIDS because of unprotected sexual intercourse. However, for many young women pregnancy is seen as a far greater risk than HIV/AIDS.

*“Youth today do not really think about the future. We do not talk about HIV and AIDS. My friend has had HIV for a long time, she didn't confess to me, I heard people say and we worry a lot about pregnancy. However, pregnancy can also make you get HIV because if you have unprotected sex that means you can get HIV as well” (Zama, 24 years)*

Although the participants did not reveal their feelings about their risk of HIV infection it is clear that women who engage in unprotected sexual intercourse with multiple partners are at heightened risk.

#### 4.19 Abortion

Family planning services are provided for women to access and utilize them. In South Africa abortion has been legalized for women to terminate their pregnancies if they wish. Young mothers who opt for abortion often fear partners' and family's reaction to the pregnancy. One participant indicated that she thought about abortion due to the consequences of having a child at a young age. The quotation below illustrates that due to the duration of her pregnancy, she could not go ahead with the termination of her pregnancy. Other participants did not discuss abortion; perhaps they felt that it was a very sensitive issue. Alternatively, while such services may be offered they are not easy to access.

*"I was crying now and then, I wanted to do an abortion, I did some research on it. I even got money and paid for the abortion and I was ready to abort but the pregnancy was too far gone, it was difficult. I spoke to my friend, who had done an abortion, and she said I must go to the doctor and buy pills. But by then the baby was too grown and I couldn't do anything. The reason why I thought of abortion was because I was scared. Even though I loved my baby daddy we were not ready to have a child. We never spoke about protecting ourselves" (Sphindile, 24 years)*

The main reason for young people to abort is because of fear. Even after the legalisation of abortion, there are still strong negative attitudes towards it. Often it is too late for women to abort because the pregnancy would have been advanced and they would have realised that they are pregnant much later.

#### 4.20 Summary

This chapter has presented results from the in-depth interviews conducted with young women in e Mpumalanga Township, Hammarsdale. It is evident that there are a number of factors influencing early childbearing in townships. The reasons why young girls fall pregnant are interrelated. Young mothers express their regret at having a child at such a young age. They have to take the responsibility for not only rearing a child out of wedlock, but also focusing on their future aspirations. Financial insecurity prevents them from furthering their studies. A number of young people feel that support from the father of the child is essential. There is not much focus on getting married but rather on building their future. The chapter has attempted to

narrate and deepen the understanding of early childbearing among black women in Mpumalanga Township, Hammarsdale. At the same, ascertain attitudes to early childbearing, as well as challenges associated with an early pregnancy.



## **Chapter 5**

### **Discussion and Conclusion**

#### **5.1 Introduction**

Youth in South Africa are faced with many challenges that influence their childbearing behaviour. Studies have also shown that fertility levels among South African youth are high (DHS, 1998 and Kaufman et al., 2001). Early childbearing in South Africa and globally has been seen as a social problem; however research on early childbearing among young, black women in townships has been neglected. In addition the social environment, in which young women live are often ignored when focusing on early childbearing. The overall aim of this study is to draw attention to the factors influencing early childbearing among young, black women. The research attempts to explain factors contributing to early childbearing. This study suggests that the socio-economic conditions in which young women find themselves increases their exposure to an early pregnancy.

The purpose of the study was to shed insights into early childbearing among young black women. It looked more specifically at firstly, attitudes to early childbearing, secondly the factors that contribute to early pregnancy and thirdly the opportunities and challenges in preventing early childbearing. Most studies have concentrated on the levels of pregnancy among young people; however this study explores reasons for early childbearing among young black women. The study draws on qualitative research methods to explore these objectives. In-depth interviews were used to gather detailed information on individual's experiences of early pregnancy. The study draws on in-depth interviews from a small sample of women living in a township in KwaZulu-Natal. Even though there are limitations of qualitative research methods the advantage of qualitative methods is in the in-depth, detailed data that is obtained. The study draws on the conceptual framework developed by Hallman (2004) to explore young women's early childbearing experiences.

The findings of this study suggest that most participants fell pregnant due to limited information. They were not aware of the risks associated with unprotected sexual intercourse and the range of methods that can be used to avert pregnancy. Other

studies have also found that young women often fall pregnant for the same reasons (Mchunu et al., 2012; Kaufman et al., 2001; Dickson-Tetteh and Ladha, 2000). The findings from the study show that South Africa's youth evidently engage in risky sexual behaviours, not only due to lack of knowledge but also, poor socio-economic conditions that influences their decision-making (Dickson, 2004). Respondents were aged between 18 to 24 years and it is worth noting that the majority of them, prior to their first pregnancy, did not understand the risks associated with engaging in unprotected sexual intercourse. Studies suggest that the low socio-economic status of young people perpetuate and increase risky sexual behaviour (Manzini, 2001; Jewkes et al., 2001). The young women in this study were living in a township characterized by poor socio-economic conditions.

Studies suggest that there are a number of factors contributing to early childbearing (Cunningham & Boulton, 1996). It is alleged by many that the child support grant plays a role in facilitating early childbearing. However, this study found that the child support grant (CSG) was not a factor in encouraging young women to bear children. It was not raised by the women as a factor influencing their decision to bear a child. In the context of South Africa, Lund (2008); Makiwane, Desmond, Richter and Udjo (2006) observe that since the introduction of the CSG, teenage pregnancy has decreased. Therefore, there is no empirical link between teenage pregnancy, increased fertility among young women and the child support grant.

The issue of early childbearing is rather complex and controversial. The study suggests that early childbearing is a consequence of unprotected sexual intercourse. Unsafe sexual behaviour increases the risk of pregnancy; particularly at a young age (Dickson, 2004). The study found that the lack of knowledge of methods to prevent pregnancy play a vital role in prompting risky sexual behaviour. In the study, it was found that there is inadequate knowledge of pregnancy prevention methods. Lack of knowledge of methods to prevent pregnancy in the study emerged as a dominant theme. Studies globally have shown that young people do not have adequate awareness of preventative measures of pregnancy (Biglan et al., 2001; Gage, 1998). In addition, young people are not informed about the consequences of unprotected sexual behaviour and activities. Other studies suggest that girls and boys often face puberty with little understanding of how conception and contraception "work" (Prelser-

Marshall and Jones, 2012: 5). According to Preiser-Marshall and Jones (2012) in Central America, for instance, survey evidence suggests that almost one in three adolescents did not know that pregnancy could occur the first time a girl had sex. In a study in India, ‘one in four girls did not know that pregnancy could occur mid-menstrual cycle and there was a general lack of awareness amongst girls that a missed period could signal pregnancy’ (Preiser-Marshall & Jones, 2012: 5). Studies also conducted in Mexico, Thailand and South Africa indicate that sexually active teenagers did not perceive themselves as high risk of pregnancy and other sexually transmitted infections. This implies lack of perception of risk of pregnancy. All three sites reveal that there is a challenge in sensitizing young people about sexual matters. (Preiser-Marshall & Jones, 2012).

Those who had some information about contraception noted that they had obtained information from their peers. Studies have reported that for most young women their main source of contraceptive information is peers (Raj, Rabi, Amudha, Edwin & Chapman, 2010:6). Interestingly, those who had inadequate information on contraceptive methods prior to their pregnancy indicated that they did not use and adhere to them. Patterns of contraceptive usage are related to a woman’s social background. Research has found that contraceptive usage is much lower amongst uneducated women compared to educated women (Bongaarts, 1978 & Chimere-Dan, 1994).

Women reported that they do not discuss contraception with their parents. Research has suggested that young people have been provided with virtually no useful information about pregnancy preventative methods by older relatives; some discussed contraception with their friends, but others did not, perceiving sexual matters to be a private matter (Wood, Maepa & Jewkes, 1998). A study conducted in the United Kingdom, Germany, Spain, Italy and United States of America found that 60% of women reported that they were likely to change their contraceptive method within the next 0–5 years (Johnson, Pion & Jennings, 2013: 7). They are numerous reasons why women would change or, not adhere to, their contraceptive methods; mainly health problems.

Another perceived barrier to contraceptive method use stems from the alienation that many young people feel when they attend maternal and child health clinics; which studies suggest is the primary source of contraceptive methods (Gage, 1998; Bongaarts, 1978; Chimere-Dan, 1996). This serves as a barrier to use and it is an area of entry in educating young people about contraceptive methods.

The study found that contraceptive knowledge is much higher among women after their first birth. Most women reported that they had obtained more information on contraceptives after their pregnancy. After the first pregnancy, young mothers were made aware of the risks associated with childbearing. Health risks associated with unprotected intercourse such as HIV and AIDS are of great concern to young women. The study indicates a much broader concern of preventing a second pregnancy because of social, educational, and financial constraints encountered from the first child birth. All participants revealed that having a second child would place a greater burden on them. The strong determination to prevent further pregnancies emerged from the life disruption caused during their first pregnancy. They felt that they were not ready for motherhood at such a young age; and that they should have delayed childbearing until they were financially and emotionally independent.

The study also found that young women held many negative attitudes towards pregnancy prevention methods. Overall, the commonly reported attitude about contraceptive methods (namely the oral pill and injectable contraception) was that it causes side effects such as weight gain, moods swings, body changes and other symptoms. According to Johnson, Pion & Jennings (2013) these are some of the attitudes that influence women to not adhere to contraceptive methods. Interestingly, clinical studies have failed to confirm these misconceptions that participants have about contraceptive methods, in fact, there is evidence to suggest that the contraceptive pill may even improve or stabilise moods (Johnson, Pion and Jennings, 2013: 8). This indicates that many myths about preventative methods persist and that young women in this context are not properly informed about contraceptive methods, (Panday et al., 2009, Johnson, Pion & Jennings, 2013). Other participants felt that pregnancy prevention should be both partners responsibility, because they feel the burden of using contraceptive methods. Male partners should use male condoms also to prevent unplanned pregnancies. According to Mfono (1998), preventing pregnancy

should be a jointly responsibility for both sexual partners. This practice could eliminate and prevent unwanted and unplanned pregnancies.

There are a number of challenges for young women obtaining contraceptives from public health facilities. These include clinic opening hours; long waiting times at clinics; concerns around confidentiality; the judgmental attitudes of staff; limited contraceptive options; limited staff knowledge and poor staff training, a finding consistent with other studies (Willan, 2013; Panday et al., 2009). The study also found that the attitudes of healthcare providers may act as a barrier for young people to use health facilities. Many participants complained about the negative attitudes of health providers. Studies have shown that many young women withdraw from seeking family planning services due to the health service providers' attitudes (Panday et al., 2009; Wood Maepa and Jewkes, 1998). The participants indicated that it is very difficult for young people to make use of family planning services because of the attitudes of health service providers; and service provided at the local clinics are not youth-friendly. Lack of trust in health providers, limited confidentiality at health services, poor quality of services; moralistic and judgmental attitudes; poor knowledge and insufficient training were repeatedly highlighted as barriers. Despite the challenges the participants encountered from healthcare providers; other studies also identify administrative and quality of care as barriers young people face in accessing services at the local clinics. Many health providers are reluctant to provide contraceptives to adolescents, believing that to do so would encourage early sexual activity (Presler-Marshall & Jones, 2012:39).

The study found that pregnant teenagers and teenage mothers also experienced stigma from family, peers and the community. The young mothers noted that this served as a barrier to them remaining in school while pregnant and returning following childbirth. However, while this was unpleasant, and such behaviour should not be tolerated, it does not appear to have been a critical factor in determining whether young mothers returned to school following childbirth in the present study.

Early childbearing also has an influence on the education of the young woman. Childbearing among young people is likely to have negative implications for their lives. The study revealed that the most salient social consequence of early

childbearing is an interrupted education. There is concern that starting a family young also limits women's opportunities for their future, as other studies also suggest (Seamark and Lings, 2007: 814). A study conducted in West Africa found pregnant black teenagers under the age of 18 are unlikely to return to school (Cunningham & Boulton, 1992). Few studies examine the direct association between continued school enrollment and adolescent pregnancy (Grant and Hallman, 2006: 4). In their studies, Grant and Hallman (2006) and Panday et al. (2009) suggest that in less developed countries young women who are enrolled in school are less likely to be sexually active, less likely to begin childbearing, and more likely to use a contraceptive method, compared with women who are not enrolled in school. This is also supported by Bongaarts, Frank and Lesthaeghe (1984) who observe that education delays childbearing. The notion has however been contradicted by other studies of early childbearing and education. Seamark and Lings (2004) reveal that in a study conducted in the United Kingdom women who become pregnant in their teenage years may well have their education interrupted but they return to school after childbirth. Young women who mention pregnancy as their reason for school leaving may be equally influenced by their family's financial situation or by potential care giving arrangements that will be available after the child is born. These factors may be significant in determining how a schoolgirl reacts to pregnancy and whether she will resume her education after her child is born (Grant and Hallman, 2006). The study results revealed that the young mothers valued education which is some of the reasons behind girls returning to school after pregnancy. For them education has a protective function and provides a structured setting in which they receive support and develop their capabilities and knowledge. For some who returned to school, their performance was poor due to interruptions and missing school days. Pregnancy was an event that caused a disruption in their education which had a negative impact on their lives.

Many studies have found that 'working women experience lower fertility than women who are not working' (Makiwane, Palamuleni, Kalule and, 2007:117). Employment opportunities for some young women in the study seem to be scarce. Participants indicated that motherhood at a young age is a challenge; hence it is difficult to find a proper job with no formal tertiary education. Having a child earlier than they had originally anticipated had a disruptive effect on their education and employment prospects. It created social disorder in their lives; and they realize the importance of

education and its role in securing employment. Furthermore, studies have shown that teenagers become mothers without the necessary knowledge, skills, resources, and networks to cope with the demands of parenthood (Grant and Hallman, 2006; Maseko, 2003; Panday et al., 2009). Parenthood comes with social and financial implications. All participants regretted having a child due to the time spent on being a caregiver to the child. They indicated that the time they spent on the child could have allowed them to seek formal employment and improve their performance whilst still in school. This has affected their ability to secure formal employment and they are left with limited qualifications due to their pregnancy. Having a child had an impact on them as some were unemployed and others were only able to secure temporary employment. Earlier studies have shown that teenage motherhood is associated with poorer socio-economic outcomes. Unemployment and job opportunities in the study continues to be a challenge among young women overall. This study found that young mothers struggled to complete their education and found it difficult to gain employment.

All participants revealed their initial reaction to the pregnancy was a sense of disappointment, despair and fear. Some even thought about abortion because of the social and financial implications associated with an early pregnancy. Interestingly, they were not so worried about having a child but rather having a child at their age. Early pregnancy thus forces the young women to assume a maternal identity instantly without prior preparation for the role (Maseko, 2003). All participants revealed that the pregnancy had a considerable influence on their lives. Studies among young mothers suggest that they are far from emotionally, cognitively and socially ready for the prospect of motherhood (Parekh and De La ray, 1997:225). In their study, Seamark and Lings (2004) suggest that young mothers often experience quite major difficulties because of their age.

The study found that discussions between parents and children are limited. The young women tend to avoid the subject of sex with their parents. Participants revealed that parents avoid talking about sexual matters with their children. As a result issues pertaining to sex are discussed among friends. Studies indicate the extent to which parents are involved and the manner in which they are involved in their children's lives are critical factors in the prevention of high risk sexual activity (Biglan et al.,

1998; Blake et al., 2001 and Varga, 2003). The study found that the black parents in this study are less open about puberty, sex, sexual behaviour and pregnancy. There is limited or no information shared in their households with regard to sex. When issues about sex are raised, they are often avoided by the children because it is an 'uncomfortable' topic to talk about. According to McWhirter et al (2003) studies have shown that parent's sexual values, together with parent and child communication, have an important effect on adolescents' experience of sexual intercourse. Children whose parents talk with them about sexual matters or provide sexuality education at home are more likely than others to delay sexual activity (Blake et al., 2001: 52). Although participants indicated their desire to discuss sexual and reproductive health matters with their parents; their parents deemed topics related to sex as unacceptable. Lack of communication between the parent and child exacerbate peer influence on young peoples' sexual lifestyle. Moreover, Miller (2002: 23) also argues that parent's involvements in children's lives reduces sexual behaviour and improves education attainment and positive future aspirations.

The present study found that parents are not an important source of information. Young women rarely discuss sexual matters with their parents. Most reported limited communication with their parents. Studies suggest that parent-child connectedness i.e. parental support, closeness, warmth is related to lower adolescent pregnancy risk and delaying and reducing sexual intercourse among young people (Miller, 2002: 24). Moreover, studies have also shown that parental authority and supervision lowers early sexual debut and risky sexual behaviours (Maseko, 2003). Some researchers have argued persuasively that parents' attitudes and values about teenage sex and pregnancy influence whether teenagers have sexual intercourse, the timing of their sexual debut, their number of sexual partners, their use of contraception, and whether or not they have been pregnant (Manzini 2001; Miller, 2002: 24 and Juhasz, 1980). Parents' preference for their children to avoid pregnancy (either through sexual abstinence or through contraceptive use) are most effectively transmitted when parents have a close relationship (connectedness) with their children (Miller, 2002). However, parents cannot determine their children's sexual onset, although they may discourage early childbearing.



The study revealed that that when sexual onset is unprotected this behaviour sometimes continues. Jewkes et al. (2001) assert that early sexual onset put not only the teenager at risk of pregnancy, but they are at risk of multiple sex partnerships, forced sexual initiation and HIV related sicknesses. Early sexual behaviour among young people seems to be the norm and socially accepted (Jewkes et al., 2001). In the study, it was found that even though sexual onset was voluntary; male partners influenced and motivated them to engage in sexual relations. As reported by Adimora and Shoenbach (2005) male partners have an influence on the timing of sexual onset. Other studies found that boys and young males are likely to engage in sexual activity at an earlier age than girls (Jewkes et al., 2001 and Chimere-Dan, 1994). This is because of the desire to prove their masculinity (Hooks, 2000). This not only perpetuates early sexual behaviour but motivates risky sexual engagement at a young age. Often women engaging in unprotected sexual intercourse are motivated by the desire to prove their fertility and womanhood and men their masculinity (Hallman, 2004; Panday et al., 2009).

This study found that peers appear to have an influence on the behaviour of young women. Since young people do not have sufficient information about the risks associated with sexual behaviour, peers are an important source of information. Almost all the participants indicated that they obtained information on sex from their peers at school and in the community. The information that is shared is not always accurate or adequate. Although peers might not pressure them to engage in sexual activity, however young people feel pressure to be accepted by their peers. Some participants reported that when they started having sex, their friends had already been sexually active. Moreover, sexual onset is also influenced by the male partner; 'giving it away' indicates that you are a woman and part of a particular peer group. Some participants revealed that their relationship with friends has changed due to their pregnancy and their parental responsibilities. Manzini (2001) found that relationships dynamics changed and peers withdraw from friends who are mothers and this results in the mother feeling the burden of motherhood.

Literature suggests that marriage is a factor influencing fertility and child birth among women (Kaufman et al., 2001). Today, many young people are getting married at an earlier age (Nour, 2006; Goodman and Greaves, 2010). However, in the study it was

found that marriage does not influence the fertility rate and early childbearing. Nour (2003) and Groat et al (1997) assert that marriage among young people is not necessary for childbearing. The study found that young women engage in premarital sex and this is likely to continue because less emphasis is attached to marriage. For young people, marriage is an option and does not necessarily mean a delay in childbearing.

Hallman's conceptual framework reveals that young people's social environment has an impact of individuals' behaviour. Therefore the conceptual framework was demonstrated by the findings of the study that exogenous factors i.e. the society, community and household influences individual's behaviour. Other exogenous factors such as socio-economic status and culture also influence early childbearing and the sexual and reproductive health of young people. The poor socio-economic conditions experienced by young mothers seem to impact on the sexual behaviours of young people.

A study conducted in the United States of America suggests that unfavourable socio-economic conditions contribute to the high teenage pregnancy (Penman, Carter, Snead and Kourtis, 2013). According to Hallman (2014) the consequences of childbirth for a young mother and her child may vary according to individual circumstances such as the age subgroup, income level, education and whether the pregnancy was intended. Socio-economic conditions may vary from an individual's interaction with peers, family, friends, school, community and policy level factors jointly influence health outcomes (Dehlendorf, Marchi, Vittinghoff, and Braveman, 2010). The socio-economic conditions as suggested by Hallman (2004) in the study indicate that the social environment of the young mother influences sexual risky behaviour - pregnancy. Socio-economic conditions such as barriers to contraceptive usage (knowledge and useful information), access to quality healthcare, educational level and employment opportunities in the study continue to influence early childbearing. In a study conducted in United States Dehlendorf, Marchi, Vittinghoff and Braveman (2010) found a positive relationship between maternal education and the perceived importance of birth control as a socio-economic determinant of fertility. This indicated that sexual and reproductive health education influences childbearing among teenagers. As revealed in the study, lack of sexual education leads to early

childbearing. Whilst other studies suggest that teenage pregnancy is influenced by socio-economic factors such as family, cultural practices; urbanisation and under-utilisation of health services (Odejimi, Pauline and Bellingham-Young, 2010).

In the context of South Africa Mchunu et al., (2012) points out that poor socio-economic conditions lead to unplanned pregnancies. Poverty and low educational attainment contribute to young women engaging in risky sexual behaviour; leading to an unplanned pregnancy. Research conducted shows that more than half of female respondents fall pregnant due to lack of knowledge, and 55% of respondents got pregnant because they did not understand the risks (Mchunu et al., 2012: 432). The findings of the present study indicate early childbearing is a complex issue and the determinants of teenage pregnancy are multifaceted.

## **5.2 Recommendations**

Early childbearing is a complex, controversial issue; hence, multidimensional and multi-objective measures are needed in tackling pregnancy among young women (Dehlendorf, Marchi, Vittinghoff and Braveman, 2010). These include school-based sex education, peer education programmes, adolescent friendly clinic initiatives, mass media interventions as well as community level programmes (Panday et al., 2009: 108). Success in preventing early childbearing requires substantial commitment to overcome challenges. Engaging communities in combating early childbearing will assist to eliminate high levels of risky sexual behaviours. Any initiatives should also work with the communities to ensure the community as well as community ‘gate-keepers’ support, so that young women are not struggling with stigma, shame and secrecy while accessing contraceptives (Wilan, 2013: 55). Awareness campaigns are useful for reducing the stigma associated with early childbearing. In addition, teachers need to be given training on how to provide adequate support to pregnant school girls (Wilan, 2013: 57).

Often young boys are overlooked when talking about teenage pregnancy. Involving young men in such initiatives is important in attempting to alleviate early childbearing. Outreach and edutainment projects should be designed to target young people; both boys and girls at a young age. Participants indicated that sexual matters in this context should involve males in combating unplanned pregnancies.

Additionally, policy needs to mainstream male involvement in women's reproductive health (Mangeni Mwangi and Mbugua, 2013). Programmes need to encourage males to become more involved and supportive of women's needs, choices, and rights in sexual and reproductive health. In addition, it is important to address men's own sexual and reproductive health needs and behaviour at a young age (Panday et al., 2009 and WHO, 2007). For instance, participants in the study revealed that if that had known and communicated with their partners about sexual matters; they might have prevented unplanned and unwanted pregnancies.

Sex education interventions should be a priority in schools. In schools there should be more emphasis on pregnancy prevention, family planning and the consequences of risky sexual behaviour. The study suggests that school attendance continues after childbirth and programmes should assist young girls to complete their education. This could lead to girls being motivated to return to school and not have to interrupt their education. Support structures should be in place in schools to also avoid stigma and discrimination from other pupils and teachers.

Sexual education programmes have the potential to tackle not only pregnancy but also, HIV/AIDS and related diseases. Moreover, initiating such projects can decrease uninterrupted schooling for both girls and boys. Interventions to encourage children from impoverished families to continue with their schooling are imperative to prevent them from engaging in risky behaviours.

There is a need for some reform of health services including the administration of opening times; waiting times in the clinic; and information on the various available contraceptive methods. Much of the literature speaks of youth friendly health services (Wilan, 2013). Youth friendly service does not necessary have to be staffed by youth, however they provide youth friendly health services. For example, they provide prenatal care consultation rooms for group discussions; different rooms for pregnant and non-pregnant young women; counselling on contraceptive methods. Research shows that such initiatives should include men because men who have unprotected intercourse also tend to engage in other risky behaviours such as abuse of alcohol and drugs (Planned Parenthood Federation of America 2013: 7).

It is obvious that young people engage in sex at a young age. Promoting abstinence is also essential in attempting to alleviate early childbearing. However, sex abstaining initiatives should not overlook the fact that young girls and boys start sexual intercourse at a young age. They should provide age-appropriate sexual health education and safer sex promotion; promote condoms and proper screening and treatment for sexually transmitted infections (Christiansen, Gibbs, and Chandra-Mouli, 2013: 3).

Young mothers need support to raise their children. It is essential to prioritize young mothers' access to parenting programmes, early intervention services for children at risk and integrated early childhood development programmes such as good and affordable crèches (Wilan, 2013: 57). There is a strong role for schools to play in expanding support to young mothers; as a learner in the school. Some may argue that managing childhood and pregnancy is difficult and young girls should discontinue with schooling. However, that is likely to have negative implications on the future of the mother and the unborn child.

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## **Appendix I : INTERVIEW SCHEDULE (In English and isiZulu)**

### **SECTION A**

#### **Interview schedule**

#### **Background demographic**

- 1.1 Pseudonym Name: (*igama*)
- 1.2 Current age (*iminyaka*)
- 1.3 Grade while pregnant (*wakhulela nini*)
- 1.4 Age at conception (*iminyaka wakhulelwa ngayo*)
- 1.5 Marital Status of the participant (*ukushada kwabazali kwakho*)
- 1.6 Period out from school(*isikhathi walova ngaso esikholeni*)
- 1.7 Marital status of parent(*ukushada kwabazali bakho*)

### **SECTION B:**

#### **2. What was your life like before you had your child/ren**

2. What were the challenges faced whilst you were pregnant:  
(*Yiziphi izingqinambi owahlangabezana nazo ngenkathi ukhulelwe?*)

2.1 At school?

(*Eskoleni?*)

2.2 And at home?

(*Ekhaya?*)

2.3 Overall experience?

(*Nje? Kukho konke*)

#### **3. How has the experience changed your life?:**

3.1 How has the experience changed the Relationship with friends?

(*Ubudlelwani bakho nabangani bashintsha kanjani ngenxa yokukhulelwa?*)

3.2 How has the experience changed regard to the relationship with the Father of the child?

(*Ubudlelwani bakho noBaba wengane bashintsha kanjani ngenxa yokukhulelwa?*)

3.3 How is the relationship between you and the father of the child, currently?

*(Bunjani ubudlelwani bakho noBaba wengane manje?)*

3.4 How has the experience change regard to your school performance/whilst at school?

*(Ngabe lwabakhona ushintsho ezifundweni zakho usaseskoleni ngenkathi usafunda?)*

#### **4. How was the Support system?**

*(Yayinjani iSupport ngenkathi ukhulelwe?)*

4.1 support from Family?

*(Yayinhanji iSupport emndenini ngenkathi ukhulelwe?)*

4.2 Support from Friends?

*(Yayinhanji iSupport kwabangani ngenkathi ukhulelwe?)*

4.3 Support from Father of the child

*(Yayinhanji iSupport kuBaba wengane ngenkathi ukhulelwe?)*

4.4 Support from Professionals i.e clinic staff, teachers?

*(Yayinhanji iSupport eClinic/ ngenkathi ukhulelwe?)*

4.1.1 Nurses yoNesi?

4.1.2 Teachers yoThisha?

#### **5. Marriage perceptions**

*(Ezomshado)*

5.1 What are your perceptions on marriage?

*(Uthini umbona wakho ngomshado?)*

5.2 What are some of the attitudes towards marriage and teenage pregnancy?

*(Uthini umbona wakho ngomshado nokukhulelwa kwabantu abasha?)*

5.3 What are some of the challenges (if any) of marriage for young people?

*(Yiziphi izingqinambi (uma zikhona) ngokushada kwabantu abasha abahlangabezana nazo?)*

5.4 What are your views of young girl's dating older men?

*(Uthini umbono wakho ngendaba yamantombazane asakhuli athandana noBaba abadal)*

## **6 Self-perceptions and Identity**

6.1 How did you find out that you were pregnant?

*(Wathola kanjani ukuthi usukulelwe?)*

6.2 How did you feel about yourself when you found out you were pregnant?

*(Wazizwaunjani ngawe ngenkathi uthola ukuthi ukhulelwe?)*

6.3 How did you feel about yourself when you were pregnant?

*(Wazizwaunjani ngawe ngenkathi ukhulelwe?)*

## **7. Future Plans /Aspirations:**

**(Ikusasa)**

7.1 What are your future plans?

*(Ikusasa lakho ilibona linjani?)*

7.2 Where do you see yourself in three years' time?

*(Uzibonaphi eminyakeni emithathu ezayo?)*

## **SECTION C**

### **8. Perceptions on Contraceptive use**

**(Umbono wamaContraceptives)**

8.1 What are your perceptions on contraceptives?

*(uthini umbono wakho ngamaContraceptives?)*

8.2 Are contraceptive available in your local clinic?

*(Ayatholakala amaContraceptives eClinic ngakini)*

8.3 What kind of contraceptives are available at your local clinic?

*(Uhlobo luni lamaContraceptives atholakali eClinic yangankini?)*

8.4 What is your knowledge about contraceptives?

*(Yikuphi okwaziyo ngamaContraceptives?)*

8.5 What are the challenges you face (if any) in accessing contraceptives?

*(Yiziphi izingqinambi ekutholakaleni kwamaContraceptives?)*

8.6 Are there reasons (if any) for not using contraceptives?

*(Sikhona isizathu (uma sikhona) ngokungawasebenzisi/ngokungawasebenzisanaga amaContraceptives?)*

9. Where do you obtain information on sex/ sexual matters?

*(Imininingwane ngezocansi uyitholaphi?)*

10. Family Structure

*(ukuhleleka komndeni)*

10.1 How many siblings do you have that has a child out of wedlock

*(ukhona yini ngodadeweni noma abafoweni abanezingane?)*

10.2 Do you stay with both parents in your household?

*(uhlala nabo yini abazali bakho bobabili endlini?)*

10.2 The parent or parents that you stay with, who has authority?

*(kumzali/kubazali ohlala nabo, ubani oshaya umthetho ekhaya?)*

## **11. Finances**

Where do you receive money to raise the child from?

*(Imali yokukhulisa umntwana uyitholaphi?)*

11.1 On estimate how much would you spend on raising a child?



*(kuyimali engaka nani ukukhulisa ingane?)*

12. What are your perception on Peer education about sexuality, boys and girls being involved?

*(Uthini umbono wakho ngokufundisana ngabantu besilisa nabesifazane ngokocansi?)*

13. What would you do differently, if so, if you had your time over again?

*(Yini ongayenza ngokuhlukile uma unganikwa elinye ithuba mayelana ngokukhulelwa kwakho?)*

## Appendix II: ETHICAL CLEARANCE APPROVAL



6 September 2013

Ms N Mjwara 208520441  
School of Built Environment & Development Studies  
Howard College Campus

Protocol reference number: HSS/0923/013M

Project title: A qualitative study of early childbearing: Experiences of black women in a South African Township.

Dear Ms Mjwara

**Full Approval – Expedited**

This letter serves to notify you that your application in connection with the above has now been granted full approval.

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach/Methods must be reviewed and approved through an amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study. Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

Best wishes for the successful completion of your research protocol.

Yours faithfully

.....  
Dr Shenuka Singh (Acting Chair)

/px

cc Supervisor: Professor P Maharaj  
cc Academic Leader Research: Professor Franco Frescura  
cc School Administrator: Mrs Meera Dalthaman

Humanities & Social Sciences Research Ethics Committee  
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Website: www.ukzn.ac.za

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

**INSPIRING GREATNESS**



### Appendix III: INFORMED CONSENT FORM (English)

#### Informed Consent Form

My name is Nompilo Mjwara (student number 208520441). I am doing research on a project entitled 'A qualitative study of early childbearing: Experiences of black women in a South African Township'. This project is supervised by Dr Pranitha Maharaj at the School of Built Environment and development Studies, University of KwaZulu-Natal. I am managing the project and should you have any questions my contact details are:

School of School of Built Environment and development Studies, University of KwaZulu-Natal Howard College, Durban. Cell: 073 136 7408 Tel: 031 704 7209. Email: [nompilomjwara@gmail.com](mailto:nompilomjwara@gmail.com) or [208520441@stu.ukzn.ac.za](mailto:208520441@stu.ukzn.ac.za).

Thank you for agreeing to take part in the project. Before we start I would like to emphasize that:

- your participation is entirely voluntary;
- you are free to refuse to answer any question;
- questions will be 45 minutes to an hour
- you are free to withdraw at any time.

The interview will be kept strictly confidential and will be available only to members of the research team. Excerpts from the interview may be made part of the final research report. Do you give your consent for: *(please tick one of the options below)*

Your name, position and organisation, or	
Your position and organisation, or	
Your organisation or type of organisation <i>(please specify)</i> , or	
None of the above	

to be used in the report?

Please sign this form to show that I have read the contents to you.

----- (signed) ----- (date)

----- (print name)

Write your address below if you wish to receive a copy of the research report:

If you wish to obtain information on your rights as a participant, please contact Ms Phumelele Ximba, Research Office, UKZN, on 031 260 3587.

### Appendix III: INFORMED CONSENT FORM (isiZulu)

#### Incwadi yesivulelwano socwaningo

Igama Lami nginguNompilo wakaMjwara (inombolo yokuba umfundi ithi 208520441). Ngeza ucwaningo elithi ‘A qualitative study of early childbearing: Experiences of black women in a South African Township’, ngamafuphi mayelana nokukhulelwa kwabantu besimame besabancane. Lolucwaningo lizobhekwa uDokotela Pranith Maharaj ngaphansi kwesikole Built Environment and development Studies eNyuvesi yakwaZulu Natali. Yimi ozobe enza ucwaningo , uma unemibuzo ungabuza

Isikole sakwa Built Environment and development Studies, eNyuvesi yakwaZulu Natali, Howard College, eThekwini. Iminigwane yami yocingo ukuze ngithinteki inombolo yeSeli foni ithi : 0731367408, eyasendlini 031 704 7209, umyalezo wombani uthu: [nompilomjwara@gmail.com](mailto:nompilomjwara@gmail.com) okanye [208520441@stu.ukzn.ac.za](mailto:208520441@stu.ukzn.ac.za).

Ngiyabonga ngokuvuma uthi ube ingxenye yocwaningo. Nagphambi ukuba siqala ngithanada ukugxila ukuthi

- ukuvuma kwakho ube igxenye yocwaningo kuku wena, ungayeka noma inin
- Ungabuza noma imiphi imbuzo noma inini
- imbuzo izoba imizuzu engu 45 kuya eHoreni
- Ungayeka noma inini

Lokhu esizokukhuluma kuphakathi kwami nawe, akekho ozokwazi yini esiyikhumayo ngaphandle kewabantu abazohlola lolucwaningo futhi mese ngibhala ireport ngalelucwaningo

Igama noma;	
Position yakho kwiOrganization	
Akho okunye?	

Ngicela usayini lapha ukuthi ngikufundelile imigomo yocwaningo.

----- (sayina) ----- (usuku)

----- (igama)

Ungabhali ikheli lakho uma ufuna ucwaningo ngikuthumelele lona

Uma ufuna ukwazi ngemininigwane ngamalungelo akho njengomuntu oyingxeny  
yalolucwaningo, ungaxhumana noNkosazane Phumelele Ximba, Ehhovisini  
noCwaningo,eNyuvesi yakwaZulu Natali UKZN, inombolo itho 031 260 3587