

# **Effectiveness of sexuality education in preventing teenage pregnancy in the Pinetown district secondary schools**

**By**

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## DECLARATION

I, **Sinikiwe Sanelisiwe Bhengu**, solemnly declare that this dissertation hereby submitted to the University of Zululand for the degree of Master of Education in Educational Psychology has never been submitted by me or any other person at this or any other University, that this is my own work in design and execution, that I am aware of the implications of plagiarism as academic dishonesty, and that all sources of reference used have been duly acknowledged.

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Signature

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Date

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## **DEDICATION**

I would like to specially dedicate this dissertation to my late mother Joyce Thabisile Ndlela. May her spirit continuously evokes in me thirst for knowledge.

## **Abstract**

The aim of this study was to determine the effectiveness of Sexuality Education as an intervention in preventing teenage pregnancy in the Pinetown district. A focus group of thirty four (35) learners from three different schools was purposefully sampled. Data was collected using structured interview schedules to allow the researcher a platform to ask open-response questions and to understand the learners' knowledge on preventive measures and the learners' preferential choices. Data were analysed by carefully identifying and expanding significant themes that emerged from the informants' knowledge and preferred measures of interventions to prevent teenage pregnancy.

The results of the study revealed that learners' knowledge of preventative measures was limited and an additional challenge was the lack of parental involvement in their children's sexuality. The participants agreed that sexuality education does provide learners with information that could equip them with knowledge of a healthy sexual behaviour. They maintained that this information could be used when they decided to engage in intimate sexual relationships. However, the knowledge which will ultimately decide their future was quite limited and it was concerning. They seemed to know the contraceptives that were available but the task of accessing them still posed a problem. On the basis of the study results, some valuable recommendations were made which include that the alternatives of accessing contraceptives and the parental involvement in their children's sexuality may curb teenage pregnancy.

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## **CHAPTER 1**

### **ORIENTATION TO THE STUDY**

#### **1.1. INTRODUCTION**

South African data indicates that dropping out of school for most teenagers often precedes pregnancy (Department of Education, 2007). Mngoma (2010) reports that pregnancy among teenage pupils is still a huge challenge for many local schools that believe they are fighting a losing battle, with some reporting as many as 20 pregnant teenagers in their schools each year. According to Karra and Lee (2012) the pregnancy rate amongst schoolgirls in South Africa remains high by international comparison and the rate of thirteen percent (13%) in rural areas in KwaZulu-Natal is twice the national average of six and a half percent (6.5%). Furthermore, the Skill Portal (2012) reports that teen pregnancy is trapping young people forcing them to drop out of school, increasing dependence, and lowers the chance of finding employment. Confirming the previous observation by Vundule, Maforal, Jewkes, and Jordaan (2001); Coley and Hase-Landale (1998); Mbizvo, Kasule, and Gupta (1995); Kapiga, Hunter and Nachtigal (1992); and Dommise (2001) maintained that teenage pregnancy results in a lack of qualifications and future unemployment among youth.

Medical risks, disruption of education and long-lasting emotional problems are associated with schoolgirl pregnancy (Kanku, 2010). Pregnancy during the teen years can be a catalyst for a lifetime of social, psychological, and economic problems (Burns & Porter, 2007). A society is also adversely affected by a high rate of teenage pregnancy, since teenage childbearing results in considerable financial and human resource costs to the taxpayers and society. According to Kantu and Mash (2010), the factors influencing teenage pregnancy were found to be broad and complex. They summarised them into socioeconomic factors including poverty, substance abuse, a lack of alternative entertainment and social infrastructure which made shebeens (local bars) a normal part of teenage social life, peer pressure from boyfriends and the broader social network understanding of contraceptives and reproductive health was poor. On their research day, the Limpopo Provincial Health (2012) service providers identified three economic factors: poverty (61.3%), child support grant (37.0%), and intergenerational relationships (11.8%). D'Onofrio (2003), Jaffee and Price (2007) argue that while the environment affects and influences a girl's sexual behaviour, a girl's genes also affect and influence her sexual behaviour.

In South Africa, schools have become important intervention sites in response to teenage pregnancy. In 1997, the Department of Basic Education introduced Life Orientation as part of curriculum 2005 and was made compulsory for all learners (Department of Basic Education, 2011). Sexuality education is integrated into the Life Orientation (LO) curriculum mainly under the heading of Personal Well-being which is designed to account for 17% or eleven out of the sixty-six LO contact hours that the Grade 10's and 11's have prescribed for the academic year (Department of Education, 2011).

## **1.2. BACKGROUND TO THE STUDY**

The public school system is the obvious source to initiate teen pregnancy prevention strategies which falls under mesosystem in terms of Bronfenbrenner ecological system. Bronfenbrenner (2005, p. 46) maintains that the “mesosystem comprises of the relations among two or more settings in which the developing person becomes an active participant”. A standard measure that is generally afforded the majority of the student body in each school district is sexuality education, which usually occurs in tandem with a health programme. However, based on research with LO teachers the time allocated to sexuality education vary and individual schools have their own curricula and timetabling priorities. Teachers are given a considerable amount of responsibility and autonomy in respect of implementation of the LO sex education programme, which means that in practice approach and information vary considerably (Francis & DePalma, 2013). Naidoo (2006) investigated how sexuality education was implemented at South African schools and raised a few concerns such as comfort levels and the character of the teacher in class providing the subject of sexuality education and what influence that would have in delivering the content. Some believe that when school personnel discuss sexuality matters, they pique the interest of hormonally-driven teens and essentially encourage the consummation of sexual acts. Enduring controversy about the nature of sexuality education plagues the direction that the curriculum is able to take, and it is ultimately imbedded in political discord (Surgan, 2004).

South Africa has a relatively progressive legislative response to teenage pregnancy and motherhood, with some even suggesting it has a ‘feminist influence’ (Bhana & Clowes, 2008). The South African Constitution (1996) “protects the right (of all citizens including children) to make decisions regarding reproduction and the right to access health care services, including reproductive health care” (Hoffman-Wanderrerr, 2013, p. 4). Since 1996 a number of laws such as the South African Children’s Act (Hoffman-Wanderrerr,

Carmody, Chai, Rohrs, 2013) have been passed. More recently the South African Children's Act (2005) (as amended by the Children's Amendment Act, No. 41 of 2007) came into effect, with regulations, on 1 April 2010. It allows those over 12 years to 'access health care services, including HIV testing, contraceptives and termination of pregnancy (TOP) services, without parental consent'. The Act stipulates that: 'contraceptives other than condoms [and also including condoms] may be provided to a child on request by the child and without parental or care-giver's consent of the child if the child is at least 12 years of age' (Hoffman-Wanderrerr, 2013, p.7). There are also advocates for alternative sexuality education who argue against contraception and maintain that the best way is abstinence.

The main point of contention exists between abstinence only sexuality education and comprehensive sexuality education (Carroll, 2009; Braeken & Cardinal, 2008; Quillen, 2009). The abstinence-only stance is rooted in conservative ideals, condemns premarital sex, and asserts that families should be responsible for disseminating information on private matters.

Comprehensive sexuality education, on the other hand, presents material on safe-sex, birth control and abstinence-only options and argues that it is naïve to solely focus on an abstinence-only approach, which has proven to be amiss given the prevalence of sexually active teens that have become pregnant and/or contracted sexually transmitted diseases. Likewise, teenagers cite discomfort about striking up what they call 'birds-and-bees' conversations with their parents, which is a topic that parents also find difficult to approach. Hence, although some argue that sex-related conversations are a family affair, the more pertinent question is whether or not families are tackling the matter at all (Rosengard, Pollock, Weitzen, Meers, & Phipps 2006; Rodriguez & Moore, 1995).

Several studies on teenage pregnancy have also suggested that there is no single universally effective intervention and each community should tailor their own interventions according to their own situation, conditions and environment. A broad intersectional strategy is needed to prevent teenage pregnancy and there is a need for all government departments to 'think health' when developing policy that may impact on teenage pregnancy (Rosengard, et al, 2006; Rodriguez & Moore, 1995).

UNESCO (2012) conducted a study on the content offered for sexuality education in ten Southern African countries and it found South Africa to be providing most curricula that did not contain enough basic information about male or female condoms and

contraception(including emergency contraception). Although knowledge about these topics is a key risk/protective factor for sexual behaviour and health outcomes, many of these curricula were - to differing degrees - essentially focused on abstinence-only rather than devoting resources and classroom time towards approaches that are more effective and contain accurate and complete information. Other key aspects of sex and sexual health were lacking, including information about reproduction, STIs, abortion, and where to access condoms and sexual health services. Most curricula also addressed the experience of puberty strictly as a biological process without acknowledging the changed social environment such as increased harassment and parental monitoring that can also generate considerable confusion and difficult feelings for pubescent girls and was introduced late in the curriculum. The topic of male circumcision was also missing from most curricula, although they agree that the topic is complex and needs to be addressed carefully. Communication, negotiation and decision-making skills were also found to be inadequate.

Sexuality education encompasses education about all aspects of sexuality, including information about family planning, and birth control methods (De La Mare, 2011, p. 8). Francis and De Palma (2013) postulate that comprehensive sexuality education needs to span the entire spectrum of discourses, from disease to desire. They argue for an approach that enables learners to appreciate sexuality as “A wonderful, extremely powerful energy, experienced in every cell of one’s being as a mighty urge to overcome incompleteness and to find fulfilment in a strong and abiding relationship with another” (Francis & DePalma, 2013, p.11). Sexual experimentation is a normal part of the course of development of all adolescents. When it occurs in the context of comprehensive sexuality education, initiation of sex can be delayed (Kirby, 2007). However, if adolescents choose to have consensual sex and are educated to use appropriate protection, there is little evidence that it is harmful (Santelli, Ott, Lyon, Rogers, Summers & Schleifer, 2006).

According to the United Nations Population Fund (2013); Kirby (2007); Kirby, Lepore, and Ryan (2005) global evaluation research has repeatedly shown that the evidence for and effectiveness of many adolescent pregnancy prevention programmes was unclear. However, among programmes they were most successful. The majority used comprehensive approaches activities related to health education and social support. Comprehensive approaches move beyond sexuality education curriculums,

contraceptives distribution programmes and abstinence-only programmes to build a package of services and programmes that target the root causes of sexual health risk and early pregnancy (Kagesten, Parekh, Tuncalp, Turke & Blum, 2014). However little is known about the range, scope or common activities of such programmes and whether such strategies can successfully improve adolescent reproductive health.

McQueston, Silverman and Glassman (2013) argue that contraceptive use among sexually active adolescents, which reduces unintended adolescent pregnancy, is an indicator for tracking the success of programmes. This outcome was evaluated in nine studies across a variety of intervention types. Of these studies five unambiguously found significant increases in contraceptive use (Kim, Kols, Marangwanda & Chibatamoto 2001; Lou, Wang, Shen & Gou, 2004; Daniel, Masilamani & Rahman 2008; Kanesathasan, Laura, Cardinal, Gupta, Mukherjee & Malthora 2008). However, Erulkar and Muthengi (2009) found a significant increase in condom use among girls but no change among boys. One study by Okonofua, Coplan and Collins (2003) reported a marginally significant increase in contraceptive use one year after the programme, but these results were no longer marginally significant at the two-year follow-up, suggesting that the benefits of a school-based intervention on contraceptive use may be short-lived.

Vundule, Maforah, Jewkes and Jordaan (2001); Buga, Amoko and Ncayiyana (1996); Meyer-Weitz, Steyn and Ghama (1999); Marston and King, (2006); Matash, Ntembeselea and Mayaund (1998) maintain that teenage pregnancy has been associated with frequent sex without reliable contraception. Access to clinics in areas where abject poverty is experienced getting these contraceptives becomes a great challenge. When teenagers approach these clinics health workers have been turning them away, accusing them of being too young for sex (Kunene, 1995). At the clinic teenagers are offered little choice of contraceptive method and given poor explanations of the side effects. For instance there is little explanation on what happens in case a teenager takes contraceptives and has not eaten on that day, as well as the mechanism of action, which contributes to a low uptake of contraception, despite it being free (Wood & Jewkes, 2006). In general, teenagers believe that teenage pregnancy is wrong and they report a need for more information about sexuality (Mwaba, 2000; Lema, 1990; Kunene, 1995).

International research has reported that some adolescents intentionally become pregnant (Cater & Coleman, 2006; Condon & Corkindale, 2001). Choosing to become pregnant is seen as a positive decision, offering a sense of purpose and future direction. Such a path

is chosen to correct negative childhood experiences characterised by dysfunctional family relationships, absent fathers, poor scholastic experiences, and growing up in homes and poverty entrenched neighbourhoods where teenage pregnancy was normative (Cater & Coleman, 2006). They often partner with adult men “sugar daddy” as these relationships are viewed as more advantageous in terms of the resources they are able to provide (Madeni & Horiuchi, 2011). However, positive attitudes towards teenage pregnancy are reported and a second pregnancy from teenage mothers has been associated with an absence of negative attitudes towards teenage pregnancy (Stevens-Simons, Kelley & Singer, 1996).

Bassey, Abasiattai, Asuquo, Udoma, and Oyo-Ita (2005); Kirby (2002) suggests that effective interventions are school based among others. (Panday, Makiwane, Ranchod, & Letsoalo 2009; Ehiri, Meremikwu & Mermikwu, 2005; Mukoma, 2007) maintain that several reviews also conclude that most school-based interventions worldwide have not been subject to systematic evaluation. Wenger (2006) proposes in his model that learning should be informal through social interaction, rather than by means of a planned mechanistic process of cognitive transmission, an approach that, it is believed, would result in authentic, motivated learning of what is needed to be known. Francis and De Palma (2013) further advocate for the repositioning of young people as positive, active sexual subjects which, in turn, will require a shift in classroom practice. Wenger’s framework allows for an investigation of the current teaching of sexuality education with the new proposition of a multispectral direction in mind and understanding the expectations of parents and how these can then influence policy and teaching.

In a newspaper article, the Minister of Basic Education, Angie Motshekga, mentioned that parents should take responsibility for educating their children about sexuality issues and not “pass the buck” (Williamss, 2012). The Minister argued that children’s sex lives are the responsibility of the parents and not of the schools, and that they should stop expecting her department to solve their problems. The Minister emphasise that teenage pregnancy is a problem imported into schools by homes and the community. This was in response to high pregnancy rates among teenage girls in schools in South Africa where a staggering 160.754 schoolgirls became pregnant between July 2008 and July 2010 (Statistics SA, 2012).

Schaalma, Abraham, Gillmore and Kok (2004) state that in order to facilitate widespread adoption of effective sexual health promotion programmes, health promotion planners must focus on mobilising parental support for comprehensive sexuality education. They

assert that this would involve designing community empowerment programmes which would be deemed effective if they prompted parents to act to demand comprehensive sexuality education. Mncube (2009) emphasises the role of parental involvement in education. He offers Epstein's model of parental involvement which suggests that the home/school communication should be a two-way communication process that must reflect a co-equal partnership between families and schools.

Culture and cultural values have proven to be important factors that affect the meaning individuals place on talking about teen sex and pregnancy (Faulkner, 2003). There are very few promising or evidence-based teen pregnancy prevention models based on theoretical frameworks that specifically and intentionally consider the social, cultural, or historical location of a study done on a Latino youths and families, the rural communities in which they live or the values to which they ascribe (Blinn-Pike, 2008). Family planning and sexual knowledge, acquired from parents, health workers, teachers, priests or mass media, can help to reduce the number of teenage pregnancies (Kapinga, Hunter & Natchigal, 1992; Lema, 1990; Kunene, 1995; Stauss, Boyas & Murphy-Erby, 2011) Other interventions are based on abstinence, delayed sexual initiation and training in decision making or sexual negotiation skills.

Communities across the globe are evidently putting effort by creating the healing systems which speak to the specific needs of those people (Washington, 2010 ). George (2008) argues that human rights advocates should appreciate more fully how cultural legitimization and change occur within the political context of a society facing an enormous public health crisis. Virginity testing practice essentially serves as a mechanism for promoting abstinence. Virginity testing advocates promoting the practice as the most effective way to stop the spread of teenage pregnancy hence it essentially serves as an abstinence-only enforcement mechanism. Indeed there are programmes that were reported to be experiencing success such as the one proposed by Jemmott, Jemmott and Fong (2010) which found that abstinence-only interventions produced significant results in preventing teenage pregnancy. Guilamo-Ramos, Jaccard, Dittus and Collins (2008) found out that there continues to be a disparity in regards to teen pregnancy prevention efforts. Jewkes, Morrell and Christofides (2009) note that accepting gender inequalities and gendered norms as a critical driver of unplanned pregnancies necessitates that responses to reduce teenage pregnancies must focus on empowering women and reducing gender inequalities (Jewkes, Morrell & Christofides, 2009). In addition responses need to address comprehensive sexuality education, and

not merely 'preventing teenage pregnancy' through a simple reproductive health or family planning lens.

However in the stage exists adolescence egocentrism, a state of self-absorption in which a teenager views the world from his or her own point of view. Egocentrism leads adolescents to be highly critical of authority figures, unwillingness to accept criticism, and quick to fault others. They develop personal fables which make adolescence feel invulnerable to the risks that threaten others (Elkind, 1985; Frankenberger; 2004). Furthermore some developmental psychologists suggest that cognitive development is more quantitative than qualitative. It is what a child can do that display cognitive abilities (Gelman & Baillargeon, 1983; Case & Okamoto, 1996). Though they do admit that the theory has an influence in that Piaget suggests that individuals cannot increase their cognitive performance unless both cognitive readiness brought about by maturation and appropriate environmental stimulation are present. This view has inspired the nature and structure of educational curricula and teaching method (Feldman, 2008).

Kohlberg (1984) suggests as well that there is also moral development. According to Berns (2007, p. 80), morals are an individual's evaluation of what is right and wrong. Morals involve acceptance of rules and govern one's behaviour toward others. Berns maintains that moral reasoning has got three levels of moral development and the highest level occurs before the age 13 years. Research evidence suggests that a relatively small percentage of adults rise above the second level model (Kohlberg & Ryncarz, 1990; Hedgebeth, 2005). These authors further maintain that moral reasoning is about judgement not behaviour. They conclude that knowing what to do will not necessary mean the behaviour will follow. Gender conceptions of what constitutes moral behaviour may lead men and women to regard the morality of a particular behaviour in different ways (Gallighan, 1990). Freud (1933) concurs and considers conscience as a manifestation of neurosis rather than a sign of emotional maturity. Conscience is more of an accuser and a tormenter than a guide. Additionally, Freud also views conscience as a repressor of conscious intentions and ideals which a person has but is afraid to manifest for fear of losing a significant relationship. Reeve (2009, p. 414) mentions that "Freud's concepts are not scientifically testable". Therefore, Freud was simply wrong on many points about human motivation, morals, development and emotion.

Bandura (1986, p. 36) states that "individuals are viewed as products and producers of their own environments and social systems". Because human lives are not lived in

isolation, Bandura expands the conception of human agency to include collective agency. People work together on shared beliefs about their capabilities and common aspirations to better their lives. Self-efficacy is the belief in one's capabilities to organize and execute the sources of action required in adapting to prospective situations (Bandura, 1986). Siegler, Deloache and Eisenberg (2003) observed that social learning theory emphasizes observation and imitation. By nature, adolescents learn most rapidly and efficiently simply from watching what other people do and then imitating them. Furthermore, the theory attempts to account for personality and other aspects of social development in terms of learning mechanisms.

Berns (2004) holds the view that the adolescent chooses models with whom to identify on the basis of whether the model is perceived to be like them, to be warm and affectionate and to have prestige. When the adolescents identify with the same sex parents, they incorporate that parent's behaviour into their own. Social learning theory points out the important distinction between the acquisition of behaviours and the performance of those behaviours, people can learn behaviours through observation, but they do not necessarily perform them (Lippa, 1994).

Vygotsky's Theory of Child Development Concepts of Periodisation saw child development as consisting of passing through a series of periods of stable development; namely, infancy, early childhood, pre-school age, school age and puberty. These periods of stable development are punctuated by periods of crisis: at birth and at the ages of 1, 3, 7, 13 and 17. He maintains that there needs to be structures for the child to be able to cope in these new periods which present a crisis which needs to be solved. A second aspect of the theory is the idea that the potential for cognitive development is limited to a "zone of proximal development" (ZPD). This "zone" is the area of exploration for which the student is cognitively prepared, but requires help and social interaction to fully develop (Vygotsky's, 1978).

A teacher or more experienced peer is able to provide the learner with "scaffolding" to support the student's evolving understanding of knowledge domains or development of complex skills (Newman & Holzman, 1993). The desired "flow over" to different functions resulting from success in performing the given task will occur only if the intervention has promoted the central or leading *neo-formation* (information that the child already has from the previous stages of life). Otherwise, teaching by assisting the child with a task

may help them learn that task, but there will be no flow over to development. In that sense, we could introduce into the concepts Vygotsky uses in this work the idea of “leading activity,” that mode of activity and social interaction which promotes the striving of the child in exercise of the central neo-formation of the age-period. During the periods of critical development however the situation is different; the child is trying to rupture the social situation of development and create a social position for themselves in a new social situation. The child’s behaviour in these periods of crisis is disruptive of the existing relationships. The child’s carers need to understand what lies behind the child’s behaviour and assist the child through to the new social situation (Zaretskii, 2009).

According to Ormrod (2011), Vygotsky acknowledged that biological factors such as brain maturation play a role in development. Children bring certain characteristics and dispositions to the situation they encounter, and their responses to those situations vary accordingly. Furthermore, children’s behaviours which are influenced in part by inherited traits affect the particular experiences that they have.

Maslows (1968) argues that people who are in poverty often grapple with issues of physiological needs, which when not met the human body cannot function properly and will ultimately fail. His theory has been criticized for not accounting for people who have displayed great talent or even genius without having many of their lower needs taken care of.

Cordova, Chandra-Mouli, Decat, Nelson, and De Meyer (2015) maintain that early pregnancy and poor reproductive outcomes among adolescents are determined by a web of micro, meso- and macro-level factors. Individual choices to engage in specific behaviours are shaped by social, economic and cultural factors that operate at the individual, interpersonal (couple, peer group), family and community level. The Bronfenbrenner (1979) ecological approach can help identify the determinants in teenage pregnancy prevention programmes, and can be used to develop better strategies, and ways to monitor and evaluate them. However Cherry (2014) argues that although the sociological models explain a great deal of the variation in sexual behaviour, integrated models (bio-psychosocial models) are more accurate and give a richer picture of the determinants of adolescent sexuality. At its most basic level, genetics determines the timing of puberty and sexual arousal. Early maturation is predictive of early sexual arousal and early sexual initiation. Neither phenomena (the timing of puberty and early

sexual arousal) are given due respect in policy or programming related to providing adolescent sexual and reproductive health. Given this basic re-conceptualization of adolescent sexuality, which is informed by our understanding of genetics, fundamental change in the way adolescent sexuality is viewed and responded to, is in order.

Bronfenbrenner's (1979) model asserts that a person's surroundings including their home, school, work, church, government and others all have an influence on the way a person develops. These influences can be positive or negative. In addition, Bronfenbrenner's model suggests that if a person grows up in high risk environment that person's development will be strongly influenced in a negative way by that environment, causing that person to potentially lead an unhealthy and unfulfilling life. Theories of health behaviour (THB) consider the individual and environmental or psychosocial factors that influence behaviour change, position these psychosocial factors as antecedents to behaviour change, and suggest that though the provision of knowledge or information is helpful, it alone is not sufficient to bring about changes in risky health behaviours (Glanz, 1997). These theories suggest that the development of core competencies or skills is a necessary prerequisite to bringing about changes in risky health behaviours. The health belief model by Becker (1974), a model of individual health behaviour, posits that key variables of susceptibility, severity, benefits, and barriers are antecedents to behaviour and influence the likelihood of an individual taking recommended preventive health action. Additionally, the health beliefs model suggests that a person must be capable of initiating change for change to happen.

### **1.3. PROBLEM STATEMENT**

In the literature a lot of effort has been put to make teenagers aware of their sexuality through the introduction of sexuality education in schools. However, most of the effort seems to be targeting HIV pandemic. Learners who may feel are not at risk of HIV may ignore these messages and not use protection and fall pregnant. Schools have access to these learners and have the opportunity to provide learners with factual information when it comes to teenage pregnancy. The high numbers in teenage pregnancy raise the question of effectiveness of sexuality education in dealing with teenage pregnancy. The current study tried to address the following research questions:

1.3.1. How effective is sexuality education in preventing teenage pregnancy among the secondary school learners in the Pine town district?

1.3.2. What type of knowledge do learners have about prevention of teenage pregnancy?

1.3.3. What prevention measures do the learners prefer to avoid falling pregnant?

#### **1. 4. AIM OF THE STUDY**

The main aim of this study was to determine the effectiveness of sexuality education as part of Life Orientation subject in raising awareness about healthy sexual behaviour in particular and healthy life-style in general.

The **objectives** of the study were:

1.4.1. To determine the effectiveness of sexuality education in preventing teenage pregnancy among secondary school learners in the Pinetown district.

1.4.2. To establish the type of knowledge learners have about prevention of teenage pregnancy.

1.4.3. To establish the type of prevention measures that learners prefer to avoid falling pregnant.

#### **1.5. INTENDED CONTRIBUTION TO THE BODY OF KNOWLEDGE**

The results of this study can uncover the element in sexuality education that is missing which may contribute in reducing teenage pregnancy. The new knowledge may allow for the modification of the current LO syllabi on sexuality education.

#### **1.6. RESEARCH METHODOLOGY**

According to Patton (1982), the practice of evaluation involves the systematic collection of information about the activities, characteristics and outcomes of programmes, personnel, and products for use by specific people to reduce uncertainties, improve effectiveness, and make decisions with regard to what those programmes, personnel, or products are doing and affecting. Patton argues that evaluation research could include any effort to judge or enhance human effectiveness through systematic data-based inquiry. Qualitative research methods are designed to help researchers understand people, within their lived social and cultural contexts. The goal of understanding a

phenomenon from the point of view of the participants and its particular social and institutional context is largely lost when textual data are quantified (Kaplan & Maxwell, 1994).

### **1.6.1 Description and selection of participants**

The researcher purposefully selected three focus groups of 34 learners from three schools which consist of seven grades 8, seven grades 9 which form Senior Phase. There were also seven grades 10, seven grades 11 and seven grades 12 which form Further Education Phase (FET). All of the learners were over 16, among them were learners who were mothers and had previously dropped out from school. The sample size was determined by the concept of theoretical saturation or the point when new data no longer bring additional insights to the research questions. Purposive sampling is one technique often employed in qualitative investigation, and which was employed in this study. With a purposive non-random sample, the number of people interviewed is less important than the criteria used to select them.

The characteristics of individuals were used as the basis of selection, most often chosen to reflect the diversity and breadth of the sample population. A feature of qualitative sampling is that the number of participants sampled is often small. This is because a phenomenon only need appear once to be of value. There is no need for scale as there is no need for estimates of statistical significance. Furthermore, because qualitative investigation aims for depth as well as breadth, the analysis of large numbers of in-depth interviews would simply be unmanageable because of the researcher's ability to effectively analyse large quantities of qualitative data (Ritchie & Lewis 2003). This allowed selection of appropriate participants who represented a range of beliefs and experiences relevant to the research topic.

The participants were African learners who came from the neighbouring community which was made mostly of Reconstructing Development Project (RDP) houses (a development project by the post-apartheid government in attempting to address the housing shortages in the country). The sampling for focus groups involved bringing together people of similar backgrounds and experiences to participate in a group interview about major issues that affect them (Patton, 2002).

Purposive sampling has two principal aims: The first is to ensure that all the key constituencies of relevance to the subject matter are covered. The second is to ensure that, within each of the key criteria, some diversity is included so that the impact of the characteristic concerned can be explored (Ritchie & Lewis, 2003). McMillan and Schumacher (2010) maintain that focus group is the primary evidence based technique in evaluation studies. Learners were interviewed in depth about their general knowledge about teenage pregnancy. Terre Blanche and Durrheim (2006) maintain that an interview is a natural form of interacting with people and it is a highly skilled performance. It allows the interviewees to express their feelings and experiences. Whatever meanings are created in the interviews are treated as co-constructed between the interviewer and the interviewees.

These meanings are moreover not only constructed by the people involved in the interview but are products of a larger social system for these individuals act as relays. Mason (2002) maintains that most qualitative researchers view knowledge as situational and the interview is just as social situation as is any other interaction. Therefore knowledge and evidence are contextual, situational and interactional as possible in the sense that it draws upon fully social experiences or processes that the research is evaluating. It might ask people to draw from their own experiences of life. Qualitative interviewing is constructing knowledge rather than collecting it.

### **1.6.2. Description of procedures**

Firstly, the rules were given to set structure and to set the limits on the group process. As a group the norms and expectations included not to divulge information that would be discussed in the interview, as well as about others in the group. Everyone should be given a chance to speak.

Secondly during interaction no one must be marginalised and everyone's view was important. There was an introductory session with the participants where there was some ice-breaker activities for the participants to help them to relax. Dover (2004) suggests that the types of ice-breaker that helps with facilitating introductions and would help to lead to the topic.

Thirdly, what was discussed in the interview was followed by a semi-structured interview format with open-ended questions, from the interview schedule (Gillham, 2002). This gave the group an opportunity to talk about what was most pressing for them by allowing a degree of meandering discussion. The content also included role playing. The

researcher listened for commonalities and differences of opinions, and got the group to reflect on the extent to which their understanding factual information or what they considered factual information about teenage pregnancy or experiences was homogenous or diverse. There was interpretation and thematising to deepen reflection on experiences. The participants' statements were frequently summarised to demonstrate clear understanding of what the participants had said. There was a concerted effort that was worked on in making the group to focus on issues but also allowing issues that are compelling to the group. A stimulus was provided to participants from the interview schedule as a way of kick-starting a discussion.

The primary data of qualitative interviews are verbatim accounts of what transpires. In the interview session, tape recording the interview ensures completeness of the verbal interaction and provides material for reliability checks. Note taking was also used to help reformulate questions and probes and to record nonverbal communication as a supplementary technique, which would facilitate data analysis. Interviewer recording enabled the interviewer to be attentive, and pace the interview and begin data analysis (King & Horrocks, 2010)

Immediately following the interview, the researcher completed and typed the hand written records. Typed drafts needed to be edited for transcription and identifying typographical errors before it was put into final form. The final record contained accurate verbatim data and the interviewer notations of nonverbal communication with initial insights and comments to show the meaning. The final form included the date, place and the informant code

A written detailed account of each interview session, self-reflections and rapport, the interviewee's reactions, additional information and extensions of interview meanings.

## **1.7. ETHICAL CONSIDERATION**

The general principles set out in the University's policies and the obligations, which the policies impose upon researchers, were undertaken, and to mitigate any ethical and other risks that might arise.

Should circumstances arise that impact upon the researcher's ethical obligations, they would disclose them to the supervisors and we would take appropriate action in terms of the relevant University policy.

According to Hennink, Hutter and Bailey (2011), the Belmont Report was created in 1979 by the National Commission for the Protection of Human Subjects of Behavioural Research to serve as a core reference on ethical principles for institutional review boards dealing with research on human subjects. The Belmont report identifies three core principles for the ethical conduct of research:

**Respect of persons:** In this study, the participants' welfare always took precedence over the interest of science or society. Participants were treated with courtesy and respect, and they entered into research voluntarily and with adequate information. Participants were not coerced but fully informed of the expectations of the study and what it entails that intimate details of their sexual lives would be looked at and they had all the right to decline to participate without incurring negative consequences.

**Beneficence:** Strived to maximise the benefits of the research for wider society, and to minimize the potential risks to research participants. The data collection sites were the safe environment at school. It was ensured that research procedures were administered in a fair, non-exploitative, and well-considered manner. Since the participants were high school learners, time for collecting data was carefully considered so that there was minimal interference with their learning.

The application of these principles to the conduct of research led to the following important considerations

***Informed consent.*** Learners were provided with sufficient information about the research, in a format that was easily understandable, and they were asked to make a voluntary decision to participate in the study. Consent forms to be recorded as well as to participate in the study was issued to participants.

***Self-determination.*** Learners were informed that they had a right to determine their own participation in research, including the right to refuse participation without negative consequences. They were told that participation in the study was voluntary.

**Minimization of harm/anonymity:** The protection of the identity of participants and would not put them at risk. The structured interview schedule was administered and participants were not required to write their names or identify themselves in anyway

**Confidentiality:** Confidentiality means not disclosing any information gained from an interviewee, deliberately or accidentally, in ways that might identify an individual. Therefore not discussing information provided by an individual with others, and presenting findings in ways that ensure individuals cannot be identified (chiefly through anonymity).

The interviews took place during the weekend and most learners were not at school just the participants. It was ensured that all data records about participants were kept confidential at all times. No third parties had access to the participants' personal data. Numbers were used instead of the learners' real names as well as of the learners' schools so that the learners remained unidentifiable.

**Children and Vulrenable young adults:** It was recognised that that the participants may experience distress or discomfort in the researchprocess and all necessary steps were taken to reduce the sense of intrusionand to put them at their ease. They were encouraged to withdraw from any action,ensuing that caused emotional or other harm.

## **1.8. SUMMARY**

This Chapter has given an overview of the study, starting from preliminary literature review on the subject to discussing methodological issues and ethical principles involved in the execution of study. The next Chapter will give a detailed literature review and raise some theoretical underpinings which inform the current study.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

Teenage pregnancy has become a serious problem in South African schools especially here in KwaZulu-Natal. According to the Minister of Basic Education (2009), teenage pregnancy undermines the Department's efforts to ensure that girl children remain in school, in order to contribute towards a quality life for all, free of poverty. Mandela (1994) asserted that when things are disorderly you take the line and regain control. The Department of Education has sexuality education as a component of Life Orientation subject which tries to address, among other things, issues about reproductive health. The departments' main goal is to prepare learners for the challenges that they will encounter in meeting life's many challenges including teenage pregnancy. Other stakeholders such as the Department of Health has the National Contraception And Fertility Planning Policy And Service Delivery Guidelines (2012) to show commitment in bringing about effort in taking an initiative to show that interventions are available to teenagers to use in preventing pregnancy.

Sexuality education as an intervention needs to be evaluated to gauge the impact it has on teenage pregnancy. A study conducted by Ramathuba (2013) shows that teenagers lack knowledge on family planning methods, including condoms use which makes them vulnerable to unplanned pregnant.

In this chapter the researcher will look at the recently discovered factors that contribute to teenage pregnancy as well as the much debated approaches in addressing teenage pregnancy. Additional question will be that, has the introduction of sexuality education been effective on teenage pregnancy? To find out as well teenage views on preventative measures that aim at preventing teenage pregnancy. The researcher will also look at what has the department of education, with the introduction of sexuality education, has done to meet the demands of this challenge. To investigate as well, the knowledge learners have and their preference when it comes to preventing teenage pregnancy. This chapter will also discuss how learning is essential in constructing knowledge that ultimately contributes to behavior of preventing pregnancy through sexuality education also the design methodology that justifies for this study.

## **2.2. Factors contributing to teenage pregnancy**

### **2.2.1. Relationship factors; family structure and teenage pregnancy**

Evidence suggests that family environments constitute the basic structure where children's behaviour is manifested, learned, encouraged, and suppressed (Dishion & Patterson, 2006). Parents' roles in the family environment have primarily been to prepare children for adulthood through rules and discipline. During adolescence, however, the influence of peers also serves as an important socialization agent. Despite this new sphere of influence, research has clearly demonstrated that parenting accounts for more variance in externalizing behaviors in adolescence than any other one factor (Crosswhite & Kerpelman, 2009; Gavazz, 2006; Simons, Chao, Conjer & Elder, 2001; Dekovic & Janssens, 2003). Understanding the quality dynamics of parenting is important to see how it influences behaviour.

#### **2.2.1.1. Intact families**

Simmons, Simmons and Wallace (2004) research has shown that adolescents in intact families; biological two-parent families generally fare better than children in single-mother, cohabiting stepfather, and married stepfather families. According to Simmons, Simmons and Wallace (2004), discovery suggested that family structure serves as a risk factor for adolescents, since adolescents from divorced or single-parent families are two to three times more likely to display problem behaviours (Simons, Simons & Wallace, 2004). In contrast, researchers have examined factors that contribute to adolescent enhanced adjustment among intact families. Adolescents in two biological parent households are more likely to have greater socioeconomic resources, as well as greater investments of parental time, attention, and support (Amato & Sobolewski, 2004).

Lansford, Deter-Deckerd, Dodge, Bates & Pettit (2004) reported that within intact families, mothers communicated more positively and supported their adolescents more than did single mothers, suggesting that having two parents in a household enhances the quality of parent-adolescent relationships. Further, Booth, Scott and King (2010) found that children do better on average in two-biological-parent families because a greater proportion of them enjoy close ties to their fathers.

Bimbola and Ayodele (2007) revealed that there is a significant relationship between parental marital status and the involvement of teenagers in teenage motherhood. This finding is supported by the studies of Bearman and Brückner, (1999) and related works of Simons-Morton, Lerner and Singer, (2005); Chassin, Hussong, Barrera, Molina, Trim

and Ritter, (2004) and Jaccard, Dodge and Blanton, (2005). Parental marital status also revealed predictive occurrence of teenage pregnancy among the female child. Predicting becomes more significant with single parents than with intact parents. It is often difficult for parents to fend for the family due to social and economic hardship usually experienced. Therefore for a single parent the circumstances could be over burdensome, the need for the child to assist in home survival. Such assistance could include hawking and selling goods, exposing the female child to rude and risky sexual advances from unsuspecting males which may lead to sexual activities and then possibly pregnancies.

#### **2.2.1.2. Single-parent families**

Fisher, Leve, Leary and Leve, (2004) indicate that growing up with a single parent is often associated with a number of adolescent behavioural problems. Adolescents in single-parent families might have more opportunities to engage in high risk behaviours since there may be only one parent to provide supervision. For example, levels of monitoring in single parent families have been examined and research indicates that single-parent families monitor their adolescents less when compared to two-biological-parent families. When the mother or father has gone to work with no one to take care of the teenager and they are left to parent themselves. Teenagers have to be responsible for other siblings, forced to grow up before time and they take this as an indication of maturity. Future decisions will later question their false sense of maturity.

According to Ellis, Bates, Dodge, Fergusson, Horwood, Pettit and Woodward (2003), research findings indicate that adolescents from single-parent families engage in the highest rates of problem behaviours when compared to other family structures. In other studies by Griffin, Botvin, Scheier, Diaz and Miller (2000) examined adolescent sexual activity and teen pregnancy and found that girls who experienced an absent father by or before age five had the highest rates of early sexual activity and teen pregnancy. Similarly, Moore (2001) found that adolescents living with single parents tend to initiate sex earlier than those living with both biological parents. These findings suggest that the presence of both parents in children's lives appears to be associated with a delay in sexual activity and less problem behaviour.

#### **2.2.1.3. Involved fathers**

Researchers have found that involved fathers have children who engage in less risky behaviours (Flouri & Buchanan, 2002). Accordingly these researchers found that

adolescents who were close to their non-resident father reported higher self-esteem, less delinquency, and fewer depressive symptoms than adolescents who lived with a father with whom they were not close (Flouri & Buchanan; 2002). Similarly, other researchers have found that active involvement of a non-resident father was associated with generally positive outcomes among adolescents (Hawkins, Amato, & King, 2007). Non-residential fathers' active involvement, such as helping with homework, talking about problems, and setting limits contributed to positive adolescent outcomes (Amato & Gilbreth, 1999). Other dimensions of the father-child relationship, which included feelings of closeness and authoritative parenting were found to be positively associated with adolescent's academic success and negatively associated with adolescents' externalizing and internalizing problems (Amato & Gilbreth, 1999). These findings suggest that non-residential fathers can positively influence adolescent outcomes when they are involved in their adolescent's life regardless of the living arrangement. However, non-residential fathers were found to be significantly less involved in parenting than fathers who live at home (Williams & Kelly, 2005). The teenagers start to feel neglected, which perpetuates feelings of abandonment and the child starts involving themselves in risky behaviours to compensate for their lack of close relationships.

#### **2.2.1.4. Grandparents**

Over the years there have been a growing number of adolescents who spend their lives with grandparents. Grandparents often serve as a positive influence in the lives of their grandchildren by taking on various roles such as caregiver, playmate, advisor, and friend (King, Elder & Conger, 2000). Research indicates that grandparent-grandchild relations are associated with positive adolescent outcomes. For instance, one study found that greater grandparent involvement is associated with fewer emotional problems and more positive outcomes among adolescents (Attar-Schwartz, Tan, Buchanan, Flouri & Griggs, 2009). The close bonds that are formed serves as reassurance for someone cares about them and is there for them.

In these findings, grandparent involvement was more strongly associated with reduced adjustment difficulties among adolescents from single-parent and step-families. Ruiz and Silverstein (2007) found that close and supportive relationships with grandparents reduced depressive symptoms especially among young people whose families of origin were absent a parent and that would reduce their likelihood of engaging in risky behaviour. Simons (2006) found that adolescent problem behaviours were no greater in

either mother-grandmother or mother relative families than in those in intact nuclear families. Therefore, the study suggests that grandparents can serve as an effective substitute when a father is not present. Overall, research findings indicate that there are positive associations between grandparent-grandchild relations and adolescent outcomes. However, though the grandparent is alone teenagers have proven to be quite problematic if the style of parenting of the grandparent is not as authoritative the teenager might still present with problematic behaviours.

#### **2.2.1.5. Child-headed households**

Child headed households are identified by Elkind (1984) as the major contributors to teenage pregnancies. As a result of poor or no parental guidance and control, children engage in sexual activities at a very young age. This is confirmed by Mfono (2003) who conducted a study on teenage pregnancy and his results revealed that teenage pregnancy is high among child headed households. The teenagers in those households often engage in several activities in exchange for money to assist them to survive. There is a definite link between teenage pregnancy and poverty as Mfono (2003) revealed in his study that there is high rate of teenage pregnancy among poor teenagers. Due to poverty a big number of teenagers get involved in unprotected sexual activities as a means to survive their circumstances. This study also confirmed that economically poor countries have more teenage mothers as compared with economically stable countries and poverty has a role in perpetuating teenage pregnancy. Teenagers engage in unprotected sex in exchange for money to survive and ignore all possible risks. Addition to that is not having a constant adult to give advice leads to many teenagers lacking knowledge of using protection during sexual encounter.

#### **2.3. Peer influence and teenage pregnancy**

Peer influence is a normal aspect for every individual emphasizing even developmental and healthy living of the individual and not something bad as many might want to interpret it. It is a period of involvement when an individual displays some level of independence from the parents. According to the Reproductive Health Outlook (2005), peer pressure is defined as emotional or mental force from people belonging to the same group such as age, grade, or status to act or behave in a manner similar to them. Peers are crucial for the adolescents' development, for the reason that development needs to

be in context which mainly implies family and peers (Oswald & Suss, 1988). A relationship with peers is an extended relation with people outside the family.

Rejection by peers or lack of peer acceptance has been associated with later academic difficulties, truancy, dropping out, disruptiveness and physical aggression (Buhs & Ladd, 2001; Rubin, Bukowski & Parker, 1998; Newcomb, Bukowski & Pattee, 1993). In fact, Haynie (2002) found out that adolescents get their self-esteem from the group they are belonging to and they cannot imagine themselves outside that gathering. Thus this heightened importance of peer influence is a hallmark of adolescent psychosocial functioning (Brown, 2004) and so should not be brushed aside. However, peer pressure can be negatively inclined and really dangerous.

This emphasized in the outcomes from increased conformity to peer pressure. Theoretically, as the teenager begins to detach self from parental, emotional and social dependency to independency the vacuum created in such transition is filled by peers. In the bid to avoid peer rejection or disapproval, the individual begins to alter their behaviour so as to fit in and show solidarity with peers even when such behaviour altercations are beyond their capacity, interest, family values and norms. In view of this peer influence has been associated with maladaptive behaviours such as substance abuse, smoking, drinking behaviours, reckless driving as well as risky sexual debuts (Simons-Morton , Lerner & Singer, 2005; Nouhad, 2006; Chassin, Hussong, Barrera, Molina, Trim & Ritter, 2004; Jaccard, Dodge & Blanton, 2005). With the need to be accepted by the group teenagers tend to go with what is popular not wanting to be left out but their other teenagers who do not engage in such behaviours that they could form friendships with.

According to Boujlaleb (2006), females are the most influenced by their peers and they suffer from the pressure put on their backs which is sometimes higher with the males. Bearman and Brückner (1999) observed that when asked why they had sex for the first time, 13 percent of young men ages 13 to 18 cited pressure from their friends compared to seven percent of young women. Eight percent of young women and one percent of young men cited pressure from a partner as a factor. In fact, teenage pregnancy is preceded by teenage risky sexual involvement or behaviours. Therefore there might be a possibility that peer influence may be related to teenage pregnancy. Adolescents whose friendship network included mostly low-risk friends were half as likely to experience first intercourse as were adolescents whose close friend network was composed mostly of

high-risk friends (Kaiser Family Foundation, 1998). The types of friends teenagers choose to have are having a direct influence on their behaviour.

## **2.4. Strategies on interventions on teenage pregnancy**

Until recently, there was a great divide in the teen pregnancy prevention arena with one group maintaining that “abstinence-only education” programmes (sometimes referred to as sexual risk avoidance programmes) are the best and healthiest strategy to prevent unintended teen pregnancies and sexually transmitted infections among teenagers. The other group claims a comprehensive approach to sex education provides today’s youth with the information and decision-making skills needed to make realistic, practical decisions about whether to engage in sexual activities. They contend that such an approach allows young people to make informed decisions regarding abstinence, gives them the information they need to set relationship limits and to resist peer pressure, and also provides them with information on the use of contraceptives and the prevention of sexually transmitted diseases.

### **2.4.1. Comprehensive approaches**

#### **2.4.1.1. Definition**

Comprehensive sexuality education is defined as a life-long process of acquiring information and forming attitudes, beliefs and values about identity, relationships and intimacy. (SIECUS, 2004) . It recognizes that information on sexuality alone is not enough, and therefore seeks to equip young people with the knowledge and skills they need to determine and enjoy their sexuality in all spheres of life. The term comprehensive indicates that this approach to sexuality education encompasses the full range of information, skills and values to enable young people to exercise their sexual and reproductive rights and to make decisions about their health and sexuality.

#### **2.4.1.2. Debates on comprehensive sexuality education**

Comprehensive sex education proponents argue that by denying teens the full range of information regarding human sexuality, abstinence-only education fails to provide young people with the information they need to protect their health and well-being (NARAL, 1999). Information is the key element in addressing the pandemic of teenage pregnancy. Surveys of young people found that students who have sex education, know more and feel better prepared to handle different situations and decisions than those who are not

exposed to information (Henry, 2000). Even if they have not encountered such situation, it is about being prepared.

In South Africa the national health policy framework which came into existence in 1996 addressed the current reproductive health challenges. It provided a comprehensive restricted access to contraceptive services and increase public knowledge of clients' rights, methods of contraception and services (Ramathuba, 2008; ANC, 1994). Integrated Primary Health Care (PHC) services are now widespread after several items of legislation, health policies and regulations came into existence. A Comprehensive Health-care approach is being implemented to improve women's health by providing contraceptives, maternal, child, adolescent and women's health-care services, together with teenage pregnancy prevention and management (Department of Health, 2001) and the choice on termination of pregnancy (CTOP) services, sexuality education and counselling services (Department of Health, 1996b:2), which constitute part of the fundamental human rights of women in South Africa.

Having this legislation yet approximately 30% of teenagers in South Africa report 'ever having been pregnant', the majority, unplanned (Jewkes, Morrell & Christofides; 2009, Lince, 2011; Flanagan, Lince, Durao & Menez, 2013; Pettifor O'Brien, MacPhail, Miller, Rees, 2005; Holt, Lince, Hargey, Struthers, Nkala, McIntyre, Gray, Mnyani & Blanchard, 2012; Ardington, 2012). While this number has decreased over the past few decades, it is still unacceptably high. This happens mostly because they were not using contraceptives. Unplanned pregnancy constitutes a health problem and has negative implication on the teenage mother and is usually associated with non- use of contraceptives, casual sex, failure to negotiate safe sex and the perception that most of their friends have become pregnant and one has to prove one's fertility.

This is rather unfortunate in spite of the presence of health awareness programmes on health and sex education that are provided by health practitioners. In terms of the health programmes mounted by health care providers, teenagers are informed about available free contraceptives from the local clinics, hospitals, mobile clinics, as well as at schools through the Life Orientation subject. During these programmes, teenagers are also encouraged to use condoms as well as a reliable family planning method during sexual activities, if they cannot abstain. The reason why they are encouraged to use condoms is because condoms provide them with dual protection, that is, simultaneous protection against STIs and unwanted pregnancy (Morrone, Myer, Mlobeli, Gutin & Grimsrud, 2007).

In one secondary school learners are reported to be calling each other by their children's names. This has a negative influence on other teenagers who might view teenage pregnancy as acceptable. Statistics from a regional hospital in Thulamela municipality revealed that 1896 adolescents aged below 18 years gave birth, to 26% of the total deliveries and 345 (31%) performed CTOP (Tshilidzini hospital maternity and CTOP register 2004/2005). These statistics underline the importance of exploring adolescent's knowledge, attitudes regarding contraceptives and sexual behaviour. Sexual and contraceptive knowledge can help to reduce the number of teenage pregnancies.

#### **2.4.1.3. Researched programmes using comprehensive sexuality education**

In a study done by UNESCO (2009) forty per cent of programmes were found to increase condom use, while sixty per cent had no impact and none decreased condom use. Forty per cent of programmes also increased contraceptive use; 53 per cent had no impact, and 7 per cent (a single programme) reduced contraceptive use. Some studies assessed measures that included both the amount of sexual activity as well as condom or contraceptive use in the same measure. For example, some studies measured the frequency of sexual intercourse without condoms or the number of sexual partners with whom condoms were not always used.

These measures were grouped and labelled 'sexual risk-taking'. Fifty-three per cent of the programmes decreased sexual risk-taking; 43 per cent had no impact and three per cent were found to increase it. In summary, these studies demonstrate that more than a third of the programmes increased condom or contraceptive use, while more than half reduced sexual risk-taking, either among entire samples or in important sub-samples. The positive results on the three measures of sexual activity, namely on condom and contraceptive use and sexual risk-taking, are essentially the same when the studies are restricted to large studies with rigorous experimental designs. Thus, the evidence for the positive impacts upon behaviour is quite strong.

Henderson et al (2007) did an evaluation study of two SHARE and RIPPLE. SHARE, a 20 session programme for 13 to 15 year olds, is an example of teacher delivered sex education programme, the most widely practiced approach to formal sex education. The main outcome was unsafe sex and secondary outcomes included contraceptive use, regret of sexual encounters, coercive sex and practical sexual health knowledge. RIPPLE, year 12 pupils (aged 16-17 years) were recruited as peer-educators and trained to use participatory methods with Year 9 pupils in three classroom sessions: on relationships, STIs, and condoms and contraceptives.

The sessions were not based on a specific theory but were meant to develop skills in sexual communication and condom use, and knowledge about pregnancy, STIs, contraception and local sexual health services. They each lasted around one hour, teachers were not present, and they replaced the usual teacher-led sex and relationships with both interventions many pupils expressed a wish to have at least some single-sex sessions (Strange, 2003; Buston & Wight, 2004), and there was some evidence that the relatively lax discipline in peer-education was attractive to boys but at the cost of girls' sense of comfort and safety (Strange, Forrest, Oakley & Stephenson, 2003). A certain level of teaching strategy is important as this will ensure a level of control to delivering the subject that it does stick to its goals and objectives.

On the other hand, prevention of unwanted pregnancies and sexually transmitted infections has been identified as an important strategy in the promotion of women and reproductive health, especially for sexually active persons. The concurrently high rates of STIs and unplanned pregnancies make a compelling case for dual protection usage, as indicated in the National Contraception Guidelines (2012) that there is a need for constant promotion of dual method use. Barrier methods, both male and female condoms, should be used in combination with all other contraceptive methods to effectively prevent pregnancy.

However, even though many efforts have been made so far to reduce the rate of teenage pregnancy, the problem continues to persist, pointing to a need for more active strategies to solve this problem. The findings from this study will inform the Department of Health in regards to which intervention programmes to use for preventing teenage pregnancy. In a study by Ramathuba (2013) discovered that out of 70 respondents, 77% (n=54) did not use contraceptives and condoms; 6% (n=4) forgot to take contraception; 11.4% (n=8) experience condom burst; 1.4% (n=1) intentional, and 4.2% (n=3) defaulted contraceptives, stated that condoms were not always available and the other 6% (n=1) said they were irritating.

The National Contraception Clinical Guidelines (2012) states that there may be challenges for young people in terms of discovering their sexuality and using their erection with male condoms, while young women may feel uncomfortable about inserting the female condom. The finding of this study supports this statement that some participants showed ignorance on the correct use of condoms. Teenagers therefore need proper counselling and information on the benefits of dual protection. The findings of this study revealed that teenagers engaged in early sexual intercourse activities, non- use

and poor use of family planning methods including condoms and these exposed the teenagers to unwanted pregnancies and sexually transmitted diseases.

Similar to Holgate (2006) study, many unplanned births occur because of the increased and widespread sexual activity among young people. Holgate (2006) conducted a study which revealed that 40% of boys and 80% of girls at a very young age of 15 years had experienced sexual intercourse. Besides, 12.8% and 28.6% of the participants at ages 15 and 16 years, respectively, were pregnant. This is worrisome, given the health and social consequences that early pregnancy would have on the life of the teenagers. In this regards, the teenagers need to be informed that one does not need to have frequent sexual intercourse to fall pregnant if condoms are not used or not used properly.

#### **2.4.2. Debates on abstinence approaches**

##### **2.4.2.1. Abstinence education**

Abstinence education interventions promote abstinence from sexual activity (either delayed initiation or abstinence until marriage) and mention condoms or other birth control methods only to highlight their failure rates, if at all. These interventions generally include messages about the psychological and health benefits of abstinence as well as the harms of sexual activity. Abstinence-only proponents point to studies concluding that the abstinence-only education message has played a central role in the decline of adolescent sexual activity, and related negative health outcomes, over the last decade.

One study by Jones, Toffler and Mohn (1999) reported that abstinence and decreased sexual activity among sexually active adolescents are primarily responsible for the decline during the 1990s in adolescent pregnancy, birth and abortion rates. Attributing these declines to increased contraception is not supported by the data. Kirby (2002) evaluates the validity of 10 studies providing proof that abstinence programmes reduced early sexual activity. Nine out of 10 studies fail to provide credible evidence and one study shows some delay, but only among specific age groups. Currently there is no existing strong abstinence-only programme with strong evidence that they either delay sex or reduce teenage pregnancy. According to Human Rights Watch (2005), Uganda is redirecting its HIV prevention strategy indirectly targeting teenage pregnancy for young people towards focusing primarily on promoting sexual abstinence until marriage. The strategy is endorsed by powerful religious and political leaders in Uganda, but the shift is orchestrated and funded by the US government who has taken the same stance by giving more funding their abstinence-only programmes.

Morrison, Myer, Mlobeli, Gutin and Grimsrud (2007) feel that it stands to reason that this new direction is to replace existing, sound public health strategies with unproven and potentially life-threatening messages, impeding the realization of the human right to information, to the highest attainable standard of health, and to life. Morrison et al (2007) revealed abstinence-only strategy in Uganda fails to offer young people information on condoms and safer sex, but additionally promotes marriage while withholding information on its inherent risks. Morrison et al (2007) argued that evidence base suggesting that AIDS reductions are due mainly to abstinence-only – discredits this argument (ABC strategy – Abstain, Be faithful, use a Condom – not even known in Uganda until 2002). A study of the ‘Postponing Sexual Involvement’ curriculum in California found that its students were more likely to report becoming pregnant or causing pregnancy (although it is unlikely that the Postponing Sexual Involvement programme was the cause). The programme showed no measurable impact on initiation of sex, frequency of sexual activity and number of sexual partners (Collins, Alagiri & Summers, 2002).

#### **2.4.2.2. Researched programmes of abstinence approaches**

The abstinence programmes studied differed greatly in their locations and included both urban and rural communities (Thenholm, 2007). Three of the programmes served mostly African-American and Hispanic students while one programme served predominantly white youth. The latter usually came from two parent homes that were working or middle class. While the former were mostly from low income households headed by one parent. The programmes differed greatly. For example, some happened during the school day and were mandatory, while others happened after school. Some were weekly and some were daily (Thenholm, 2007).

The programmes ranged from one year programmes to four year programs and they targeted all different grades between third and eighth. Overall the programmes, according to the study, did not impact students’ likelihood to remain abstinent. About fifty percent of students in the study, and in the control group that did not receive abstinence education, remained abstinent (Thenholm, 2007). There was also no difference shown between study participants and the control group in the age of sexual debut or the number of sex partners. The study revealed that contrary to concerns by those who question abstinence education, participants in the abstinence education programme were no more likely to have unprotected sex than those who did not participate. Very similar proportions of both groups reported not using a condom at first sex and not consistently using a condom over the course of the previous year.

The lack of understanding about the effectiveness of condoms discovered in this study demonstrates the harmful effects of the misinformation given to students in abstinence-only programmes. These programmes were effective in delivering this message, but the message was inaccurate. It is obvious that the programmes focused on STDs to dissuade students from having sex. While the discussion of STDs probably succeeded in scaring them, students walked away with the false notion that condoms are never effective. When the images of the diseased genitalia are forgotten, all students will be left with is the idea that condoms do not work and therefore are not worth the hassle.

#### **2.4.2.2.1. Virginitiy pledges**

Data obtained from a study of a virginitiy pledge movement in the United States by the National Longitudinal Survey of Youth suggested that many teenagers who intend to abstain fail to do so and that when abstainers do initiate intercourse, they may fail to protect themselves by using contraception (Santelli, Ott, Lyon, Rogers, Summers & Schleifer, 2006b). A United States study conducted in 2000 concluded that pledgers were more likely to delay initiation (on average by 18 months), but less likely to use contraception after they did initiate sexual activity. Additionally, pledges were found to be effective only when they were taken by a decent-sized minority group, making the person feel part of a select group. The following results were found at a six-year follow-up: prevalence of sexually transmitted infections was similar among pledgers and non-pledgers; pledgers tended to marry earlier, but 88 per cent of those married had had intercourse before marriage; pledgers had fewer sexual partners than non-pledgers, but they were less likely to see a doctor for concerns about sexually transmitted infections and less likely to receive testing for sexually transmitted infections (Santelli et al., 2006b). Many commentators argued then (and now) that sexual activity in and of itself is wrong if the individuals are not married.

Advocates of the abstinence education approach argue that teenagers need to hear a single, unambiguous message that sex outside of marriage is wrong and harmful to their physical and emotional health. These advocates contend that youth can and should be empowered to say no to sex. They argue that supporting both abstinence and birth control is hypocritical and undermines the strength of an abstinence-only message. They also cite research that indicates that teens who take virginitiy pledges to refrain from sex until marriage appear to delay having sex longer than those teens that do not make such a commitment. Peter and Hannah (2001) further argue that abstinence is the most effective means (i.e., 100%) of preventing unwanted pregnancy and sexually transmitted

diseases. However, Kirby concedes that they found “no significant differences in STD infection rates between pledgers and non-pledgers” (Kirby, 2008, p.13).

#### **2.4.2.2.2. Virginitv testing**

For the past 21 years there has been the re-emergence of mass based virginitv testing particularly amongst the Zulu people. Virginitv testing involves young girls being physically examined by traditional examiners to determine if they are still virgins. Thereafter they are provided with certificates in a public ceremony and others attend the annual Royal Reed Dance sanctioned by King Zwelithini. The re-emergence of this cultural practice has led to concerns being raised about the potential invasion and violation of guaranteed constitutional rights of the young women who are tested. These concerns have also been voiced by the Commission for Gender Equality and the South African Human Rights Commission.

Virginitv testing has both proponents and opponents. Some proponents see the practice as “a back- to-basics remedy for some of the country’s worst social ills, including the growing teenage pregnancy pandemic. Murphy (1999) maintains that virginitv testing also viewed as a long over-due revival and appreciation of Zulu culture, helping in detecting child abuse, minimizing teenage pregnancy and preserving and instilling a sense of good morals. Some opponents of this practice see it as a violation of human rights, especially the right to privacy.

The Gender Commission in KwaZulu-Natal is reported to have said that they are trying to teach children that their body is theirs but to sending them to a woman who invades it sends a mixed message. According to the commission, the doing away with the practice would be a positive move. Other opponents see the practice as endangering the lives of girl certified as virgins in that many of these girls become easy targets for rapists, especially with rape incidents being so high in South Africa.

The South African Human Rights Commission (SAHRC) as one of the chapter 9 state institutions supporting constitutional democracy is mandated amongst others to promote respect for human rights and a culture of human rights; and, to promote the protection, development and attainment of human rights (Section 184(1)(a) and (b). It is within this mandate that the commission has observed the debates surrounding the prohibition of virginitv testing in the Children’s Bill. In section 31, the Constitution provides that: 31. (1) Persons belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community – (a) to enjoy their culture, practice their

religion and use their language. The people looked what has worked for them in their culture to use in their communities to respond to teenage pregnancy and virginity testing to them seemed the next best thing.

## **2.5. Discussions on the effectiveness of sexuality education**

Until the start of this century there was little robust research evidence on the effectiveness of school-based sex education. Eggleston, Jackson, Rountree and Pan (2000) in health promotion argued that well designed, timely sex education could substantially reduce sexual risk taking, but others argued that if delivered too early it promotes greater sexual activity.

### **2.5.1 The role of school**

In the larger context, the education sector has a critical role to play in preparing children and young people for their adult roles and responsibilities (Eggleston, Jackson, Rountree & Pan, 2000). The transition to adulthood requires being informed and equipped with the appropriate skills and knowledge to make responsible choices in our social and sexual lives. In most countries, young people between the ages of five and thirteen spend relatively large amounts of time in school. Thus, schools provide a practical means of reaching large numbers of young people from diverse social backgrounds in ways that are replicable and sustainable.

Teachers are likely to be the most skilled and trusted sources of information. Evidence from UNESCO, WHO, UNICEF and World Bank points to the core set of cost-effective activities that can contribute to making schools healthy for children (Fawole, 1999). Moreover, in many countries, young people have their first sexual experiences while they are still attending school, making the setting even more important as an opportunity to provide education about sexual and reproductive health. In many communities, schools are also social support centres, trusted institutions that can link children, parents, families and communities with other services (for example, health services). Thus, they have the potential to promote communication about important issues between young people, trusted adults and the broader community.

According to UNESCO (2009), the overall school context within which sexuality education is to be delivered is crucially important. In this regard, two linked factors will make a difference: leadership, and policy guidance. Firstly, school management is expected to take the lead in motivating and supporting, as well as creating the right climate in which to implement sexuality education and address the needs of young

people. From the perspective of a classroom, instructional leadership requires teachers to take the lead in how children and young people experience sexuality education through discovery, learning and growth. In a climate of uncertainty or conflict, the capacity to lead amongst managers and teachers can make the difference between successful programmatic interventions and those that falter. This will be effective by implementing sexuality education within the framework of a clear set of relevant school wide policies or guidelines concerning, for example, sexual and reproductive health, gender discrimination.

Schools can serve as an effective platform for reproductive health education, and schooling itself appears to have a beneficial effect (Cabezón, Guyatt, William & Griffith, 2005; Dupas, 2011). In sub-Saharan Africa, the combined effects of increasing levels of school enrolment, delayed school entry, grade repetition, and periods of temporary withdrawal from school lead many young women to remain enrolled at the primary or junior secondary level well past puberty and into their late teens, thus increasing their risk of pregnancy-related school disruptions (Lloyd, Kauffman & Hewett, 2000; Hewett & Lloyd, 2005). At that level there is no sexuality education that is supposed to empower these young girls, who have reached puberty and has high risk of getting pregnant when engaging in unprotected sexual activities.

However, few studies (HSRC, 2005), examine the direct association between continued school enrolment and adolescent pregnancy. Various qualitative studies, many from Southern Africa, have attempted to examine aspects of this issue, most using focus-group discussions and semi structured interviews to identify policy factors perceived to contribute to the risk of schoolgirl pregnancy what adolescents perceive to be the consequences of schoolgirl pregnancy (Bledsoe, 1992; HSRC, 2005). Fertility-related indicators decreased at least marginally significantly in six interventions. Three of these interventions included school-based programming or enabled school attendance (Cabezón, Pilar, Rojas, Leiva, Riquelme, Aranda & Garcia, 2005; Duflo, Dupas & Kremer 2011; Dupas, 2011). Results were positive from conditional cash transfers overall, although only a subset of included cash transfer programmes produced a statistically significant decrease in fertility. The study by Duflo, Esther, Pascaline, Dupas and Kremer (2011) found that a school-based intervention successfully reduced fertility as of three and five years after the programmes by lowering the barriers to school attendance through the provision of free uniforms. This result is theoretically consistent, as cash transfers can both incentivize school attendance and increase girls' financial

independence, both of which have been found to reduce adolescent marriage and fertility. These results indicate that improving school attendance may be just as effective—and perhaps even more effective—in reducing adolescent childbearing as providing reproductive health education as part of a school curriculum.

### **2.5.2. Programme characteristics**

Programme characteristics mostly outlined by UNESCO (2009) address human rights and lead to behaviour change. There are several characteristics that Kirby (2007) believes are present in effective curriculum-based sex education programmes. He argues that programmes need to be “focused on clear health goals—the prevention of, pregnancy” (Kirby 2007, p131). He maintains that schools should provide these contraceptives. Kirby (2007) states content should cover strategies for meeting these goals such as abstinence or contraceptive use. He also states that content should prepare students by discussing circumstances that lead to unhealthy sexual decision making and how to avoid difficult situations.

He acknowledges the importance of psychosocial elements such as “knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy,” and influencing them in a way that keeps youth healthy (Kirby 2007, p.131). Furthermore, Kirby argues that effective programmes happen in environments where youth feel comfortable participating and involve students in a variety of activities that honestly address the psychosocial elements involved in sexual decision making. Good programmes use sound instructional methods that make students identify personally with the information (Kirby, 2007). Specifically, those effective programmes “Employed activities, instructional methods, and behavioural messages that were appropriate to the teens’ culture, developmental age, and sexual experience” (Kirby 2007, p131). Finally, topics in effective sexuality education programmes were also covered in logical sequence. Promoting sequence showing how a situation will present itself in real life but that is not always successful in implementing the curriculum.

Consequently schoolgirls in South Africa pregnancy rate remain high by international comparison and the rate of thirteen percent (13%) in rural areas in KwaZulu-Natal is twice the national average of six and a half percent (6.5%) (Karra & Lee, 2012). Berry and Hall (2010) revealed that teenage girls (15-19 years) 18% became pregnant in 1998 and 14% in 2008. Although the numbers dropped in 2008, 14% is still too high for young girls whose dreams are not realized because of pregnancy. The incidence of adolescent pregnancies is high and therefore the effect of sex education remains disappointing.

Another explanation for this lack of impact of the education programmes is that education can only be effective if it is combined with an adequate service delivery. Education on contraceptives is useless if it is very difficult to obtain contraceptives. In particular there are important barriers to the successful access by adolescents to family-planning services, including the tendency of parents to monitor closely any medical care their children receive. One of the main aims of the education programmes was the delay of initiation of sexual intercourse; consequently the use of contraceptives may have been described as a “second-best” solution (DiCenso, Guyatt, Willan & Griffith, 2002).

### **2.5.3. Sexuality education and the law**

A Medical Research Council (2007) recommended sex education at school before the age of 14, when young people become sexually active. They recommended that it should include information for teenagers about avoiding getting pregnant. At the same time it should provide detailed information about contraception and its side effects, as well as better management and training of nurses so they can deal with teenagers requiring contraception and provide the necessary information and education, in a more empathetic manner so that teenagers are not afraid to ask for contraceptives. Where the law of South Africa enables access to contraceptives currently, children can consent to contraceptives and contraceptive advice from the age of 12 Section 134 of the Children’s Act No. 38 of 2005. This norm is not likely to change in the immediate future. Section 15 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007 currently, says it is an offence to have sex below the age of 16, even when sex is consensual.

This means that if one or both of the persons engaged in consensual sex are below the age of 16, they are committing a criminal offence. This norm is not likely to change in the immediate future. Service-providers and researchers are not clear what the additional capacity requirements outlined in the law actually entail. However, maturity could also entail stable values, longer-term perspectives or impulse control. Furthermore, it appears that norms that allow children to consent independently to services in some instances may jar with other legal requirements. For example, children can access sexual health services from age 12, whereas sex under age 16 is illegal. Medical practitioners are under a statutory duty to report under-age sex. Therefore, service providers and researchers acting lawfully in terms of the Children’s Act by providing contraceptives to a sexually active 13-year-old will be acting unlawfully in terms of the law if they fail to report the child’s engaging in a sexual offence to the police (Sexual Offences Act, 2007).

However in the revised bill changes to the criminal law (Sexual offences and related Matters Amendment Bill) were adopted by the National Assembly (Act 15 of 2015) states that teenagers between the ages of 12 and 15 can consent to sexual acts with each other.

## **2.6. Measures that learners prefer on prevention of teenage pregnancy**

It is beyond doubt that adolescents need good information about their own bodies, their sexual development and about the ways of avoiding pregnancy. Moreover they need to be informed about teenage pregnancy. In the past it has often been said that this is the task of parents, It is important that young girls and boys receive information about these matters before they themselves get involved in sexual activity. In many developed countries sex education is part of the curriculum of primary and/or secondary schools. (Scher, Maynard & Stagner, 2006)

## **2.7. Knowledge of learners about prevention and contraceptive**

In a context where ignorance and misinformation can be life-threatening, sexuality education is part of the duty of care of education and health authorities and institutions. In its simplest interpretation, teachers in the classroom have a responsibility to act in the place of parents as a number of studies have shown that parents do not talk to their children about these matters because they feel confused, ill-informed or embarrassed about the topics (Hughes & McCauley, 1998). Therefore teachers contribute towards ensuring the protection and well-being of children and young people.

In a study conducted by Nika, Bereda, Thakhati and Goon (2015) indicate that there is an increase in teenage pregnancy despite the presence of dual protection practice and health care awareness programmes related to health and sexuality education in South Africa. During these programmes, teenagers are also encouraged to use condoms as well as a reliable family planning method during sexual activities, if they cannot abstain. The reason why they are encouraged to use condoms is because condoms provide them with dual protection, that is, simultaneous protection against STIs and unwanted pregnancy (Morrone, Myer, Mlobeli, Gutin & Grimsrud, 2007).

The study explored the underlying causes of high teenage pregnancy and sexually transmitted disease in Fort Beaufort. The sample comprised of 70 conveniently selected pregnant teenagers aged 15-19 years. Data were collected through self-administered questionnaire. About 56.9% participants knew nothing about family planning, 27.5% conceived family planning as prevention of pregnancy, and regard injection as a method

of family planning, while 11% described family planning as planning for future babies. Those who knew about family planning mentioned friends, clinics, schools, family and neighbours as the source of information about family planning. Concerning condom use, majority (96.1%) heard about condoms, 66.7% once used the condoms and 72.5% were knowledgeable about condom use and 27.5% did not know how to use the condoms. About 34% knew that condoms protect against pregnancy (20.0%), and 9% did not know anything about condoms. Teenagers are not well informed about family planning methods. Those who used condoms are not consistent and had limited knowledge about their use.

Other similar study done earlier by Ramathuba (2013), on learners were showing alarming finding planning methods, were guided by religious beliefs and did not want to use family planning methods. About 66.7% (n= 47) had used condoms before and 33.3% (n= 23) never used a condom. Majority (72.5% (n=51)) knew how to a use condom and 27.5% (n=11) did not know how to use a condom. Concerning reasons for using condoms for sex, 20% (n-14) maintained that condoms protects against pregnancy, 37% (n=26) stated it protects against STIs; protects against pregnancy and STIs (34 (n=24)) and 6 (9%) did not know anything. Most (47%; n=11) participants had no reason for not using condoms; 24% (n=6) did not like using the condoms; 17% (n=4) had pressure from boyfriends; 6% (n=1). The study showed the respondent knowledge about family planning (Ramathuba, 2013).

About 56.9% (n=40) knew nothing about family planning; 27.5% (n=19) had knowledge about family planning in terms of prevention of pregnancy and 5.7% (n=11) had little knowledge as they stated that family planning is about discussing as a family and taking decision on the number of babies to have as well as planning on their future, and getting an injection at the clinic. provides information on family planning and condoms. About 13.3% (n=4) heard about family planning from friends; 10% (n=3) family; 26.6% (n=8) school 33.3% (n=10) clinic and 16.6% (n=5) neighbours. Majority (54.2%; n=38) of the participants have used family planning methods before pregnancy and 45.7% (n=32) have never used family planning (Ramathuba, 2013).

Adolescents are particularly susceptible to unintended pregnancy. They are often uninformed, and frequently misinformed, about sexuality and the risk associated with early and unprotected sex (WHO, 2000). Teenage pregnancy is a socio-economic challenge and a public health problem for communities in South Africa

UNESCO (2009) deliberated on a report published in 2007 by the UK Youth Parliament, based on questionnaire responses from over 20,000 young people, says that 40 per cent of young people described the Sex and Relationships Education (SRE) they had received as either 'poor' or 'very poor' with a further 33 per cent describing it as only average. Other key findings from the survey were that: 20 per cent of respondents reported not having been taught anything about relationships; 55 per cent of the 12-15 year olds and 57 per cent of the 16-17 year old females reported not having been taught how to use a condom; Just over half of respondents had not been told where their local sexual health service was located. Involving a structure like the Youth Parliament in the process of reviewing SRE provision yielded important data. The data also shows the scale of the challenge in meeting young people's needs, even in developed countries' education systems.

Kenkel (1991) argues there is a causal effect of knowledge on health behavior. In doing so, researchers have been aware that an OLS regression of behavior on knowledge does not provide consistent estimates due to the presence of unobserved factors which can influence both variables such as parental education or expectations about the future (Kearney & Levine, 2012). Reverse causation may also contribute to the lack of consistency in OLS estimates. For example, a risky sex event may trigger a search for information and hence an increase in knowledge. Kenkel (1991) in particular posits a structural relationship between knowledge and behavior, where knowledge is an endogenous variable, and then uses an instrumental variables approach to estimate the impact of knowledge on behavior. A requirement for the consistency of this strategy is that the sole mechanism through which behavior can be affected is knowledge. However, caution is warranted. For instance, perhaps the course also has an impact on behavior due to shifting social norms, which would happen concurrently with the shifts in knowledge and attitudes.

Knowledge and attitudes are important because these two factors have been shown to be the strongest protective factors in preventing pregnancy among teens (Kirby, Lepore & Ryan, 2005). Furthermore, recent research Ross, Dick and Ferguson (2006) has documented the important role that social norms play in responsible sexual behavior

### **2.7.1. Knowledge of emergency contraceptives**

When asked what one could do immediately after having unprotected sex to prevent pregnancy, an alarmingly low sixteen percent (16%) of females reported use of an emergency pill, seventeen percent (17%) did not answer, and five percent (5%) indicated that drinking water, cold drinks or quinine or “washing the private parts well” would act as a deterrent (Ramathuba, 2008). Ehlers (2003) indicated that 40 out of 60 adolescent mothers in Tshwane, South Africa, did not know about the availability of emergency contraceptives to be taken within 72 hours after unprotected sex.

Netshikweta (1999) also reported in a survey conducted in Limpopo Province that seventy three percent (73%) of student nurses had no knowledge of emergency contraceptives despite being health-care providers. Ehlers (2003) indicated that 40 out of 60 adolescent mothers in Tshwane, South Africa, did not know about the availability of emergency contraceptives. There is a need for adolescents to be proactive and take measures to protect themselves from unintended pregnancies, and also have effective knowledge contraceptives can prevent unplanned pregnancies.

An earlier study by Kistnasamy, Reddy and Jordaan (2009) showed that majority of respondents (99.2%) have not used emergency contraceptive, and were not aware where it could be accessed and that no prescription was required. However, when further asked if they think it is a good option, some thought that it will promote promiscuity as it make a person to deliberately sleep around. This statement is an indication that secondary-school girls lack information about emergency contraceptives and are not independent and responsible enough to claim their reproductive right of making informed choices for students across ethnic groups had myriad of concerns related to religion and morality, as they believed that EC kills any foetus that may have been conceived.

Ramathuba (2013) maintains that a lack of education on basic reproductive anatomy, the physiology of conception and contraception could lead to early initiation of sexual activity and risky sexual behaviour. The study revealed that secondary school girls lacked information on sexuality and contraceptive, sexuality decision-making skills and negotiation skills and responsible sex. Failure to help teenage girls to deal with sexuality and contraception could lead to incidences of pregnancy, STI and HIV/AIDS. Reproductive health-care services need be available and accessible to the secondary-school girls.

The majority of the respondents (83%) displayed lack of knowledge about EC. Only 17% of the respondents claimed to be knowledgeable about emergency contraceptives and when further asked to specify, 1% indicated it was the morning-after pill. When further asked to specify the time the pill should be taken, 0.4% said it should be taken after 72 hours, 0.4% said it should be taken after 12 hours, and 0.4% said it should be taken after sex.

This disparity clearly indicates that knowledge of emergency contraceptive is lacking and this is in contrast to the Department of Health (DoH) policy which maintains that extensive promotion of emergency contraceptives should be conducted with all service users capable of falling pregnant so as to prevent unwanted pregnancies and TOP (South Africa, 1999a:66). Maja and Ehlers (2004) also reported that 31.3% had heard about the morning-after pill but only 12.8% could provide information, with only a minority knowing about the dose and under which circumstances emergency contraceptive can be used. Ramathuba (2015) further recommends that, the knowledge and attitudes of the adolescent girls should be improved through sex education, as it has a direct effect on contraceptive use and prevention of unwanted pregnancies.

## **2.8. Theoretical orientation for the study**

Many of the interventions on teenage pregnancy suggestions are simply based in sound learning theory. Students have to be engaged with information in order to retain it and have it influence their lives. Students learn best when they identify with and connect emotionally to the curriculum. Both abstinence-only programmes and comprehensive sex education programmes include hands on activities to engage students. Kirby (2002) maintains that no programme is going to be effective if it does not apply the basics of learning theory.

### **2.8.1. Learning**

Learning has been defined functionally as changes in behavior that result from experience or mechanistically as changes in the organism that result from experience (Houwer, Barnes-Holmes, & Moores, 2013; Hergenhahn & Olson, 2005). Contrary to that though Skinner had asserted that behaviour changes that are being observed learning. Behaviour changes are learning and no inferences are needed (Houwer, Barnes-Holmes, & Moores, 2013). The changes that we see are therefore learning but how can you change if you have not learnt anything. The content that has been delivered by sexuality

education should show effectiveness through behavior change therefore a decline in teenage pregnancy.

As was noted by Lachman (1997), most textbook definitions of learning refer to learning as a change in behavior that is due to experience. This is essentially a very basic functional definition of learning in that learning is seen as a function that maps experience onto behavior. In other words, learning is defined as an effect of experience on behavior. Many researchers have claimed that such a simple functional definition of learning is unsatisfactory (Domjan; 2010, Lachman; 1997; Ormrod; 1999, 2008). Most important, it has been argued that a simple functional definition has difficulties dealing with the fact that changes in behavior are neither necessary nor sufficient for learning to occur. A learner might have learnt but not necessary demonstrate immediately what they have learnt on measures to prevent teenage pregnancy.

First, latent learning effects suggest that changes in behavior are not necessary for learning to occur. Ever since Tolman and Honzik (1930) observed on one of their earlier studies on latent learning discovered that experiences at time 1 that do not appear to have any effect on behavior at that point in time can suddenly influence behavior at a subsequent time 2 Hence, organisms seem to learn something at time 1 that is expressed in behavior only at time 2. The learning that occurs at time 1 is latent in that it does not yet produce a change in behavior at that point in time. Second, it has been argued that observing a change in behavior is not sufficient to infer the presence of learning because (1) not all effects of experience on behavior can be regarded as learning and (2) not all changes in behavior are due to experience. However it shows there was some learning that took place, but not being certain what influenced that behavior of deciding of using contraceptives or condoms.

What is most crucial for present purposes is that the identification of the problems of a simple functional definition led to the proposal of other definitions of learning. Most of these alternative definitions have in common the assumption that learning involves some kind of change in the organism, and this change is necessary but not sufficient for observing a change in behavior. For instance, in his highly influential textbook, Domjan (2010) defines learning as an enduring change in the mechanisms of behavior therefore permanently altering behavior of deciding to use protection always when having sex.

Likewise, Lachman (1997) typifies learning as a process that underlies behavior. He argues that learning should not be confused with the product of this process that is, the change in behavior. (Hall, 2003; Ormrod, 2008) argue that the change in the organism

that is assumed to lie at the core of learning is sometimes described at a very abstract merely as some kind of internal change but sometimes involves a specific mental process. Because learning is seen as only one of many mechanisms that determine behavior, it follows that changes in behavior are neither necessary because other determinants of behavior can block the impact of learning. A lack nor sufficient motivation or other determinants of behavior might be responsible for a change in behavior, the genetic makeup of an organism to infer the presence of learning.

Although many of these alternative definitions of learning still refer to the impact of experience on behavior, they are no longer functional in a strict sense of the word, because they refer to the mechanism that mediates the impact of experience on behavior. Mechanistic approaches in psychology aim to uncover the mechanisms that drive behavior—more specifically, the parts of a mechanism, the organization of the parts, and how each part operates (Bechtel, 2005, 2008). For present purposes, it is important to note that mechanistic accounts of behavior imply that some part of the mechanism operates at the time of the behavior change. In other words, mechanistic accounts imply the presence of contiguous causes of behavior:” If a behavior change occurs at time 2, there needs to be an element that is present immediately before time 2 and that causes the change in behavior at time 2” (Chiesa, 1992, p. 129).

### **2.8.2. Regularities in the environment influence behavior**

Once a change in behavior has occurred and has been attributed to regularity in the environment that is parents, peer influence and sexual education, one can start exploring the variables that determine when the regularity influences behavior. Adopting a functional definition of learning also allows for the study of seemingly cognitive forms of learning, such as learning via instruction and inference.

Defining learning as the effect of regularities in the environment on behavior reveals that learning research can address two questions. (1) When do the regularities lead to changes in behavior? (2) How do the regularities lead to changes in behavior? From this perspective, cognitive learning research deals with the how-question. Its aim is to specify a mechanism of mediating mental states and operations by which regularities in the environment produce changes in behavior (Bechtel, 2005; De Houwer, 2011). Cognitive learning researchers postulate that regularities in the environment can influence behavior only via the formation, transformation, and activation of mental representations within the organism. As such, mental

processes are assumed to act as necessary intervening causal agents that provide contiguous causes of behavior (Dickinson, 1980; Wagner, 1981). Different cognitive theories of learning differ with regard to assumptions about (1) the precise nature of the intervening mental representations, (2) the conditions under which they are formed, and (3) the conditions under which they influence behavior. Therefore the curriculum needs to be designed in a way that favours the conditions which they are formed namely the learners being instrumental in what they are being taught for the learning to be effective. Correspondingly that would create conditions that are conducive to influence behavior which is the goal of sexuality education as an intervention of teenage pregnancy.

## **2.9. Behavioral or cognitive approach to learning**

Different theories have their own strengths and weaknesses, and continue to evolve. We should not totally discard one just because something new is trendy. For example, behaviorist theories of human learning are not necessarily wrong, but rather fail to explain certain phenomenon. Thus, cognitive information processing and cognitive constructivist theories have developed to explain a greater degree of variance. Behaviorist theories, however, still clarify certain behaviors quite well. Thus, one could utilize the strengths of different approaches when appropriate.

### **2.9.1. Constructive perspective to learning**

Constructive perspective explores learners thinking about the curriculum. It is learner centred and the learning is focused on features of the learner, the learning context and the teaching. It also offers a theoretical basis for designing effective curriculum that is accessible to everyone interacting with it. The key point that arises from this perspective is that teaching is seldom about helping learners build up knowledge from nothing: indeed the constructivist approach suggests that would not be possible, as learning always builds upon and with the cognitive and conceptual resources already available. Teaching involves activating relevant ideas already available ideas to learners to help construct new knowledge. As well as build their new knowledge upon partial, incorrect, or apparently irrelevant existing knowledge unless carefully designed. Instructional strategies should be based on desired learning outcome and learners' prior knowledge, experience and interests. In contrast, when the primary learning objective is to have students' critically analyse, interpret and apply an ill-defined body of research,

constructivist approaches may be more appropriate than teacher-directed methods. Choi and Hannafin (1995) argue that situated cognition suggests that learning is determined by both contextual and human factors. For knowledge to be useful, it is believed that learning must be situated in authentic tasks to enable transfer to similar situations. In short, instruction about prevention of pregnancy should be embedded in real-life contexts, and address issues that are familiar to students, and are relevant to their needs and interests.

Research, however, indicates that students are not empty vessels. They come to class with their own perceptual frameworks about pregnancy; learn in different ways from family and community members. Learning is no longer viewed as a passive process where static bodies of facts and formulas are passed along to the uninitiated. Rather, learning is an active, dynamic process in which connections are constantly changing and the structure is continually reformatted. In short, students construct their own meaning by talking, listening, writing, reading, and reflecting on content, ideas, issues and concerns. In student centred environments, learners are given direct access to the knowledge base and work individually and in small groups to solve authentic problems. In such environments, parents and community members also have direct access to teachers and the knowledge base, playing an integral role in schooling process. For this dissertation the researcher looked at Piaget (1972) who suggested a model with an invariant of stages of cognitive development that all individual normally passed through, Vygotsky's socio-cultural perspective suggested that more advanced forms of thinking were themselves culturally mediated (Vygotsky; 1978).

Luria et al (1976 ) argue that culturally acquired knowledge are not necessarily universal however illiterate peasants in a study she did could not engage with standard modes of thought common among those who have been through the formal education system. This is somewhat different from suggesting that these individuals did not attain what Piaget would call formal operations, but certainly suggests that schooling, it seems encultures us to certain 'language games' that might seem quite bizarre to the uninitiated.

### **2.9.2. Two types of concepts.**

Vygotsky suggested that there were two origins for concepts (Vygotsky; 1934/1986) that we construct our own informal concepts spontaneously, without initially being able to

operate with them effectively or having language to talk about them; and that we also learn about 'scientific' or 'academic concepts from others. We might think of the former type of concepts as those acquired through the types of action in/on the environment discussed by Piaget, based on the inherent pattern-recognition qualities of the human cognitive apparatus. Piaget's model would suggest that these spontaneous concepts would have the potential to be developed into formal tools for conscious thought through the iterative processes of cognitive development he studied.

Vygotsky, however, focussed on how in normal circumstances the individual exist in a social and cultural context, where the personal concepts of individuals are modified by interactions with others, to allow the development of a somewhat common language and to some extent at least a sharing of concepts and prevention of teenage pregnancy. That is although each individual has to construct their own conceptual frameworks around teenage pregnancy, these are 'moderated' by interactions with others.

Vygotsky had the insight to appreciate that academic concepts presented in formal teaching for example, whilst pre-packaged in linguistic and logical forms, would not automatically be available to the learner. In other words he seems to have appreciated the notion of rote learning, and realised that concepts cannot be problematically copied from one mind to another, as meaningful concepts are those that are integrated into existing frameworks of understanding. In Vygotsky model, the process of cognitive development is one of the gradual linking of the personal, largely implicit, spontaneous concepts with the formal but initially isolated and non-functioning academic concepts.

Ivic as cited by Daniels (2001), stated: School does not always teach systems of knowledge but in many cases overburdens its pupils with isolated and meaningless facts; school curricula do not incorporate tools and intellectual techniques, all too often schools do not provide a setting for social interaction conducive to knowledge construction.

Vygotsky however maintains that is when instruction and learning occurs in the Zone of Proximal Development (ZPD) where adults and peers come to help (Daniels; 2001). New knowledge is acquired when the learner has received this information, they cannot identify it with what they already have and that is when the adult who knows comes in to help. Vygotsky (1978) argued that learning, as it happens during the child's preschool years, is qualitatively different from the learning that occurs during formal schooling, which is concerned with learning the fundamentals of scientific knowledge. The introduction of the scientific form of knowledge to children, and the associated methods of its acquisition creates, in learners, new zones of proximal development (Vygotsky,

1978). Thus, learning formal knowledge in school changes the course of development and creates new developmental pathways, which might not occur otherwise. Therefore sexuality education cannot be left only just to informal social learning context but needs to take a form of formal learning in school.

### **2.9.3. Relevance of concept development in modern learning**

#### **2.9.3.1. Promotion of a healthy behaviour**

Teenage pregnancy is a health pandemic in schools and needs to be approached with a theory that is specifically deals with health promotion. Sexuality education cannot afford to be just the topic that has been covered in the subject but needs to be effective in changing the learners and having an impact on their lives.

Attitude change that occurs through thoughtful consideration (central processing) is longer-lasting and more resistant to counter argument than attitude change occurring through a less thoughtful, more reactive process (peripheral processing). Strong attitude change is more likely to result in behavior change. Petty et al (2008) are in concurrence that people act after they have developed an intention, which requires adopting a positive attitude toward the behavior, seeing it as a norm, and believing they have the ability to act.

Ajzen and Fishbein (1980) developed the theory of reasoned action out of social-psychological research on attitudes and the attitude-behavior relationship. The model assumes that most behaviors of social relevance (including health behaviors) are under volitional control, and that a person's intention to perform a behavior is both the immediate determinant and the single best predictor of that behavior. Intention in turn is held to be a function of two basic determinants: attitude towards the behavior (the person's overall evaluation of performing the behavior) and subjective norm (the perceived expectations of important others with regard to the individual performing the behavior in question). Generally speaking, people will have strong intentions to perform a given action if they evaluate it positively and if they believe that important others think they should perform it. The relative importance of the two factors may vary across behaviors and populations.

The TRA also specifies the determinants of attitude and subjective norm. Attitude is held to reflect the person's salient behavioral beliefs concerning the possible personal consequences of the action. For example, a person who believes that performing a given behavior will lead to mostly positive personal consequences will hold a favorable attitude

towards the behavior. Specifically, attitude is held to be a function of the sum of the person's salient behavioral beliefs concerning the outcome of the action each weighted by their evaluation of that outcome. An indirect, belief-based, measure of attitude can be created by multiplying each behavioral belief by its corresponding outcome evaluation and then summing over outcomes.

In a similar way, subjective norm is a function of the person's beliefs that specific individuals or groups think he or she should, or should not, perform the behavior. A person who believes that most significant referents think he or she should perform the behavior will perceive social pressure to do so. Specifically, subjective norm is held to be a function of the person's salient normative beliefs with respect to each referent, each weighted by their motivation to comply with that referent. An indirect measure of subjective norm can be created by multiplying each normative belief by its corresponding motivation to comply and then summing over referents.

Many behaviors cannot simply be performed at will; they require skills, opportunities, resources, or cooperation for their successful execution. The theory of planned behavior (TPB) was an attempt to extend the TRA to include behaviors that are not entirely under volitional control, for example using a condom. To accommodate such behaviors, Ajzen added a variable called perceived behavioral control to the TRA. This refers to the perceived ease or difficulty of performing the behavior, and is assumed to reflect past experience as well as anticipated obstacles. According to Ajzen, perceived behavioral control is a function of control beliefs in just the same way as subjective norm is a function of normative beliefs. It is assumed to have a direct influence on intention. For desirable behaviors, greater perceived behavioral control should lead to stronger intentions. Perceived behavioral control may also have a direct predictive effect on behavior, through two different mechanisms.

First, holding intention constant, an individual with higher perceived behavioral control is likely to try harder and to persevere for longer than an individual who has lower perceived control. Second, people may have accurate perceptions of the amount of actual control they have over the behavior. A number of meta-analyses of the TRA/TPB have been conducted. The findings show that when intention is predicted from attitude and subjective norm, or from attitude, subjective norm and perceived behavioral control, between 40 and 50 percent of the variance is explained, on average.

## **2.10. Review of relevant literature on theory and methodology**

Providing effective sexual education to teenagers is a pervasive world-wide policy challenge. Deficient sexual education potentially explains the high levels of sexually transmitted diseases and teenage pregnancies we observe in many of the world's developing countries (WHO, 2004). Efficient sexual education will see the turnaround in figures of teenage pregnancy in our schools.

The evidence on the effectiveness of sex education programmes with a contraception focus is somewhat more encouraging, though still limited. Kirby (2007) reviewed forty-eight studies of comprehensive sex education programmes. Kirby reports that about two-thirds of the evaluations show a reduction in unprotected sex among programme participants. Scher, Maynard, and Stagner (2006) identify eighteen studies of programmes of this type that meet their inclusion criteria, including four from 1990 or earlier and some with sample sizes of fewer than 100 observations. They conclude from these reviews that there is no consistent evidence that sex education programmes altered the likelihood that youth would initiate sex, would have unprotected sex, or would become (or get someone) pregnant.

However, they report that a number of individual studies found positive programme effects, particularly related to increased contraception use. These include the evaluations by DiClemente, Wingood, and Harrington (2004) of an untitled HIV prevention serving African American females between ages fourteen and eighteen and the evaluation by St. Lawrence et al. (1995) of *Becoming a Responsible Teen (BART)*. An important issue in determining the effectiveness of programmes is whether positive results found for one implementation can be replicated in other communities, a point made by Kirby (2001). The programme *Be Proud!*

*Be Responsible!* and curricula derived from it have been evaluated a number of times. This programme was designed to be implemented outside school, often on Saturdays. Original evaluations of three- and six-month implementations suggested positive results (Jemmott, Jemmott & Fong, 1992; Jemmott, Jemmott, Fong, & McCaffree, 1999). The programme was modified, lengthened, implemented under the name *Making Proud Choices! A Safer Sex Curriculum*. A related abstinence curriculum was developed and named *Making a Difference! A Sexual Abstinence Curriculum*. Jemmott, Jemmott, and Fong (1998) evaluated the implementation of these programmes in three middle schools in Philadelphia in the early 1990s.

The programmes were run over the course of two Saturdays. Recruited participants—sixth- and seventh-grade boys and girls—were randomly assigned to one of three intervention groups: the safer sex intervention that included lesson modules about condom use and negotiation; the abstinence intervention; and a control intervention that consisted of a health promotion workshop. There were initially 659 sample adolescents; at the twelve-month follow-up there were 610 adolescents. At the twelve-month follow-up, for the full sample of youth, there were no statistically significant differences between participants in either treatment programme relative to the control programme in the likelihood of sexual intercourse or in the person reporting unprotected sex.

However, among the 102 adolescents who were sexually experienced at baseline, those in the safer sex programme reported a lower frequency of unprotected sex as compared to control programme participants and abstinence programme participants. Naturally, evaluations of sexual health curricula have been done before. Review papers by Kirby, Laris and Roller (2007), Chin et al. (2012), Fonner et al. (2014), and Goesling et al. (2014) conclude that most comprehensive sexual education programmes that have been evaluated rigorously are effective at improving knowledge, attitudes, and self-reported behaviors. Fonner et al. (2014) in particular focus on poor and middle income country studies and reach the same conclusion.

Contrary, as Collins et al (2002) argues, this large literature focuses on facilitator-led interventions which require extensively trained personnel to ensure consistent delivery in face to face interventions. Furthermore, not all educators are comfortable discussing sex-related decisions with teens, nor are all teens comfortable with such interactions and, as a result of this, elaborate interventions struggle to translate encouraging results from controlled trials into larger settings. Origanje (2010) unintended pregnancy among adolescents represent an important public health challenge in developed and developing countries. Numerous prevention strategies such as health education, skills-building and improving accessibility to contraceptives have been employed by countries across the world, in an effort to address this problem. However, there is uncertainty regarding the effects of these intervention, and hence the need to review their evidence-base.

To assess the effects of primary prevention interventions (school-based, community/home-based, clinic-based, and faith-based) on unintended pregnancies among adolescents it had Eleven studies randomized individuals, twenty seven randomized clusters (schools (19), classrooms (5), it mainly represented the lower socio-economic groups and a few in less developed countries. Interventions were administered

in schools, All interventions including education, contraception education and promotion, and combinations of education and contraception promotion, reduced (at a slightly significant level) unintended pregnancy over the medium term and long term follow up period. Results for behavioral (secondary) outcomes were inconsistent across trials. Limited information suggests that programmes that involve concurrent application of multiple interventions (educational, skill building and contraception promotion) can reduce rates of unintended pregnancies in adolescents.

Reviews done by Kirby (2004); Manlove (2002); National Research Council (NRC, 1987) have also highlighted the need for multiple strategies to address this public health challenge. Sensitivity analyses including trials with lower risk of bias showed that more cases of unintended pregnancy were reported in the control group than those that received multiple, preventive interventions. Promoting the use of contraceptive measures alone did not appear to reduce the risk of unintended pregnancy. There was insufficient data to show whether education as a single intervention would reduce the risk of unintended pregnancy. The possible effects of these preventive interventions on secondary outcomes such as time of initiation of sexual intercourse, risk of sexually transmitted infections and use of contraceptive measures like condoms and pills were not conclusively determined because of insufficient data and variation in methods of reporting.

Evidence-based programmes are evaluated using an experimental or quasi-experimental design, which assigns an independent variable and measures the resulting dependent or responding variable. The experimental design includes a treatment group and a control or comparison group to evaluate the effectiveness of each programme on reducing teen pregnancy rates, reducing STI rates, delaying sexual initiation and other risk factors and sexual behaviors (Advocates for Youth, 2012). Origanje (2009) in their review on the effectiveness of intervention of teenage pregnancy the review included forty one randomized controlled trials comparing the aforementioned interventions to various control groups (mostly usual standard sex education offered by schools). Scher, Maynard, and Stagner (2006) only consider evaluations based on randomized control trials, yielding a sample of thirty-one evaluations conducted between 1981 and 2006. They further limit their sample to evaluations of programmes with a primary goal of reducing heterosexual risk-taking behavior and that include measures of sexual experience, pregnancy risk, and/or pregnancy as outcomes. Note that many programme

evaluations have only short-term follow-up periods and focus on measures of attitude and knowledge, as opposed to actual risk-taking behavior.

Ramathumba (2013) study was done to explore secondary school girls' knowledge and attitudes regarding emergency contraception (EC), teenage pregnancy and sexuality. A quantitative, explorative, descriptive approach was used to address the research objective. The respondents in the study were secondary school girls aged 14-18 years from grades 8-12. Questionnaires were distributed to a convenient sample of 273 girls who consented to participate in the study. Six secondary schools in Thulamela municipality were chosen by random sampling from a population of twenty schools in the circuit; however one circuit was purposely included due to high rate of teen pregnancies (Malamulele-East). One teacher was assigned to assist at each school. The questionnaires were administered with respondents seated in a classroom and the questions explained to them. Items on the questionnaires were focused on demographics, sexual behaviour, teenage pregnancy, knowledge of EC, attitude towards EC and access to EC.

A structured questionnaire was used as a research tool. The questionnaire consisted of two sections. The focus was on the causes of teenage pregnancy, knowledge of family planning, condom use. The questionnaire was anonymous; and the information was confidential and consisted of both closed and open ended questions. The questionnaire was written in English and translations were done where necessary. The questionnaire took about 25-30 minutes to administer.

Data were collected while the respondents were waiting for consultation and when exiting the clinic using private rooms that were allocated to them at the clinics during the time of data collection. The questionnaire was explained to the respondents and their rights to refuse and withdraw any time. Those who volunteered to respond to the questions were given consent forms to sign. Biddlecom (2007) reemphasizes that young people want and need sexual and reproductive health information. A self-report questionnaire was used to collect data from 273 secondary school girls.

The questionnaire addressed knowledge and attitude regarding emergency contraception, sexual practices, and teenage pregnancy. The results indicated that the respondents were aware of different contraceptive methods that can prevent pregnancy, but they did not have knowledge of emergency contraceptives. Pressure from male partners, fear of parental reaction to contraceptive use, reluctance to use contraceptives, poor contraceptive education and counseling were seen as the main causes of

ineffective contraceptive use and non-utilization (Ramathuba; 2013). The awareness and knowledge needs to be reinforced by support partner as well which will guarantee action.

### **2.11 Alternative approaches**

One study using a focus group approach, Aquilino and Bragadottir (2000) interviewed 57 high school learners (ages 14 to 17) to explore their views on pregnancy and strategies for prevention. The main themes identified included (a) denial; (b) lack of planning ahead, failure to use contraceptives; (c) need for somebody to love, to be close to; and (d) to get attention. One participant stated, “Some girls do it [get pregnant] just to trap the guy” or “because of their families . . . they’re [the families] not really close . . . they want somebody to love them” (p. 197). The adolescents were concerned about pregnancy and supportive of comprehensive sex education. “Don’t tell them [young people] not to have sex, but teach that it is a really good decision not to” (p. 195). Limited qualitative research reveals that adolescents are strongly influenced by their families and that family influence can either promote or inhibit adolescent childbearing. In Danziger’s (1995) study, adolescents who delayed sexual intercourse had strong family support to stay in school. Burton’s (1990) study illustrated strong family influence in that early childbearing was seen as assurance of future intergenerational care giving.

### **2.12 Synthesis of previous research findings**

The on-going debate about the comprehensive or abstinence approach being the most effective remains debatable. Depending on what the stakeholders deem most appropriate but many of them fail to engage the most crucial element which is the main factor, the learner. The learner needs to engage with the given knowledge and the learner needs to be fully engaged with content. The approach on how the content is delivered remains a relevant factor as well to deem its function effective.

In the major findings the studies in this literature review based their findings on what knowledge teenagers had about interventions on teenage pregnancy (Ramathunga; 2013). The studies used mostly quantitative approach, deliberately as to get feedback from their own intervention not how learners’ lives have been impacted by these interventions. Most of the studies had their own intervention but were not looking at what the schools had in place and evaluate their findings based on only that. There are fewer studies that are doing vigorous evaluation on sexuality education that are based on the curriculum offered by schools.

### **2.13. Critique of previous research**

The methodological strengths of research reviewed on this study are the selection of participants. The purposive sampling used to select participants assured that they were interviewing the relevant subjects. However, most studies used randomized trials with control groups, that in particular was problematic because that means the researchers are using their own interventions not the one the schools are using. The evaluation of the existing intervention needed evaluation. The size of the samples was too big lacking that personal interaction.

The research instruments used to collect data were structured questionnaires which were too long, most of them were 30 to 40 minutes, evidently showing that the researchers tried to find out too many things in one questionnaires. Using an interview for this type of study would have justified such a length of time.

The theoretical approach that most studies used was ecological model in explaining the teenage pregnancy which is quite appropriate when understanding the causes of teenage pregnancy. However this study seeks to gauge the impact of interventions used to address the causes of teenage pregnancy. The information needs to be given to learners for the learner to use to ultimately change the behavior. The theories of learning particularly constructivism need to interact with the information and see how well it fits with their context therefore deeming it relevant to the learners' life. The integration of the appropriate health promotion model and learning approach will assist investigating the phenomenon at hand.

### **2.14 Summary**

The studies that used abstinence programs had backing from government that had already deemed abstinence as effective and gave a lot of support to initiative that were using it, even though research that is opposing it comes up with valid arguments. Comprehensive approach had its flaws, that having access to condoms does not guarantee or correct use. Conducting a qualitative study affords an opportunity to assess both the abstinence and comprehensive approach which one is effective in sexuality education or the combination of the two approaches will both be preferable. The study used interviews in collecting the data to arrive at a conclusion.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3. Introduction**

Sexuality education seeks to provide young people with formal opportunities to acquire knowledge and understanding of human sexuality, through processes, which will enable them to form values and establish behaviours, within a moral, spiritual and social framework (Naidoo, 2006). While parents have the primary responsibility for the overall education of their children, it is accepted that the school should play an important role in supporting and complementing them in this task, including sexuality education. The general aim of education is to contribute towards the development of all aspects of the individual. Sexuality education is an important element of the process. It is a lifelong task of acquiring knowledge and understanding and developing attitudes, beliefs and values about sexual identity, relationships and intimacy. Contrarily Hoffman-Wanderer et al. (2013) reviewed a number of teenage pregnancy studies and found that: “pregnant teenagers have relatively low levels of knowledge about modes of contraceptives” (Hoffman-Wanderer, Carmody, Chai, & Rohrs, 2013, p. 15). The recent data from Statistics South Africa (2014) which asked whether any females between the ages of 12 and 50 were pregnant during the 12 months before the survey shows that 5,6% of females in the age group 14–19 years were pregnant during the 12 months before they were surveyed. The prevalence of pregnancy increased with age, rising from 0,8% for females aged 14, to 11,9% for females aged 19. This shows that the long standing battle against teenage pregnancy in this country is still persisting.

In this chapter the researcher describes in detail how the research was collected. To gain meaningful data the researcher chose a research design that would allow learners to tell their experience with ease while the discussions around the research questions being guided. This chapter essentially contains a description of the research design and methodology used to conduct the research process. The purpose of the study, research questions, sampling procedures, instruments, method of data collection, and data analysis will be presented. The ethical considerations will also be addressed.

#### **3.2. Research design**

Parahoo (1997, p. 142) describes a research design as “a plan that describes how, when and where data are to be collected and analysed”. Since the purpose of this study is to determine the effectiveness of sexuality education on teenage pregnancy. It was decided

to use interpretive phenomenological design. The aim of interpretive phenomenological analysis (IPA) is to explore in detail how participants are making sense of their personal and social world, and the main currency for an IPA study is the meanings particular experiences, events, states hold for participants. In this study approach was phenomenological in that it involved detailed examination of the participant's life-world. It attempts to explore personal experience and is concerned with an individual's personal perception or account of an object or event, as opposed to an attempt to produce an objective statement of the object or event itself. The participants were the expert in this context and the researcher was guided through their experiences. At the same time, IPA also emphasizes that the research exercise is a dynamic process with an active role for the researcher in that process. Therefore the researcher was an active participant in collecting their story. As in Conrad's (1987) words "One is trying to get close to the participant's personal world, an 'insider's perspective'".

### **3.2.1. Qualitative research**

Qualitative research methods are designed to help researchers understand people, within their lived social and cultural contexts. Qualitative researchers are interested in "understanding the meaning people have constructed, that is, how people make sense of their world and the experiences they have in the world". (Merriam, 2009, p.13). It consists of a set of interpretive, material practices that makes the world visible. These practices transform the world. They view the world through the series of interviews gathered. At this level, qualitative research involves an "interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them". (Denzin & Lincoln, 2005, p.3). The goal of understanding a phenomenon from the point of view of the participants and its particular social and institutional context is largely lost when textual data are quantified (Kaplan & Maxwell, 1994).

Researchers who used this approach to adopt a person-centred holistic and humanistic perspective to understand human lived experiences without focusing on the specific concepts (Field & Morse 1996, p.8). The researcher focused on the experiences from the participants' perspective, to achieve that, the researcher became involved and immersed in the study. The researcher's first hand experience of participants accounts of their experience in the study added to the uniqueness of data collection and analysis (Streubert & Carpenter, 1999, p.17). Complete objectivity is impossible and qualitative

methodology is not completely precise because human beings do not always act logically or predictably (Holloway & Wheeler, 2002, p. 3).

The rationale for using a qualitative approach in this research was to determine the effectiveness of Sexuality Education in preventing teenage pregnancy. A qualitative approach was appropriate to capture the knowledge and prevention measures learners prefer in the best way that they understood it to be. Such activities allow to determine and attach meaning and significance within wider paradigm of knowledge. Although an event is best understood and described contextually, qualitative research allows us to understand the social context better.

### **3. 3. Target population and participant selection**

The study used three focus groups which were purposely selected from three schools. Each group consisted of 12, 11 and 12 respectively. They ranged from grade 8 to 12. The participants are African learners who come from the neighbouring community which is made of mostly Reconstructing Development Project (RDP) houses (a development project by the post-apartheid government in attempting to address the housing shortages in the country). Learners were between the ages 13 to 19; they include learners who are mothers who previously dropped out of school and are now back to school.

According to Patton (2002), sampling for focus groups involves bringing together people of similar backgrounds and experiences to participate in a group interview about major issues that affect them. Purposive sampling has two principal aims: The first is to ensure that all the key constituencies of relevance to the subject matter are covered. The second is to ensure that, within each of the key criteria, some diversity is included so that the impact of the characteristic concerned can be explored (Ritchie & Lewis, 2003). McMillan and Schumacher (2010) maintain that focus group be the primary evidence based technique in evaluation studies. The participants will be interviewed in depth about their general knowledge on teenage pregnancy. Terre Blanche and Durrheim (2006) maintain that an interview is a natural form of interacting with people and it is a highly skilled performance. During the interview the researcher allowed the participants to express their feelings and experiences about interventions of teenage pregnancy.

The feelings and experiences are moreover not only constructed by the people involved in the interview but are products of a larger social system for these individuals. Mason (2002) concurs with that most qualitative researcher's view knowledge as situational and the interview is just as social situation as is any other interaction. Therefore knowledge

and evidence are contextual, situational and interactional as possible in the sense that it draws upon fully social experiences or processes that the research is evaluating. It might ask people to draw from their own experiences of life. Qualitative interviewing is constructing knowledge rather than collecting it. To construct this knowledge participants must be made to feel at ease in non-threatening environment and to accomplish this certain procedures must be followed.

### **3.4. Procedures**

Firstly, the rules were given to set structure and to set the limits on the group process. As a group, the norms and expectations included: not to divulge information that would be discussed in the interview, as well as about others in the group and that everyone should be given a chance to speak.

Secondly, during interaction, no-one must be marginalised and everyone's view is important. There was an introductory session of the participants where there was some ice-breaker activities for the participants to help them to relax. Dover (2004) suggests that the types of ice-breakers that help with facilitating introductions and would help to lead to the topic.

Thirdly, what was spoken about in the interview followed a semi-structured interview format with open-ended questions, from the interview schedule (Gillham, 2002). This gave the group an opportunity to talk about what was most pressing for them by allowing a degree of meandering discussion. The content included role playing. The researcher listened for commonalities and differences of opinions, and got the group to reflect to the extent to which their understanding factual information or what they considered factual information about teenage pregnancy or experiences was homogenous or diverse. The researcher involved interpretation and thematising to deepen reflection on experiences. Participants statements were frequently summarised to demonstrate clear understand of what the participants had said. It was worked on to make the group to focus on issues but also allowed issues that were compelling to the group. It was initiated to provide participants with a stimulus from the interview schedule as a way to respond to initiating discussion.

The primary data of qualitative interviews are verbatim accounts of what transpires. In the interview session, tape recording the interview ensured completeness of the verbal interaction and provided material for reliability checks. Note taking was also used to help reformulate questions and probes and to record nonverbal communication as a

supplementary technique, which facilitated data analysis. Interviewer recording enabled the interviewer to be attentive, and pace the interview and begin data analysis (King & Horrocks, 2010)

Immediately following the interview, the researcher completed and typed the hand written records and transcribed the tape. Typed drafts needed to be edited for transcribers and typist error and it will be put into final form. The final record contained accurate verbatim data and the interviewer notations of nonverbal communication with initial insights and comments to show the meaning. The final form included the date, place and the informant code

An interview elaboration of each interview session- self-reflections of the role and rapport, the interviewee's reactions, additional information and extensions of interview meanings was written.

### **3.5. Instrument**

An instrument is a tool that refers to devices used to collect data such as structured interview schedules. An instrument was developed, to measure variables. In this research, the researcher used structured interviews. The structured Interviews are useful for gathering in-depth information about the viewpoint and opinions of a limited number of participants (Seaman 1991).

#### **3.5.1. Structured interviews**

Structured interviews can be used as a qualitative research methodology (Kvale & Brinkman, 2008). The researcher saw that this type of interview would be best suited for participating in knowledge construction in the focus group in which it would be beneficial to compare/ contrast participants' responses in order to answer a research question (Lindlof & Taylor, 2002). For structured qualitative interviews, it is usually necessary for researchers to develop an interview schedule which lists the wording and sequencing of questions (Patton; 1991). Interview schedules are sometimes considered means by which researchers can increase the reliability and credibility (Lindolf & Taylor, 2002)

#### **3.5.2. Structured interview schedule**

An interview schedule is a set of questions with structured answers to guide an observer or an interviewer or a researcher. It is a plan to guide line of investigation. According to Mattar, (1994), is a list of questions which is formulated to answer a research question. To an important extent the effectiveness of the interview depends on the questions, listed

in the interview schedule, which the re-researcher will put to the informant. Thus the directness of the questions, the exact wording and the order in which they are put, are all critical issues. In addition the questions asked need to be focused on the research question and its sub-questions. This alignment between the research question and the interview schedule is of considerable importance and thus time needs to be spent by the researcher reflecting on what questions to ask and how these questions may be put to the participant. The instrument was designed to gather information about learners knowledge therefore it involved decisions about the following:

- what questions to ask
- how to phrase the questions
- depth and breadth of topics to be included
- question sequence

The interview schedule depended on the purpose and focus on the research. Therefore, there were guidelines that were followed.

- The questions had to be answerable. There was no point in asking questions that the interviewees were able to answer because of lack of experience or knowledge.
- Leading questions were avoided. Asking a learner, 'Don't you agree that your Life Orientation lessons on sexuality education are excellent?' is not acceptable as it encourages a particular response. Open-ended questions were used such as, 'Tell me what you think about your Life Orientation lessons on sexuality education '.
- Interviews are time consuming for the interviewee as well as the interviewer and as a courtesy, the interview was kept to the minimum time necessary to deal with the topic. The interviewer ensured that the key issues had been addressed and resisted the temptation to get side tracked.
- The language we used with the participant was simple and we avoided using jargon and psychological terms.

Focus groups were used to gather information.

### **3.5.3. Focus group**

According to (Oppenheim, 1993; Krueger, 1994; Morgan, 1988; Mattar, 1994), focus group is a type of in-depth interview accomplished in a group, whose meetings present

characteristics defined with respect to the proposal, size, composition, and interview procedures. The focus or object of analysis is the interaction inside the group. The participants influence each other through their answers to the ideas and contributions during the discussion. The fundamental data produced by this technique are the transcripts of the group discussions and the researcher's reflections and annotations. The general characteristics of the focus group are people's involvement, a series of meetings, the homogeneity of participants with respect to research interests, the generation of qualitative data, and discussion focused on a topic, which is determined by the purpose of the research.

Focused group were particularly selected to understand better the learners' thoughts and feelings about sexuality education as an intervention in prevention of teenage pregnancy. The discussion in the focus group meetings were effective in supplying information about what learners thought, or how they felt and most importantly being able to observe their behaviour as they participated. The application of the focus group technique, allowed for the collection of an appropriate amount of data in a short period of time, although it could not argue with full conviction about the spontaneity of the contributions from the participants. Focus group permitted richness and a flexibility in the collection of data that are not usually achieved when applying an instrument individually; at the same time permitted spontaneity of interaction among the participants.

There were three separate groups, with 12, 11 and 12 participants in each group. The interviews lasted for 40 minutes in each group and each group had only one session. The same type of participants in terms of age, gender and learners who took Life Orientation as a subject in school was purposely selected. The more homogeneous the groups in terms of background and perspectives, the smaller the number of groups needed. It should be noted that a single group is never enough, therefore the researcher used three groups. A single group could not be used because it was thought of an instance if it came across a "cold" group, where the participants were quiet, reluctant to participate, not reacting to the researcher, and also, because they can happen not to be representative due to the influence of some inflammatory comment of some participant or other internal or external factors to the meeting.

With respect to the number of participants in the sessions, the usual approach was to use groups of moderate size, of ten people. Several researchers (Oppenheim, 1993; Krueger, 1994; Morgan, 1988; Mattar, 1994) maintain that when prescribing the size of the focus group, it should be pondered that the group be small enough that everybody

has an opportunity to share his perceptions, and big enough to provide diversity of perceptions. If the researcher clearly can predict what will be said in the next group, then the research is concluded. This usually happens after the third or fourth session (Krueger, 1994; Morgan, 1988 & Greenbaum, 1993). Using focus groups can achieve credibility and reliability in the study.

### **3.6. Credibility and Reliability**

#### **3.6.1 Credibility**

Credibility is demonstrated “when participants recognise the reported research findings as their own experiences” (Streubert-Speziale & Carpenter 2003, p. 38). It is “the truth of how the participants know and experience the phenomenon” (Talbot, 1995, p.529). To ensure credibility the researcher must make sure that those participants are identified and described accurately (Holloway, 2005). Activities increasing the probability that credible findings will be produced are: prolonged engagement reflexivity; triangulation; peer and participants debriefing; and member checks. The following strategies were applied to ensure credibility:

##### **3.6.1.1. Reflexivity**

It was part of and not divorced from the phenomenon under study and, in the study; it was constantly taking the position of a main research tool. The researcher explored personal feelings and experiences that might influence the study and integrated this understanding into the study to promote objectivity. The analysis of the researcher’s experience was made aware of possible biases and preconceived ideas. Bracketing was implemented throughout the study and each phase of the research was carefully approached using bracketing (to lay aside what is known) and intuiting (looking at the phenomenon) to avoid bias and approach the phenomenon with an open mind (Burns & Grove, 2003).

##### **3.6.1.2. Peer and participants debriefing**

Peer debriefing is a process of exposing oneself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the enquiry that might otherwise remain only implicit in the inquirer’s mind. Peer debriefing exposes “a researcher to the searching questions of others who are experienced in the method of enquiry, the phenomenon or both” (Lincoln & Guba, 1985, p.308; Polit & Hungler, 2004,

p.432). In this study, the researcher exposed the research work to a colleague for constructive criticism about the research methodology and not the data collected.

Debriefing by peer and of participants increases credibility. Participant debriefing or member checks involved the researcher returning to the participants and checking the findings with him/her to confirm their experience as true (Holloway, 2005; Polit & Hungler, 2004).

Member checks, which Guba and Lincoln (1985) consider the single most important provision that can be made to bolster a study's credibility. Checks relating to the accuracy of the data may take place "on the spot" in the course, and at the end, of the data collection dialogues. Informants may also be asked to read any transcripts of dialogues in which they have participated. Here, the emphasis will be on whether the informants consider that their words match what they actually intended, since, if a tape recorder has been used, the articulations themselves should at least have been accurately captured.

### **3.6.1.3. Transferability**

Merriam (1998) writes that external validity is concerned with the extent to which the findings of one study can be applied to other situations. In positivist work, the concern often lies in demonstrating that the results of the work at hand can be applied to a wider population. Since the findings of this qualitative project were specific to a small number of particular environment and individuals, it is impossible to demonstrate that the findings and conclusions will be applicable to other situations and populations.

However, Erlandson (1993) noted that many naturalistic inquirers believe that, in practice, even conventional generalization is never possible as all observations are defined by the specific contexts in which they occur. Researchers hold contrasting views (Stake, 1994; Denscombe, 1998) that, although each case may be unique, it is also an example within a broader group and, as a result, the prospect of transferability should not be immediately rejected. Nevertheless, such an approach can be pursued only with caution since, as Gomm, Hammersley and Foster (2000) recognises that it appears to belittle the importance of the contextual factors which impinge on the case.

Bassey (1981) proposed that, if practitioners believe their situations to be similar to that described in the study, they may relate the findings to their own positions. Researchers (Lincoln & Guba, 1989; Firestone, 1993) are among those who present a similar argument, and suggest that it is the responsibility of the investigator to ensure that sufficient contextual information about the fieldwork sites is provided to enable the trustworthiness in qualitative research projects reader to make such a transfer. They maintain that, since the researcher knows only the “sending context”, he or she cannot make transferability inferences.

Ultimately, the results of a qualitative study must be understood within the context of the particular characteristics of the organisation or organisations and, perhaps, geographical area in which the fieldwork was carried out. In order to assess the extent to which the findings of this study may be true of people in other settings, similar projects employing the same methods but conducted in different environments could well be of great value ( Lincoln & Guba, 1989; Firestone, 1993)

#### **3.6.1.4. Dependability**

In addressing the issue of reliability, the researcher employed techniques to show that, if the work were repeated, in the same context, with the same methods and with the same participants, similar results would be obtained. Fidel (1993), and Marshall and Rossman (1999), however, noted the changing nature of the phenomena scrutinised by qualitative researchers renders such provisions problematic in their work. Florio-Ruane (1999, p. 234) highlights how the investigator’s observations are tied to the situation of the study, arguing that the “published descriptions are static and frozen in the ‘ethnographic present’ ”.

In order to address the dependability issue more directly, the processes within the study reported in detail, thereby enabling a future researcher to repeat the work, if not necessarily to gain the same results. Thus, the research design may be viewed as a “prototype model”. Such in-depth coverage also allows the reader to assess the extent to which proper research practices have been followed. So as to enable readers of the research report to develop a thorough understanding of the methods and their effectiveness, the researcher included sections devoted to:

a) the research design and its implementation, describing what was planned and executed on a strategic level;

- a) Strategies for ensuring trustworthiness in qualitative research projects
- b) The operational detail of data gathering, addressing the details of what was done in the field;
- c) Reflective appraisal of the project, evaluating the effectiveness of the process of inquiry undertaken.

### **3.6.6 Confirmability**

Confirmability is a neutral criterion for measuring the trustworthiness of qualitative research. If a study “demonstrates credibility and fittingness, the study is also said to possess confirmability” (Lincoln & Guba 1985, p.331; Streubert-Speziale & Carpenter 2003, p.38). It is a creation for evaluating data quality and refers to the neutrality or objectivity of the data by an agreement between two or more dependent persons that the data is similar (Polit & Hungler 2004, p.435). Confirmability is a strategy to ensure neutrality (De Vos, 1998, p.331). It means that the findings are free from bias. In qualitative research, neutrality refers to data neutrality and not the researcher’s neutrality. The use of audit strategies is a systematic collection of materials and documents so that dependent or external auditors come to comparable conclusions about the data.

The purpose of confirmability is to illustrate that the evidence and thought processes give another researcher the same conclusions as in the research context (Streubert, Speziale & Carpenter, 2003, p.38). Holloway and Wheeler (1996, p.168) suggests that the following auditing criteria be utilised for examining the information of the study:

- the raw data, namely, tape recording and field notes
- findings of the study through analysed data
- how the significant statements, themes, codes and categories were reconstructed
- the research process, designs and procedure used
- early intentions of the study, for instance proposal and expectations
- the development of the data collection instruments, for instance open-ended questions and early interviews.

### **3.7. Recording data.**

Interviewers have a choice of whether to take notes of responses during the interview or to tape record the interview. The latter was used for a number of reasons. The researcher was able to concentrate on listening and responding to the interviewee and was not distracted by trying to write down what has been said. The discussion flowed because the interviewer did not have to write down the response to one question before moving on to the next. In note taking there is an increased risk of interviewer bias because the interviewer is likely to make notes of the comments which make immediate sense or are perceived as being directly relevant or particularly interesting. Tape recording ensured that the whole interview was captured and provided complete data for analysis so cues that were missed the first time can be recognised when listening to the recording. Lastly, interviewees might have felt inhibited if the interviewer suddenly started to scribble: they might have wondered why what they have just said was of particular interest.

The tape recorder was small, unobtrusive and produced good quality recording. An in-built microphone made the participants less self-conscious. An auto reverse facility meant that the tape automatically "turns itself over" when the interview lasts longer than the recording time available on one side of the tape: this prevented an interruption in the flow of conversation.

### **3.8. Data collection and data analyses**

Polit and Hungler (1999, p.267) define data as "information obtained during the course of an investigation or study". In this study, interviews were used to obtain data relevant to the study's objectives and research questions. The researcher conducted interviews at three schools using focus groups which were purposely chosen. Every learner who was willing to participate received a letter with information about the study and a consent form. The researcher conducted the interviews at the schools in three consecutive weekends. When the interviews were completed, the researcher proceeded to compile transcripts for data analysis.

The researcher will use an interpretative phenomenological analysis (Smith, 2003). This analysis assisted with listing the categories and creates the report being guided by the research question which the researcher will use for further analysis and to draw conclusions.

### **3.8.1.The analysis process**

According to Kruger (1998), once the researcher has collected the data, the steps below describe the basic elements of narrative data analysis and interpretation. Kruger advised that the process is fluid, so moving back and forth between steps is likely.

#### **3.8.1.1 Step 1 Understanding the data.**

Good analysis depends on understanding the data. For qualitative analysis, this means the researcher had tape recordings and had to listen to them several times. The impressions were written down as the data was being checked and were useful later on. Also, just because one has data does not mean those are quality data. Sometimes, information provided does not add meaning or value or it may have found that it has been collected in a biased way.

Before beginning any analysis, the researcher had to consider the quality of the data and proceeded accordingly. Investing time and effort in analysis may give the impression of greater value than is merited.

#### **3.8.1 2.Step 2 Focus the analysis.**

The purpose of this study was to evaluate the effectiveness of Sexuality education lessons, the knowledge learners have about prevention of pregnancy as well as the type of prevention measures learners prefer to use. Writing out the questions assisted the researcher to begin the analysis however the researcher was aware that the way they were asked could change but assisted in getting the analysis started.

##### **3.8.1.2.1. Focus by question**

The analysis was focused at looking how the groups responded to each question together, to identify consistencies and differences. All the data from each question was put together. Later, the connections and relationships between questions were explored.

#### **3.8.3 Step 3: Categorize information.**

The researcher categorised the information by coding it to bring meaning to the words by identifying the themes and patterns of ideas, phrases used, terminology and interactions. The researcher organised them into coherent categories that summarise and brought meaning to the text. The researcher assigned abbreviated codes of a few letters and words and placed them next to the themes and ideas. This helped organized the data into categories. The researcher provided a descriptive label (name) for each category

and subcategories were created. To categorize narrative data the researcher used what is called emergent category.

#### **3.8.4. Emergent categories**

Rather than using preconceived themes or categories, the researcher read through the text and found the themes and issues that recurred in the data. They became the categories. Some ideas and concepts emerged from the data and were useful in answering the research questions.

This approach allows the categories to emerge from the data. Categories are defined after the researcher worked with the data. While the researcher wanted to try to create mutually exclusive and exhaustive categories, sometimes sections of data fitted into more categories. So the researcher could create a way to cross-index.

Reading and re-reading the text helped to ensure that the data were correctly categorized. All responses were numbered and given a label to capture the idea(s) in each comment. Later, the researcher could sort and organize the data into their categories to identify patterns and bring meaning to the responses

#### **3.9. Expected findings**

Learners would give information about what they think is the best means of preventing teenage pregnancy. When learners are narrating their experiences it is to discover elements in the Sexuality Education that could help in understanding what information could be added or modified to speak to the context of the learner. Interventions are in place to prevent teenage pregnancy however there exists a gap that creates these staggering rates of teenage pregnancy.

#### **3.10. Ethical considerations**

There are ethical issues that are to be addressed in this study since this kind of study is more direct to the participants and sensitive. Agreed-upon standards for research ethics helped to ensure that the researcher explicitly considers the needs and concerns of the people they study, that appropriate oversight for the conduct of research takes place, and that a basis for trust is established between the researcher and study participants. The following research ethics have been considered in this study: permission, informed consent, confidentiality, and anonymity.

### **3.10.1 Permission**

In this study the researcher found it necessary to obtain formal permission from Principals under the Kwa-Zulu Department of Education or gatekeepers before the research could begin. Permission to conduct the research project in secondary schools in the Pinetown district was requested and granted at Provincial Level, by the Provincial head of Department.

### **3.10.2 Informed consent**

Minors were going to be interviewed therefore the researcher provided informed consent forms of the parent or guardian of the participants to be completed and signed before the commencement of the interview sessions. However, the participants were given consent form as well. Informed consent is one of the most important tools for ensuring respect for persons during research and Written consent means that a person receives a written form that describes the research and then signs that form to document his or her consent to participate (Qualitative Research Methods: A Data Collector's Field Guide, 2012). The researcher explained to the participants so that they fully understood what they were participating in.

Participants were told about the purpose of research, that interviews would be tape recorded, how confidentiality would be protected, that they have the right to withdraw from the study at any time without negative repercussions and that participation is done voluntarily or willingly.

### **3.10.3 Confidentiality**

Participants were given an assurance of confidentiality and a description of the intended use of the data. The researcher promised to protect the individuals' confidences from other persons in the setting and from the general reading public (McMillan & Schumacher, 2006).

### **3.10.4 Anonymity**

Anonymity entails making use of pseudonyms instead of the participants' real names, ensuring that the participants are not identifiable in print (Leedy & Omrod, 2010). In this study number were used to refer to various participants, for example, "Participant 8".

**3.10.5. Children and Vulrenable young adults:** It was recognised that that the participants may experience distress or discomfort in the researchprocess and all necessary steps were taken to reduce the sense of intrusionand to put them at their ease. They were encouereaged to withdraw from any action,ensuing that caused emotional or other harm.

### **3.13. Summary**

This chapter has covered the research design, sample, instrumentation, procedure, data analysis, and ethical issues. The following chapter discusses data presentation and analysis.

## CHAPTER 4

### DATA PRESENTATION, ANALYSIS AND INTERPRETATION

#### 4.1. Introduction

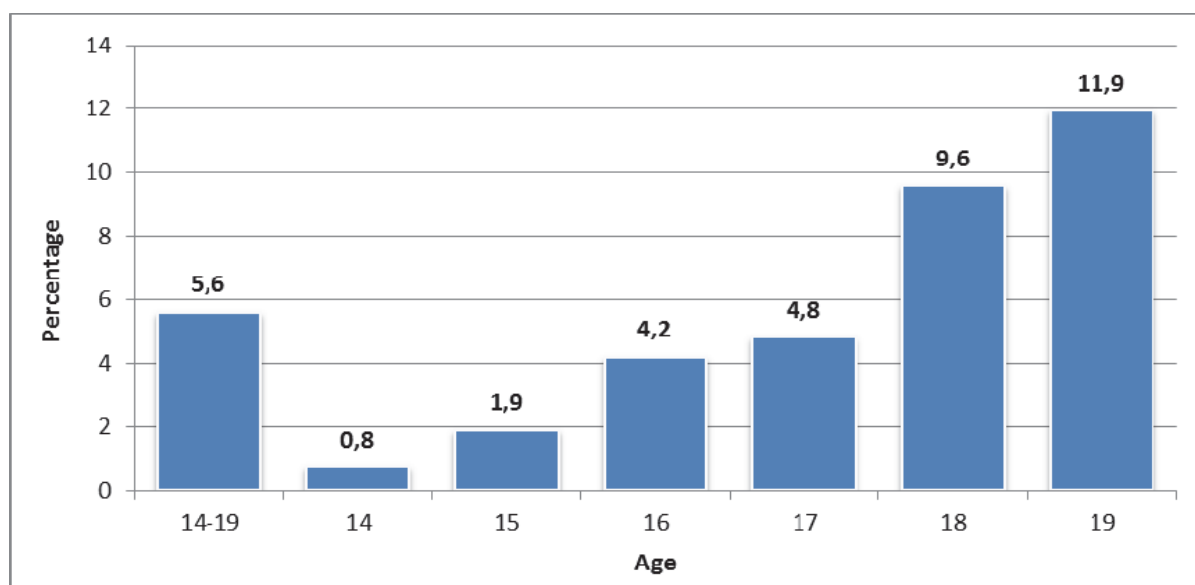
As in the larger context, the education sector has a critical role to play in preparing children and young people for their adult roles and responsibilities (Eggleston, Jackson, Rountree & Pan, 2000). The transition to adulthood requires being informed and equipped with the appropriate skills and knowledge to make responsible choices in our social and sexual lives. The purpose of this study is to determine the effectiveness of sexuality education in preventing teenage pregnancy in secondary schools. According to Cabezon, Guyatt, William and Griffith (2005) and Dupas (2011) schools can serve as effective platforms for reproductive health education, and schooling itself appears to have a beneficial effect. Therefore this study sort to determine the effectiveness schooling has through sexuality education on learners' knowledge about prevention of teenage pregnancy.

To realise this, the researcher conducted structured interviews using focus groups to get the sense of the learners' world through the interviews gathered. Merriem (2009) maintains that qualitative researchers are interested in understanding the meaning people have constructed, that is, how people make sense of their world view and the experiences they have in the world. Chapter three described in detail the research design and methodology used to achieve this end.

This chapter will draw upon the main themes and present the findings which arose out of the interview process and subsequent data analysis. "Valid analysis is immensely aided by data displays that are focused enough to permit viewing of a full data set in one location and are systematically arranged to answer the research question at hand." (Huberman & Miles, 1994, p. 432) "Identifying salient themes, recurring ideas or language, and patterns of belief that link people and settings together is the most intellectually challenging phase of the analysis and one that can integrate the entire endeavor"(Marshall & Ross, 1995, p.114). This chapter will present description of sample, a brief methodological approach, and the discussion of the three main themes as well as sub-themes that were identified and are set out separately in Table 4.4.1, and are further discussed separately below.

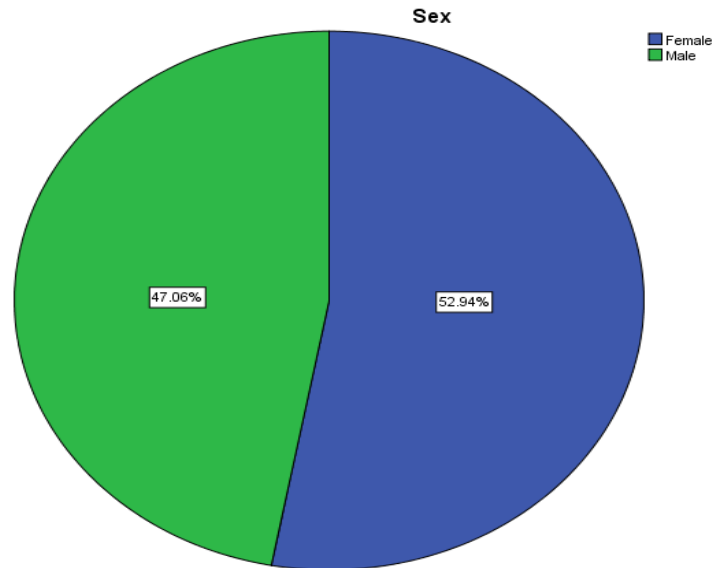
## 4.2. Description of sample

There were thirty five participants who were selected from three different schools within the Pinetown District. Participants were from the ages of 13 to 18, grade 8 to 12 both males and females. Their family structures comprised both parents, single and by guardians. Below is the graphical representation of biographical information of participants. However, the graph on percentages of pregnancies per household was taken from Statistics South Africa in 2014 that shows the gravity of teenage pregnancy in this country.



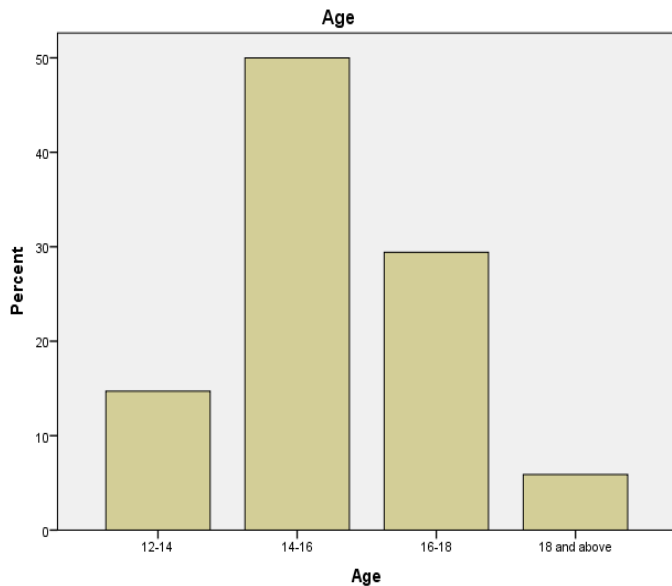
### 4.2.1: Figure 1: General Household Survey Percentage of females in the aged 14–19 who were pregnant during the year preceding the survey, 2014

Statistics South Africa (2014) asked whether any females between the ages of 12 and 50 were pregnant during the 12 months before the survey. Figure 1 shows that 5,6% of females in the age group 14–19 years were pregnant during the 12 months before they were surveyed. The prevalence of pregnancy increased with age, rising from 0,8% for females aged 14 years, to 11,9% for females aged 19 years.



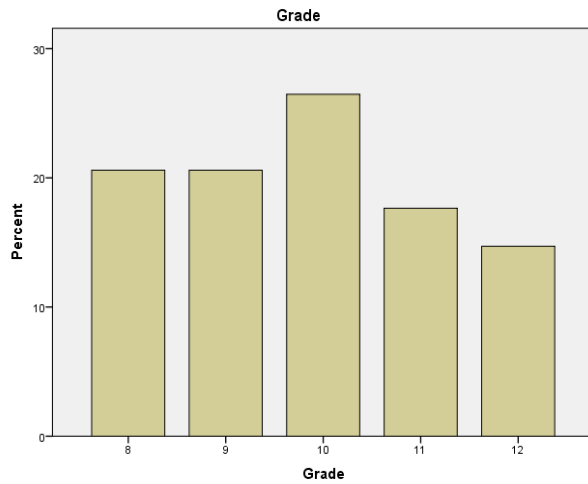
**4.2.2. Figure 2: Graphical representation of gender of the participants.**

The participants in the study were females 18 (52.94%) and males 16 (47.06%), there were more females than males. The study wanted the views of both gender as stipulated by Greene and Biddlecom (2000) who maintains that the lack of attention to gender dynamics in teenage pregnancy is compounded because the focus of much research concerning decision making surrounding pregnancy is on couples. Far less is known about the role gender plays in fertility decisions and costs such as adolescence. Such a focus is particularly relevant in contexts like South Africa where the events of teenage pregnancy are rife. Exploring gender roles as they relate to teenage pregnancy is also important for gaining insight into the dynamics of adolescences' sexual and reproduction choices and behaviour and for learning what must be done to improve well-being.



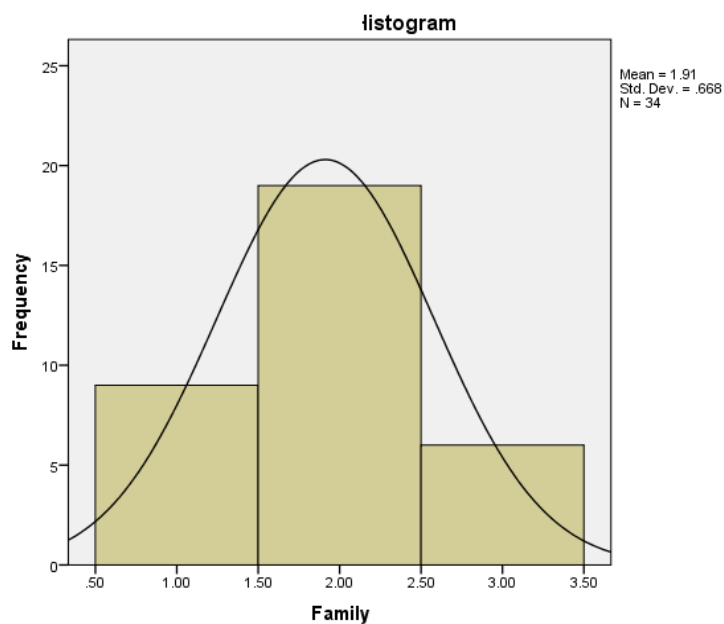
#### 4.2.3: Figure 3: Graphical representation of age of the participants

The participants were from a secondary school and from ages 12-14 (25%), 14-16 (50%) 16-18 (30%) and 18-above (5%) representation. These ages are consistent with the Department of Basic Education (2014) the appropriate age for attending secondary school is 14 years and above. However, the age at entry varies, depending on the age of completion of primary education. According to Piaget's stages of development, 12 years and above are in the formal operation stage where children can think deeply about concrete events and can reason abstractly and hypothetically. Sexuality education is appropriate at this age group. Marule (2008) stipulates that at the ages of 15-19 years or even earlier than 15 years of age, children are likely to become more sexually active during this stage of development. The age group was important to be represented to get their experiences on teenage pregnancy.



#### 4.2.4: Figure 4: Graphical representation of grade of the participants

Participants in the study were from grade 8 (20%), grade 9 (20%), grade 10 (28%), grade 11 (18%) and grade 12 (17%). According to the Department of Basic Education (2014) in South Africa, secondary education spans Grade 8 to 12. Majority of the participants were from grade 10.



#### 4.2.5: Figure 5: Graphical representation of family structure of the participants

Participants were from three types of family structures (n=34): Single parent 18 (52%), both parents 8 (24%) and participants living with guardian 8 (24%). Fisher, Leve, Leary and Leve, (2004) indicate that growing up with a single parent is often associated with a number of adolescent behavioural problems. Adolescents in single-parent families might have more opportunities to engage in high risk behaviours since there may be only one parent to provide supervision. For example, levels of monitoring in single parent families

have been examined and research indicates that single-parent families monitor their adolescents less when compared to two-biological-parent families

### **4.3. Brief description of the methodological approach.**

#### **4.3.1. Interpretative phenomenological analysis**

The aim of interpretative phenomenological analysis (IPA) is to explore in detail how participants are making sense of their personal and social world, and the main currency for an IPA study is the meanings particular experiences, events, states hold for participants. In this study approach was phenomenological in that it involved detailed examination of the participant's life-world. It attempts to explore personal experience and is concerned with an individual's personal perception or account of an object or event, as opposed to an attempt to produce an objective statement of the object or event itself. At the same time, IPA also emphasizes that the research exercise is a dynamic process with an active role for the researcher in that process. One is trying to get close to the participant's personal world, to take, in Conrad's (1987) words, an 'insider's perspective'.

This involves the investigator engaging in an interpretative relationship with the transcript. While one is attempting to capture and do justice to the meanings of the respondents to learn about their mental and social world, those meanings are not transparently available – they must be obtained through a sustained engagement with the text and a process of interpretation. The following section describes a step-by-step approach to the analysis in IPA. This follows the idiographic approach to analysis, beginning with particular examples and only slowly working up to more general categorization or claims (Smith, Harre & van Langenhove, 1995).

##### **4.3.1.1. Looking for themes in the first case**

The researcher read the transcript a number of times, the left-hand margin being used to annotate what was interesting or significant about what the respondent said. It was important in the first stage of the analysis to read and reread the transcript closely in order to become as familiar as possible with the account. Each reading had the potential to throw up new insights.

##### **4.3.1.2. Connecting the themes**

The emergent themes were listed on a sheet of paper, and the researcher looked for connections between them. So, in the initial list, the order provided was chronological – it was based on the sequence with which they came up in the transcript. The next stage

involved a more analytical or theoretical ordering, as the researcher tried to make sense of the connections between themes which were emerging. Some of the themes were clustered together, and some emerged as superordinate concepts.

#### **4.3.1.3. Continuing the analysis with other cases**

A single participant's transcript was written up as a case study in its own right or, more often, the analysis was moved on to incorporate interviews with a number of different individuals. The researcher put the table of themes for participant 1 aside and worked on transcript 2 from scratch. The researcher needed to be disciplined to discern repeating patterns but also acknowledged new issues emerging as the researcher worked through the transcripts. Thus, the researcher was aiming to respect convergences and divergences in the data – recognizing ways in which accounts from participants were similar but also different.

#### **4.3.1.4. Writing up**

This stage was concerned with translating the themes into a narrative account. Here the analysis became expansive again, as the themes were explained, illustrated and nuanced. The table of themes was the basis for the account of the participants' responses, which takes the form of the narrative argument interspersed with verbatim extracts from the transcripts to support the case and supported with relevant literature.

### **4.4. PRESENTATION AND ANALYSIS OF DATA**

The following general themes or pre-determined descriptive categories have primarily emerged from the interview schedule and are substantiated by direct quotes from interview transcripts to verify their validity or authenticity. The sub-themes are derived from the data after thorough reading of the interview transcripts. Interviewees contributed differing amounts of information to the themes that comprise the narrative. Some participants talked at length on one or two themes; some participants made nearly equal contributions across all themes. Thus, all participants' voices and views are represented in this study. Below is a table with the Themes and sub-themes that emerged from the data.

#### 4.4.0. Table 1: Themes and sub-themes that emerged from the data:

THEMES	SUB-THEMES
1.The effectiveness of sexuality education	Sub-theme 1: The goal of sexuality education <ul style="list-style-type: none"> <li>• Creating Awareness</li> <li>• Providing information on intervention.</li> </ul>
2. The type of knowledge learners have about prevention of teenage pregnancy.	Sub-Theme 1: Contributing factors of teenage pregnancy. Sub-Theme 2: The responsibilities of a sexually active person. Sub-Theme 3: Measures to avoid pregnancy Sub-Theme 4: Abstinence initiative programmes Sub-Theme 5: Instances that can lead to having unprotected sex Sub-Theme 4: Steps to take when exposed to unprotected sex
3. Type of prevention measures learners prefer to use.	Sub-Theme 1: Preventative measures suitable for the learners Sub-Theme 2: Person responsible for prevention against pregnancy. Sub-Theme 3: Community initiative programmes on prevention of teenage pregnancy. Sub-Theme 4: Parental support. Sub-Theme 5: Parent-child communication

#### 4.4.1. The effectiveness of sexuality education in preventing teenage pregnancy.

Forrest (2004) defines sexuality education as the process of acquiring information and forming attitudes and beliefs about sex, sexual identity, relationships and intimacy. It is also about developing young people's skills on sex issues in order to enable them to make informed choices about their behaviour and feel confident and competent about acting on their choices.

Unplanned pregnancy constitutes a health problem and has negative implication on the teenage mother and is usually associated with non-use of contraceptives, casual sex, failure to negotiate safe sex and the perception that most of their friends have become pregnant and one has to prove one's fertility. Approximately 30% of teenagers in South Africa report 'ever having been pregnant', the majority, unplanned (Jewkes, Morrell & Christofides; 2009, Lince, 2011; Flanagan, Lince, Durao & Menez, 2013; Pettifor O'Brien,

MacPhail, Miller, Rees, 2005; Holt, Lince, Hargey, Struthers, nkala, McIntyre, Gray, Mnyani & Blanchard, 2012; Ardington, 2012). While this number has decreased over the past few decades, it is still unacceptably high.

According to literature sexuality education as an intervention needs to be evaluated to gauge the impact it has on teenage pregnancy. A study conducted by Ramathuba (2013) shows that teenagers lack knowledge on family planning methods, including condoms use which makes them vulnerable to unplanned pregnancy. The Department of Basic Education has sexuality education as a component of Life Orientation subject which tries to address, among other things, issues about reproductive health. The departments' main goal is to prepare learners for the challenges that they will encounter in meeting life's many challenges including teenage pregnancy.

#### **4.4.1.1. Sub-Theme 1: The main goal of sexuality education**

Most learners were of the view that Sexuality Education **creates awareness** by providing information on intervention on teenage pregnancy. The following verbal quotes reflected the above idea:

*"I think that **educating learners about sexuality**, helps the learners to know what it is to engage in sex and what are the consequences of having sex" Participant 2*

Sexuality Education creates awareness by **providing information on intervention on teenage pregnancy**. Researchers agree that sexuality education encompasses education about all aspects of sexuality, including information about family planning, and birth control methods (De La Mare, 2011). Kirby (2007) argues that programmes need to be "focused on clear health goals—the prevention of, pregnancy" (Kirby 2007, p.131).

*" Sexuality Education helps you **to have knowledge** that when you engage in sexual intercourse what results are going to come out of it." Participant 7.*

Kirby acknowledges the importance of psychosocial elements such as "**knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy**," and influencing them in a way that keeps youth healthy (Kirby 2007, p131). Furthermore, Kirby argues that effective programmes happen in environments where youth feel comfortable participating and involve students in a variety of activities that honestly address the psychosocial elements involved in sexual decision making.

*"The main goal is to reduce the teenage pregnancy rate that's why we are taught sexuality education. Adolescence is a tricky stage for teenagers, you go through a lot*

*emotional stuff and you need someone to talk to about those things and easy when you speak to a teacher about those things whereas going at it alone or speaking to your parent. Because your parent will just wouldn't understand and would tell you that you are still young to be talking about such things." Participant 3*

Good programmes use sound instructional methods that make students identify personally with the information (Kirby, 2007). Specifically, those **effective programmes** "Employed activities, instructional methods, and behavioural messages that were appropriate to the teens' culture, developmental age, and sexual experience".

*"Sexuality education helps us on how to **look after ourselves and guide** on when we want engage in sexual intercourse about its effect. It guides us as well not to get any diseases." Participant 7*

It is important that young girls and boys **receive information** about these matters before they themselves get involved in sexual activity. In many developed countries sex education is part of the curriculum of primary and/or secondary schools. (Scher, Maynard & Stagner, 2006).

Adolescents are particularly susceptible to unintended pregnancy. They are often uninformed, and frequently misinformed, about sexuality and the risk associated with early and unprotected sex (WHO, 2000). The latest study Ramathuba (2013) maintains that a lack of education on basic reproductive anatomy, the physiology of conception and contraception could lead to early initiation of sexual activity and risky sexual behaviour. The study revealed that secondary school girls lacked information on sexuality and contraceptive, sexuality decision-making skills and negotiation skills and responsible sex. Information is necessary to be made available. Learners revealed that adequate information is given however the form of disseminating information is not appropriate.

*"Most **information is vested in books** and our problem is that since we do not like to read is that we end up not getting the information that we are supposed to get. With television, **people love entertainment** and they do not like to watch programmes that can make a difference in our lives. Participant 4*

According to Victor, Strasburger, Jordan, and Donnerstein (2010), the media has a profound impact both positive and negative on young people's knowledge, beliefs, and attitudes related to reproductive health and sexual relationships. They maintain an example, of the Internet and social media can perpetuate misconceptions about sexuality matters and can lure young people to inappropriate websites, particularly boys who use

Internet cafes. Yet the media can also be used to disseminate accurate information about sexuality issues. Thus, in the information age, sexuality education programmes are critical to providing young people access to reliable sources of information and empowering them to make **wise choices when using social media**.

#### **4.4.2. Theme 2: The type of knowledge learners have about prevention of teenage pregnancy.**

Knowledge is defined as “the facts, feelings or experiences known by a person or group of people; awareness, consciousness, or familiarity gained by experience or learning; specific information about a subject” (Collins English Dictionary, 1991:860). Knowledge is gained from peers, institutions of socialisation such as the school, family and church, the media such as newspapers, magazines, radio, films, television and the Internet. Knowledge is very important as it is the basis upon which decisions are made. It is also essential as it helps shape an individual’s reality. Sexual health knowledge is vital not only to adults but to teenagers as well. In the absence of adequate and factual knowledge teenagers are bound to make unsound decisions that have a negative bearing on their lives.

There are different types of knowledge; conceptual, procedural, declarative, strategic and descriptive. These types of knowledge are dependent on whether the knowledge is factual or mythical (Byners, 2001). This study focuses on conceptual, procedural and declarative knowledge.

Static knowledge about facts, concepts and principles that apply within a certain field is known as conceptual knowledge domain (de Jong & Ferguson-Hessler, 1996). Conceptual knowledge allows an individual to rationalise a phenomenon. Conceptual knowledge is significant for this study as it is important to understand what teenagers know about teenage pregnancy. Such knowledge comprises what the phenomenon is all about (teenage pregnancy), the drivers of and contributory factors to teenage pregnancy, the effects of teenage pregnancy on both individuals and society and prevention and management of the phenomenon.

Procedural knowledge is knowledge exercised in the performance of a task (de Jong & Ferguson-Hessler, 1996). This type of knowledge manifests for example when teenagers use contraceptives and condoms to prevent pregnancy and other sexually transmitted infections (STIs) and making use of health services. Knowledge on its own is not enough to influence behaviour change. "Heightened awareness and knowledge of health risks

are important preconditions for self-directed change. Information on sexuality alone however does not necessarily exert much influence on refractory health impairing habits" (Bandura, 1990:1). Attitudes and perceptions then play a role in supporting knowledge in realising behaviour change. "Behaviour change can be attributed to a change in knowledge levels, attitudes and perceptions. A combination of all three results in behaviour change" (Becker, 1990:4). Teenage pregnancy is evidence that procedural knowledge is not being used and opens avenues to identifying the gaps in knowledge that need to be addressed.

Declarative or descriptive knowledge is "knowledge that involves knowing 'that' is the case" (de Jong & Ferguson-Hessler, 1996: 12). Knowing that unprotected sex can lead to unwanted and unplanned pregnancy is descriptive knowledge. In some cases, declarative knowledge does not translate to action, for example knowledge that smoking is not good for one's health does not stop an individual from smoking. In the same vein, knowledge on the effects of teenage pregnancy may not stop a teenager from engaging in practices that result in pregnancy. Thus, "raising levels of knowledge and correcting misconceptions is necessary as a first strategy by which individuals can begin to protect themselves against diseases" (Coates, Stall, Catania & Kegeles, 1988:6).

In a context where ignorance and misinformation can be life-threatening, sexuality education is part of the duty of care of education and health authorities and institutions. In its simplest interpretation, teachers in the classroom have a responsibility to act in the place of parents as a number of studies have shown that parents do not talk to their children about these matters because they feel confused, ill-informed or embarrassed about the topics (Hughes & McCauley, 1998). Therefore teachers contribute towards ensuring the protection and well-being of children and young people.

In a study conducted by Nika, Bereda, Thakhati and Goon (2015) indicate that there is an increase in teenage pregnancy despite the presence of dual protection practice and health care awareness programmes related to health and sexuality education in South Africa. During these programmes, teenagers are also encouraged to use condoms as well as a reliable family planning method during sexual activities, if they cannot abstain. The reason why they are encouraged to use condoms is because condoms provide them with dual protection, that is, simultaneous protection against STIs and unwanted pregnancy (Morrone, Myer, Mlobeli, Gutin & Grimsrud, 2007). The participant's level of knowledge is discussed in the following sub-themes.

#### 4.4.2.1. Sub-Theme 1: Contributing factors of teenage pregnancy

Participants had the understanding in their responses that the major contributing factors of teenage pregnancy were the following as per their verbatim quotation:

*“Some of the learners **coerces each other into having sex** and when people they do something they do not think when they see other people but people are not the same. Maybe that person can do something and not get pregnant but when the other tries it and falls pregnant after just doing for the first time and they end up getting pregnant.”*  
*Participant 1*

Peer influence is a normal aspect for every individual emphasizing even developmental and healthy living of the individual and not something bad as many might want to interpret it. It is a period of involvement when an individual displays some level of independence from the parents.

*“**Peer pressure**, friends force the person to engage in sex because they have started as well.”* *Participant 8*

According to the Reproductive Health Outlook (2005), peer pressure is defined as emotional or mental force from people belonging to the same group such as age, grade, or status to act or behave in a manner similar to them. Peers are crucial for the adolescents' development, for the reason that development needs to be in context which mainly implies family and peers (Oswald & Suss, 1988). A relationship with peers is an extended relation with people outside the family. Parents spend more time at work, and their concern is about shelter and food. Therefore they neglect their children's emotional needs and development. This often leads to children spending more time with their peers and then copying them and older gang members or negative role models in the community (Bezuidenhout & Joubert, 2008).

*“They are mostly **influenced by their friends.**”* *Participant 3*

According to Varga (1999), peer pressure has multiple dimensions. There appears to be a trend of young people to incorporate sex much earlier into their social lives than in the previous generations, to engage in multiple partnerships and for young men to feel pressurized in terms of their expectations of their sexual conduct.

Kansumba (2002) further stated that peers play a measure role in the transfer of sexual knowledge. This is/ has been viewed as problematic in that peers are seen as less reliable, or as providing less accurate information than teachers or health professionals.

Moore and Rosenthal, (1993) agrees that these days there is a shift in adolescents as compared to the past years. Peers today have become more important in forming teenager's beliefs and regulating their behavior. Peer influence and pressure is often cited as one of the most influential factors affecting adolescents' sexual decisions. Presumably, peer influence can operate in a number of ways. Teenagers can obtain information about sex from their friends, which may serve to guide decision-making about sex. This information is not always accurate, as reflected in long-standing teenage myths such as that a person cannot get pregnant the first time she has sex.

*"Another thing is that after you have slept with a boy, most **girls drink disprin** (painkillers) **with a coke**. It is believed to get rid of sperms in your body so that you do not get pregnant"* Participant 5

*"I Think the main cause of teenage pregnancy its these **rights that we have**. A few months back there was this talk about a new law allows young children can start having sex at the age of thirteen. If there is such a law that allow children start to have sex at the age of thirteen they are not reducing teenage pregnancy but it is increasing it."* Participant 7

The participant was referring to the Matters Amendment Bill adopted by the National Assembly (Act 15 of 2015) which states that teenagers between the ages of 12 and 15 can consent to sexual acts with each other. The participant below feels that this law would worsen teenage pregnancy

*"**Stress**, because at home your **parents are fighting** and when the child sees them fighting , what the child will feel is that there could be something that could make them feel better rather than smoke or drink. So they **opt to behave like an adult** and go be with someone rather than watching my parents fighting, that stress causes that. That person will now **engage in sex** and things turns bad and she finds herself pregnant. She will then ask herself what happened and which will be obvious of what happened."* Participant 5

*"Sometimes it happens that you meet up with someone who does not like using it then **he will force to sleep with him without a condom**. In a relationship we understand that is one who is powerful than the other."* Participant 7

*"**Powerful** meaning he is **able to convince the other of what should happen** in the relationship."* Participant 8

**Communication skills:** A second and related set of consequences examined are sexual communication skills. It is likely that feeling able to be assertive about one's sexual communication skills may be useful in maintaining clear boundaries, preventing unwanted experiences, and contributing to positive sexual encounters. The literature on partner communication and adolescent sexuality supports the idea that open communication yields positive outcomes. Communication practices have been found to be an important behavioral factor in the reduction of risky sexual behavior and good communication has been identified as critical in making healthy sexual decisions (Hulton, 2001).

Female adolescents who are able to talk with partners about aspects of STI risk before (or without) having intercourse are significantly less likely to engage in high-risk sexual behavior (Sieving et al., 1997; Taylor-Seehafer & Rew, 2000), and adolescents who are more comfortable with safe-sex communication are more likely to use condoms (Troth & Peterson, 2000). Little research has been conducted on the specific impact of the three targeted discourses on sexual communication in sexual encounters. However, studies have shown that gendered discourses, particularly the double standard discourse, may contribute to power discrepancies between women and men, specifically to increased female passivity and less communication in sexual situations (Crawford & Popp, 2003; Gavey & McPhillips, 1999; Hynie & Lydon, 1995).

*“It can happen that a boy tells you that **you are his steady girlfriend** and he **can’t have sex with you with a condom** because he loves you and you are his steady girlfriend and you end up sleeping with the boy without a condom.” Participant 4*

Studies have also shown that women who accept and endorse feminine notions in which they do not always feel comfortable being authentic and expressing their voice also tend to show less sexual agency (Impett, Schooler, & Tolman, 2006).

#### **4.4.2.2. Sub-Theme 2: The responsibilities of a sexually active person**

Most learners revealed that the responsibility of a sexually active person in the following quotes:

*“There are pills that are common knowledge to everyone can use so that they do not get pregnant” Participant 4*

*“You must make sure as you see these things called STDs, STIs and worse HIV the lifelong disease. Especially the latter, you have to say that I’m now sexually active, as we*

are taught that **there are condoms for girls, boys, and contraceptives**. There is also a gel that a woman can smear it at the opening and inside her vagina so that she won't be infected with HIV. The way I see it is that when you are start to be sexually active just use everything that is out there that will protect you because you don't know and you cannot trust a person very person present themselves to you as clean only to find that it's the opposite." Participant 1

McQueston, Silverman and Glassman, (2013) state that contraceptive use among sexually active adolescents, which reduces unintended adolescent pregnancy, is an indicator for tracking the success of programmes. This outcome was evaluated in nine studies across a variety of intervention types five studies unambiguously found significant increases in contraceptive use (Kim et al. 2001; Lou et al. 2004; Daniel, Masilamani, & Rahman 2008; Kanesathasan et al. 2008; Erulkar & Muthengi 2009) found a significant increase in condom use among girls but no change among boys. One study of Okonofua et al. (2003) reported a marginally significant increase in contraceptive use one year after the program, but these results were no longer marginally significant at the two-year follow-up, suggesting that the benefits of a school-based intervention on contraceptive use may be short-lived.

However, Vudule, et al, (2001); Buga, Amoko and Ncayiyana, (1996); Meyer-Weitz, Steyn and Ghama, (1999); Marston and King, (2006); Matash, Ntembeselea, Mayaund, et al, (1998) argue that teenage pregnancy has been associated with frequent sex without reliable contraception. The participants verbally expressed this notion:

*"You must always have protection, when you have sex or you will face the consequences of what may happen and so it's important to use protection because without using condoms you may find yourself pregnant"* Participant 8

#### **4.4.2.3. Sub-Theme 3: Measures to avoid pregnancy**

Learners know that they can access contraceptives at clinics however they feel that people at the clinic judge them.

*"There are also different types of contraceptive methods like pills, injections and there is plenty more of other stuff. A person who engages in sexual activities they must know that not only a **condom is a form of contraceptive** that can prevent you from*

*getting pregnant. There are a lot that I have mentioned as well as emergency contraception.” Participant 9*

*“Clinics can give you **contraceptives like condoms**” Participant 1*

According to the HSRC (2008), contraceptives like the male condom and injections for the girls are easily accessible, but teenagers fear the attitudes of the nurses at the clinics. The other reason why teenagers are wary to access contraceptives at government clinics is discovery by community members who will in turn tell their parents.

*“It is easy but most teenagers **find it difficult** because when they get to the clinic they find this old lady sitting and next to her there is a box of condoms. I go to the nurse to ask for condoms, **this old lady the way that she will look at me**, she could only just be staring at me but through my mind it will be like she is asking herself what do I want these condoms for? Such a young boy what could he possibly want with condoms. **It’s even worse for girls** because the girl is scared more than a boy” Participant 3*

Access to clinics in areas where abject poverty is experienced, getting these contraceptives gets to be a challenge. When teenagers get to these clinics health workers have been accused of **turning away young teenagers** from family planning clinics, and accusing them of being too young for sex (Kunene, 1995). In a study conducted by Wood, Maepa and Jewkes (1997) Clinic nurses were undoubtedly perceived to be most unkind. Teenagers reported variously that doctors ‘speak to you nicely’, don’t ask awkward questions about why they are sexually active so young, and get a chance to ‘sit with you’ and provide health education about STDs. From the teenagers’ side, one of the most important problems with clinic use was their anxiety about **elder clients’ perceptions of them**. Since older women were said to ‘joke and gossip’ about adolescents and speculate publicly that they were sexually active, several informants reported that being ‘seen’ at the clinic made them unhappy and ashamed. As one teenager put it, ‘we think they’ll judge us that we are so young, and they just gossip, they don’t tell us straight’. **Lack of anonymity** in clinics was a particular obstacle for adolescents who wanted to keep contraceptive use a secret from their sexual partners, female relatives and neighbours (because they were church members or had partners or mothers who disallowed contraceptive use).. Although these problems with the clinics were significant, by far the most important and commonly reported problems encountered by teenagers were the attitudes of nursing staff towards them.

Experiences of 'harassment' by nurses emerged as a strong theme in the interviews despite the fact that teenagers participating in the research were usually recruited and interviewed in a clinic and so potentially could have been inhibited about discussing their perceptions of nurses. Many teenagers reported their own experiences of verbal 'harassment' by clinic nurses, while others relayed their friends' descriptions of it. **Nurses were commonly described as rude, short-tempered** and arrogant, and liable to harass clients without any provocation. Teenagers seeking contraception without parental permission was frequently a source of conflict between staff and clients.

#### **4.4.2.4. Sub-Theme 4: Abstinence initiative programmes**

Abstinence education interventions promote abstinence from sexual activity (either delayed initiation or abstinence until marriage) and mention condoms or other birth control methods only to highlight their failure rates, if at all. These interventions generally include messages about the psychological and health benefits of abstinence as well as the harms of sexual activity. Abstinence-only proponents point to studies concluding that the abstinence-only education message has played a central role in the decline of adolescent sexual activity, and related negative health outcomes, over the last decade. Abstinence-only programs are popular with religious groups in that they promote a moral agenda. Abstinence-plus programmes include "a wide variety of programmes, ranging from sex or AIDS education programs taught during regular school classes, to programmes taught on school campuses after school, to programs taught in homeless shelters and detention centres" (Kirby, 1997a, p. 25).

The learners know about the programmes in their area however were very sceptical about them. Abstinence programmes emphasize both the morality in being abstinent until marriage and the health risks of not doing so. Abstinence proponents believe that sex before marriage is inappropriate and immoral. They support the message that abstinence is the only way to avoid sexually transmitted diseases and unwanted pregnancy. Furthermore, they say that sex outside of marriage can cause, "serious, debilitating, and sometimes deadly consequences" (Morin et. al. 2002, p.12).

Although abstinence programmes are no longer allowed to mention religion specifically, "Abstinence programs often include moral undertones that traditionally are tied to religious beliefs," they go on to say that "programmes identify one moral belief and promote it," they continue saying, "abstinence programmes suggest that abstinence is the only morally correct way to deal with adolescent sexuality" (Levesque 2003, 32). However, most abstinence-only programmes are not effective because they fail to delay

the onset of intercourse and often provide information that is medically inaccurate and potentially misleading (Kirby, 2007; Kohler et al., 2008; Lin & Santelli, 2008; Trenholm et al., 2007).

*“There is a programme that I know but sometimes this whole thing has some **element of being deceitful**. It is all a lie because at times we see a girl who sleeps with a boy and they go to these schools that why I say it is all a lie. There is a school around where I live and we see everything and as boys we talk. **As friends we share most of the things and we also know**. The boy will admit that the girl refused to sleep with me and he wouldn't lie about it but obviously the girl will deny it”* Participant 8

The study revealed that contrary to concerns by those who question abstinence education, participants in the abstinence education programme were no more likely to have unprotected sex than those who did not participate. Very similar proportions of both groups reported not using a condom at first sexual encounter and not consistently using a condom over the course of the previous year (Thenholm, 2007).

#### **4.4.2.5. Sub-Theme 5: Instances that can lead to having unprotected sex**

What emerged was that girls were scared to express themselves when they were with a guy.

*“Also the way I look at it as he was saying, most of the time we as girls, **we are scared to express the way we feel when you are with a guy**. He said that when you reach that moment when you are about to have sex and then you suggests that you use a condom to protect yourself. The boy will then say that **you don't trust him** and at that time you scared to say yes you don't but you start pretending that you and you give in”*  
Participant 12

Jewkes, Morrell and Christofides (2009) note that accepting gender inequalities and gendered norms as a critical driver of unplanned pregnancies necessitates that responses to reduce teenage pregnancies must focus on empowering women and reducing gender inequalities (Jewkes, Morrell & Christofides, 2009). The study done by Ramathuba (2013) revealed that secondary school girls lacked information on sexuality and contraception, sexuality decision-making, negotiation skills and responsible sex. Failure to help teenage girls to deal with sexuality and contraception could lead to incidences of pregnancy, STI and HIV/AIDS. Reproductive health-care services need be available and accessible to the secondary-school girls. Although poor knowledge is often cited as a reason for ineffective or non-use of contraceptives and studies have shown

that most young people are well-informed about modern methods of contraception (Panday et al., 2009, p. 56). However the girls' **lack of self-confidence** propels them to engage in things that they would not have engaged in. Macleod (1999, p. 6) stated that teenagers that have a poorly defined sense of identity and low self-image and self-confidence, they experience themselves as inadequate and inferior and are plagued by the feeling of insecurity. Therefore there is an association between poor self-esteem and teenage pregnancy. Skills in communication and negotiating in terms of consenting to sex are important. The literature repeatedly points to teenage girls not always being in control of whether, and how they have sex: 'In South Africa, studies cite unequal decision-making about sex between partners, where girls lacked autonomy, thus hindering the practice of safe sex' (Flanagan, Lince, de Menezes, & Mdlopane, 2013, p. 15).

There is general agreement that women hold responsibility for contraception in the relationship although there is little space for open discussion about contraceptive choices with male partners. Although many participants in the study supported contraceptive use, it is still a stigmatized practice bearing the negative social connotation of being promiscuous. Women also have little room to suggest condom use as it is considered inappropriate and indicative of sexual permissiveness (Varga, 2003).

#### **4.4.2.6. Sub-Theme 6: Steps to take when exposed to unprotected sex**

*"At times when people go to a bar and they drink. You meet a girl at the bar and you ask to talk to her, she agrees and then you start kissing. You get so overwhelmed with feelings you take her to the toilet and you sleep with her there." Participant 2*

Learners revealed that their first reaction would be to check for HIV and pregnancy. This alarming response indicates that learners have very little knowledge about emergency pills

*"Firstly I would go to the clinic and **check if I had contracted any disease** or if I am pregnant" **Participant 10.***

None of the participants mentioned the use of emergency contraceptives in response this particular question which would obviously been the barrier towards pregnancy. While not much was reported on emergency contraceptive and access to PEP services, Cooper , Morroni, Orner, Moodley, Harries, Cullingworth, and Hoffman (2004) noted that while emergency contraceptives are available at many public clinics, **usage is very low**, and they concluded this was due to a lack of knowledge among teenagers. Ehlers (2003)

found that some pharmacists would not advocate the use of the emergency contraceptive, even if the teenage girl had a prescription. The suggestion of this review is that both are universally difficult to access.

Ehlers (2003, p. 238) also enquired about other means of protection such as the emergency contraceptive: '189 out of the 250 respondents (75.6%) did not know about the availability of emergency contraceptives to be taken within 48-72 hours after unprotected sex' and a very large percentage of not having knowledge of emergency contraceptives. The National Contraception Policy Guidelines, (2012, p.17) noted that: 'The 2003 SADHS indicates that knowledge of emergency contraception remains low (19.6% women and 3.6 % of men knew about emergency contraception).' when reflecting on levels of knowledge it seems apparent that teenagers in South Africa have good basic knowledge but there appear to be significant gaps and inaccuracies in this knowledge.

This review supports Panday, Makiwane, Ranchod and Letsoalo (2009, p. 56) point out: 'While adolescents have high levels of knowledge about contraceptive methods, gaps exist in the accuracy of their knowledge or skill regarding correct use of contraception. Incorrect usage can lead to tears in condoms and missed doses of birth control pills can lead to ovulation' (Panday et al., 2009:56). Some studies of Health Care Workers (HCWs) also reflected low levels of knowledge among teenagers. Holt et al. (2012) in their work with HCWs highlighted that some of the HCWs they spoke to felt the level of knowledge was insufficient: 'young women don't have sufficient information about consequences of sex and the importance of prevention.' They went on to highlight poor communication, often between teenage girls and their mothers: 'for example when mothers take their daughters for family planning but do not discuss sex or why the daughter might need family planning' (Holt, Lince, Hargey, Struthers, Nkala, McIntyre, Gray, Mnyani & Blanchard, 2012, p. 288). Hoffman-Wanderer, Carmody, Chai and Rohrs (2013) also interviewed Health Care Workers and again they stressed their belief that teenage girls do not have enough information to protect themselves adequately.

#### **4.4.3. Type of prevention measures learners prefer to use.**

It is beyond doubt that adolescents need good information about their own bodies, their sexual development and about the ways of avoiding pregnancy. Moreover they need to be informed about teenage pregnancy. In the past it has often been said that this is the task of parents, It is important that young girls and boys receive information about these matters before they themselves get involved in sexual activity. In many developed

countries sex education is part of the curriculum of primary and/or secondary schools. (Scher, Maynard & Stagner, 2006).

The most basic needs of adolescent are for accurate and complete information about their body functions, sex, safer sex, reproduction, and sexual negotiation and refusal skills. Without information, adolescents are forced to make poorly informed decisions (Bearinger, 2007).

#### **4.4.3.1. Sub-Theme 1: Preventative measures suitable for the learners**

*“I do not like using injections because it makes your body to be lethargic and you turn to retain water. Most of these things you will end up not being able to have children in the future” Participant 1*

“Others are, others are not, example like the injection that girls use where every month you suppose to go through your menstruation cycle, you suppose to bleed but this injection you are given sometimes is for two or three months. When you take the injection you do not go through your menstruation cycle the period that the injection is still in your body and it prevents you from getting pregnant.” Participant 4

*“Sometimes it can **affect you because the blood that is supposed to leave your body, will stay somewhere in the body and it will chose where and it affects you in any different way. Let’s say you have used this injection for seven years and this blood that is supposed to leave your body is not, it builds up and the time when it does you over bleed and you may not survive that. I think using injection is not the right one to use. What is better is using pills after you have had sex or after because the injection the blood that stays in your body is building something that at some point will end up affecting you.” Participant 24***

Cooper et al. (2004) highlighted that this overwhelmingly high preference for hormonal contraceptives ‘may reflect use preference (however), the role of health care providers in influencing contraceptive choice is well-documented. Method choice is frequently limited in the public sector by the opinions and practices of primary care nurses.

Learners take on this was that most of the preventative measures are not suitable for them whereas with the implant there was hope, even though they do reveal that it does possess some challenges. According to Maries and Stopes (2015) Implant Contraceptive is a tiny white plastic rod that is inserted under the skin of the inner, upper arm to prevent pregnancy. The implant works by releasing small amounts of the hormone progesterone

into the body. Progestogen stops ovulation (the release of an egg by the ovaries) and thickens the mucous at the opening of the uterus, so that sperm can't implant in it and start to grow.

*“There is this **thing like a match stick that they insert in your arm** which helps for not getting pregnant.” Participant 9*

*“I prefer the implant, where you are protected for three years against pregnancy therefore you do not have to go to the clinic all the time every month. You do not have to worry about remembering because it's already there. Saying that your body gets sluggish and it retains water, all of those things are just allergies. Firstly before you take that contraceptive, you first have to know what is it that you are allergic to so that you will be able to know which one is best for your type of body.” Participant 12*

The implant is a relatively new in South Africa and for that reason there's a lot of mystery and uncertainty surrounding it to. (Maries & Stopes, 2015)

*“Others say the implant is not good because after three weeks you start bleeding (menstruation) endlessly.” Participant 10*

#### **4.4.3.2. Sub-Theme 2: Person responsible for prevention against pregnancy**

The learners felt that the person responsible for prevention against teenage pregnancy is the teenagers but others disagreed and said it should be girls. However The literature repeatedly points to teenage girls not always being in control of whether, and how they have sex: 'In South Africa, studies cite unequal decision-making about sex between partners, where girls lacked autonomy, thus hindering the practice of safe sex' (Harrison, 2001; Varga, 2003; Flanagan et al, 2013, p. 15). Holt et al. (2012, p. 288) noted that health care workers (HCWs) found that 'gender dynamics in relationships also played a factor in determining young women's risk' (Holt et al., 2012, p. 288). They went on to note that peer pressure to have sex and the 'culture of submission to male partners' often led to unprotected sex.

*“**Teenagers have to be responsible** because you can't hold your parent responsible. Firstly she does not know when you are going to sexual relationships and you are **withholding information from your parents** they will not be able to help you. So you need to be responsible because it's you who is going to suffer if you do not prioritise yourself by saying this is what I'm going to and this is how I am going to protect myself. So you need to be responsible” Participant 3*

Girl's subordinate position in the gender and social hierarchy contains their ability to make real choices around pregnancy (Jewkes, Morrell & Christofides, 2009). An inequity in gender power shape young women's first and subsequent sexual experiences and makes many of these encounters risky (Pettifor, O'Brien, MacPhail, Miller, & Rees, 2009).

*“**Mostly its girls** and the reason I say that is because girls will be the ones at the end who will get hurt because **the boy is just there to have sex** and obviously once he is done he is done he will just leave I could be there because I'm visiting and I find myself a girlfriend, we have sex and forget to use a condom. **I will leave and she will be left alone, pregnant.** So girls should be responsible because it backfires on them”*  
Participants 6

There is general agreement that women hold responsibility for contraception in the relationship although there is little space for open discussion about contraceptive choices with male partners. Although many participants in the study supported contraceptive use, it is still a stigmatized practice bearing the negative social connotation of being promiscuous. Women also have little room to suggest condom use as it is considered inappropriate and indicative of sexual permissiveness (Varga, 2003).

#### **4.4.3.3. Sub-Theme 3: Community initiative programmes on prevention of teenage pregnancy.**

Information, communication and education should be provided to the existing groups in the community, in relation to changes which take place in adolescent girls' bodies and the consequences of early sexuality, namely teenage pregnancy and sexually transmitted infections including HIV/AIDS, and ill-effect of abortion (Ikamba & Quedraogo 2003). If women and church/religious groups are empowered, they can play a big role in educating adolescent girls. However, participants feel that they are trying but not enough effort.

*“I would say they do try and they should keep on trying because they can **encourage and motivate the youth** to stop the things they are doing. They should carry-on helping us as the youth. We also should make an effort to attend these meetings. When they have these meetings there are just **a few people that attend** we have to try to go and listen to what they have to say”* Participant 2

According to Brace (2009), parents, as well as the community and society, need to do all they can to develop positive attributes in their children. They should not only encourage

them, but also educate their teenagers about premarital relations and its consequences, especially as it pertains to engaging in inappropriate behavior at an early age.

*“I think the effort that community is not making enough as much as they try to tell people that there are consequences of a person who gets pregnant at an early stage. We don’t see the much difference because we see at school the rate of learners getting pregnant is increasing so they are not solving this issue of pregnancy” Participant 5*

*“Yes I will use them because I want to finish school but not virginity testing because you end up becoming a target because I’m now having sex I would use pills because I know how dangerous others are and because I wouldn’t have a problem in my body.” Participant 11*

*“They are not risky which will allow me to finish school. I do not agree with virginity testing because you have to know yourself that I’m still a virgin and now I’m ready to have sex and this boy will take my virginity. As boys we have different skills of getting a girl to sleep with you. I will try my skill on a girl and another boy will follow but one of us will at the end be able to win the girl over. Once one of us manages to sleep with you and the whole country will now know that you are no longer a virgin.” Participant 7*

#### **4.4.3.4. Sub-Theme 4: Parental support.**

Sexuality education needs to be supported by parents. Among the various dimensions of family social support, parent-adolescent communication on issues of sexual behaviour and childbearing has received considerable attention (Camlin & Snow, 2008; Wilson & Donenber, 2004). Positive, open and frequent family **communication about sex is linked to postponement of sexual activity**, increased contraceptive use and fewer sexual partners (Blake, Simkin, Ledsky, Perkins & Calabrese, 2001; Dittus & Jaccard 2000; Hutchinson, Jemmott, Jemmott, Braverman & Fong, 2002; Karofsky, Zeng & Kosorok, 2000). Similarly, parent-child communication is vital for the prevention and reduction of teenage pregnancy (Hollander, 2003). Many adolescents concur that it would be easier for them to avoid teen pregnancy if they were able to have more open and honest conversations about these topics with their parents (Albert, 2004).

*“I think you **should involve your parent** because when you start having sex your parent can see that now you are having sex and it must be them who give you advise that since you have started to do this why we don’t go to the clinic and get contraceptives to*

*prevent against teenage pregnancy. Now we do not hide things and things are in the open and there is no reason to hide things from them. They might have an experience of what you going through and so if you tell them they might be able to help you. The more we hide stuff from them that is when we kill ourselves by taking decision on our own by no consulting with our parents. So it's important to tell our parents, that they may be able help you". Participant 9*

Parent-child communication about sex increases the likelihood that sexual risk will be discussed with partners and can mediate negative peer norms about sexual behaviour (Whitaker & Miller, 2000).

***"Sexuality education is not enough, you need your parents. It all comes down to family values, when you talk with your parent, you just know that my mom will not approve of this because at home this is what we believe in. So if you are going to go according to the sexuality education that you are taught in LO, that will not be adequate for you in the future. It won't be sustainable you also need your family values"*** Participant 1

*"As important as it is to speak to parents but **it's not all of us that has parents** for instance you stay with your sister , one when its 22;00 she goes out, you wake up its midnight another one is gone and you left alone."* Participant 4

However, learners and parents only living with siblings possess a challenge. Poverty, and child headed households are identified by Elkind (1984) as the major contributors to teenage pregnancies. As a result of poor or no parental guidance and control, children engage in sexual activities at a very young age. This is confirmed by Mfono (2003) who conducted a study on teenage pregnancy and his results revealed that teenage pregnancy is high among child headed households. The teenagers in those households often engage in several activities in exchange for money to assist them to survive.

#### **4.4.3.5. Sub-Theme 5: Parent-child communication**

Parent-child communication is another dimension or process in family relationships and its association with adolescent pregnancy risk. Parent-child communication is defined as how often in the past year adolescents communicated with their parents about a variety of topics such as drugs and alcohol, sex and/or birth control, and personal problems or concerns (Cleveland, 2005; Guilamo-Ramos, Jaccard, Dittus & Bouris, 2006).

*“Adolescence is a tricky stage for teenagers, you go through a lot emotional stuff and you need someone to talk to about those things and easy whey you speak to a teacher about those things whereas **going at it alone or speaking to your parent**. Because your parent will just wouldn’t understand and would tell you that you are still young to be talking about such things.” Participant 3*

This lack of communication could also be as a result of a reduction in communication between the parent and the female child. This would lead the female child to source for information particularly on sex from other sources which might not be helpful and thus cause an increased exposure to earlier sexual intercourse, risky sexual engagements and pregnancy. Open communication between parents and children is strongly correlated with a reduction in teen pregnancy rates, as well as in reducing high-risk sexual behaviours; and other reduced delinquent behaviours (DiClemente et al., 2001 ; Resnick,1997). However both parents and youth report that parents do not know how to speak to their children about this subject (Albert, 2012). Interventions designed to strengthen parent-child communication around sexual behavior change interventions targeting youth have been shown to be effective (Catalano, Gavin, & Markham, 2010; Markham et al., 2012).

Parents can play an important role in the sexual socialization of their children by educating and talking to youth about sexuality and by reinforcing safer HIV-related and pregnancy prevention behaviors (Miller, Norton, Fan, Christopherson, 1998).The timing, as well as the content, of this communication in relation to an adolescent’s sexual behavior may be critical in determining whether an adolescent experiences unintended pregnancy or contracts a sexually transmitted disease (STD). Talking about sex is not an all-or-nothing event. A recent study found that repetition of sexual discussions— talking about topics more than once— was associated with adolescents’ feeling closer to the parent and having a sense of open communication (Martino, Elliott, Corona & Kanouse, 2008).

The content of parent–adolescent sexual discussions can cover a range of topics, including biological and developmental issues such as puberty, values, healthy relationships, and pregnancy and STD prevention. Few studies have examined the timing of parent– child discussions about various sex-related topics and youth sexual behavior. Prior studies have also suggested communication between parent and child should have a problem solving component. This allows families to communicate issues of sexual behavior through a set of rules and expectations which can resolve potential

conflicts which may arise when a child becomes pregnant (Corcoran, 2001). The level of closeness between parent and child is also related to adolescent pregnancy. This, combined with open and positive communication, increases the likelihood of abstinence, reduces the number of sexual partners and increases contraceptive use (Barnett, Papini & Gbur, 1991; Gupta, Weiss & Mane, 1996; Miller 2001).

*“Yes **you have to communicate with your parents** because everything that happens, you are still under your parents care and you need your parents. The **contraceptive that you are going to use has side effect** and your parent needs to consent to that and can withstand anything that can come from that. It may happen that the contraceptive may not agree with your body and something starts happening and your parent can now help you because they would know what is happening.” Participant 3*

More recent research has found that parents, particularly mothers, play an important role in preventing teen pregnancy if the adolescent perceives parental disapproval (Calhoun & Friel, 2001; Jaccard & Dittus, 1991.) This impact on adolescent sexual behavior, however, is regulated based on the quality of the parent-child relationship (Calhoun & Friel, 2001). Perceived maternal disapproval of sexual intercourse which includes a high level of connectedness and communication between mother and daughter can delay an adolescent’s first sexual experience (Blum, McNeely & Sieving, 2000).

Other recent studies have found parents are able to provide more rational and reliable information on sexuality than their children and peers. Parents should be proactive in their communication on sexuality with their children regardless of the possible misinterpretations (Fitzharris & Werner-Wilson, 2004). **Openness in communication** on issues of adolescent sex in families can be construed as positive but its relevant meaning is determined by an individual family’s social and moral values and beliefs (Feldman, Kirkman & Rosenthal, 2005).

*“There is this thing of **softening the word sex**, sex is sex. Not saying you are not supposed to sleep with a boy. When you are talking to your child as a parent, **just be candid with your child** and tell them that a boy just wants to have sex with you nothing else. When this boy is asking you out, he is looking for nothing else from you but sex. Use the word as it is ‘sex’ because children grow up knowing what is sex but now when we grow up we put it in a decent way. You just have to **tell the child that when a person sleeps with you**, this is what they are going to do and this happens. Not saying “Please my child do not be involved in relationships”. We know that is impossible, we are going to be in relationships. Parents should not even attempt to tell us otherwise. You*

*should just accept that okay my child you are now in a relationship and the boy will have sex with you.” Respondent 5*

In a study on parent-child communication, Eisenberg, Sieving, Bearinger, Swain, and Resnick (2006), conducted telephone surveys to study parent-child communication on various sex-related topics. The authors found parents tended to have sex-related communication with their child if the teen was romantically involved. Participants tended to agree on the information been given early.

*“I think that in order to be protected parents have to **start from grade 5 learners tell them everything and not hide anything** so when they get to a stage when they are and they reach it knowing everything” Participant 3*

*“They must start from **primary school teaching learners about teenage pregnancy.**” Participant 4*

The authors argue that in delaying the communication until their teen is romantically involved, parents do not take advantage of the early opportunity they have to influence their child’s behavior prior getting into a relationship (Eisenberg et al., 2006). Today, most research indicates that communication has some level of importance as a process that can indicate parental-child influences on the issues of sexuality (Feldman, Kirkman & Rosenthal, 2005). However, parents and their children may have a different interpretation on the amount and quality of communication which occurs on the issue of sexuality (Fitzharris & Werner-Wilson, 2004).

#### **4.5. Summary**

In this chapter, the researcher presented the findings of the study. These findings are based primarily on analysis of interview transcripts, and are supported by observations throughout the structured interviews of a sample of 34 learners. The knowledge that learners shared was compared to the relevant literature, The learners responses were framed into themes. The data from the structured interviews was coded into three main themes: the effectiveness of sexuality education, the knowledge and preferred preventative measure of teenage pregnancy. Findings were discussed in three parts that correspond with the aims and major themes that emerged from the data. The above themes were discussed in sub-themes to explore all aspects of all the learners experience and knowledge of prevention of teenage pregnancy.

The learners interviewed responded confidently about their knowledge and gave information which was relevant to the data of the study. Most of the literature quoted depicted the learners' experience and supported most of their responses. The participants' experiences pointed out the following with regards to sexuality education as an intervention of teenage pregnancy:

- Sexuality education does create awareness about intervention methods they can use.
- Made them aware of the contributions of the factors of teenage pregnancy that the learners had to look out for to avoid getting pregnant.
- Responsibility of a sexually active person.
- Highlighted the difficult experiences when trying to access interventions at the public health institutions
- Support from parented was pointed out for learners to be able to face the many challenges about tackling the issues of teenage sexuality.

Chapter 5 discusses and recommends future practice and research.

## **CHAPTER 5:**

### **LIMITATIONS, RECOMMENDATIONS AND CONCLUSION**

#### **5.1. Introduction**

Research was conducted using focus group structured interviews with learners from three schools in the Pinetown district. This final chapter concludes the research report by making recommendations for future research, implications for schools who offer sexuality education, to learners who may be vulnerable to falling pregnant.

#### **5.2. Limitations of the study**

The study was limited by the following constraints which ultimately influenced the acquisition of knowledge gained about teenage pregnancy: participants were from grade 8 to 12 which might have contributed to the participants from grade 8 being uncomfortable; interviewing the participants outside school time made some of the learners feel they were being deprived of their leisure time; interviews were conducted during weekends. Experienced financial constraint were experienced such as transport costs when moving from one school to another.

##### **5.2.1 Overcoming the Limitations**

The researcher ensured always being on time for interview sessions and working within the parameters of the duration of interviews agreed upon to avoid anxiety on the side of the participants. The challenge that was posed by limited time due to working on weekends was dealt with by the interview protocol to guide the interview to relevant questions in order to acquire enough and relevant information about the study.

In order to overcome the problems related to financial constraints, lodgings near the schools was acquired to minimise the cost of transportation and this was all done to achieve good results in the study.

## **5.3. Summary**

### **5.3.1. Methodology**

The research methodology and design selected for this study proved to be an effective means of gaining insight into sexuality education's effectiveness in preventing teenage pregnancy. Employing the qualitative research approach by means of conducting structured interviews on secondary learners (focused group) as a method of data collection was effective. It was possible for the researcher to gain insight into the knowledge of learners and their experiences of sexuality education. The participants' descriptions of their knowledge were reported from an insider's perspective which is typical of qualitative research, hence proving that the methodology selected was suited to achieving the objectives of this study.

### **5.3.2. General discussions of findings**

The data collected was organised into themes and sub-themes and discussed. The conclusions are many and varied, but the underlying essence of their experiences with sexuality education was not enough and needed parents to take better interest in their sexuality especially when it comes to deciding on using contraception. Teenagers needed parents to accept that as teenagers are now grown-ups but needed parents to help teenagers with demands of life. As the person teenagers have known their whole life, felt that parents could trust them as their children more.

## **5.4. RECOMMENDATIONS**

### **5.4.1. RECOMMENDATION 1: Curriculum should offer more information on contraceptive use.**

Firstly the results of this study revealed that learners maintain that sexuality information does give information that helps them to make decision about family planning. However, UNESCO (2012) did a study on the content offered for sexuality education in ten Southern African countries and it found South Africa to be providing most curricula that did not contain enough basic information about male/female condoms and contraception (including emergency contraception). Although knowledge about these topics is a key risk/protective factor for sexual behaviour and health outcomes, many of these curricula were, to differing degrees, essentially focused on abstinence-only, rather than devoting resources and classroom time towards approaches that are more effective and contain

accurate and complete information. Secondly, to help learners identify with that information, the use of popular media can be of benefit. However, teachers still remain the most reliable source. Teachers are likely to be the most skilled and trusted source of information. Evidence provided by UNESCO, WHO, the UNICEF and the World Bank points to a core set of cost-effective activities that can contribute to making schools healthy for children (Fawole, 1999).

Moreover, in many countries, young people have their first sexual experiences while they are still attending school, making the setting even more important as an opportunity to provide education about sexual and reproductive health. In many communities, schools are also social support centres, trusted institutions that can link children, parents, families and communities with other services (for example, health services). Thus, they have the potential to promote communication about important issues between young people, trusted adults and the broader community. One of the participants mentioned that learners are not particularly keen on reading which could be a problem that the department of education will have to address.

#### **5.4.1.2. Recommendation 2: Parents should go with their children to access contraceptives**

Learners are aware of their responsibilities as sexually active people but the challenges still lie in the support that they receive from institutions that offer these contraceptives as well as the involvement of their parents or guardians. Evidence suggests that family environments constitute the basic structure where children's behaviour is manifested, learned, encouraged, and suppressed (Dishion & Patterson, 2006). Parents' roles in the family environment have primarily been to prepare children for adulthood through rules and discipline. Research has clearly demonstrated that parenting accounts for more variance in externalizing behaviors in adolescence than any other one factor (Crosswhite & Kerpelman, 2009; Gavazz, 2006; Simons, Chao, Conjer & Elder, 2001; Dekovic & Janssens, 2003).

- The parents should talk with their children and
- Accompany their children to facilities that would relatively reduce the counter effort that is met at these institutions.

#### **5.4.1.3. Recommendation 3: Emergency contraceptives form part of the curriculum**

The data collected concerning knowledge of emergency contraceptives, learners had little knowledge about it. This is also supported by an early study conducted by Ramathuba (2008) when asked what one could do immediately after having unprotected sex to prevent pregnancy, an alarmingly low sixteen percent (16%) of females reported use of an emergency pill, seventeen percent (17%) did not answer, and five percent (5%) indicated that drinking water, cold drinks or quinine or “washing the private parts well” would act as a deterrent. Ehlers (2003) indicated that 40 out of 60 adolescent mothers in Tshwane, South Africa, did not know about the availability of emergency contraceptives to be taken within 72 hours after unprotected sex.

#### **5.4.2. Recommendations derived from methodological, research design, or other limitations of the study.**

It is recommended that the grouping of participants should be separated and the interviews be held separately per grade and have the interviews per grade separately. Observation was that the grade 8 learners did not contribute much because they were intimidated by the higher grade learners. The researcher did not get much contribution from the grade 8, which could also be the fact they did not have much knowledge on the questions posed to them apart from the previously stated reason.

#### **5.4.3. Recommendations based on delimitations**

There are suspected antecedences of an effective intervention programme of teenage pregnancy; namely, the attitude of learners towards the subject sexuality education. Hence, the prior collection of data of these antecedences from participant would be of added value. Combining the results with the current study would be extremely useful and would have added some methodological rigour to the comparison of programme effects.

#### **5.4.4. Recommendations to investigate issues not supported by the data but relevant to the research problem.**

When participants were asked about what they would do if they realised that they have had unprotected sex, most learners' response had some indication of unproven myth of what to do. One participant said he would wash his penis with a Dettol (a liquid disinfectant). The other would drink Disprin (painkiller tablet) to safeguard against getting

pregnant. If these are kind of beliefs and practices learners hold, that would prompt further investigation. These false ideologies learners hold could explain possibility of ineffectiveness of teenage pregnancies intervention.

## **5.5. Conclusion**

Determining the effectiveness of sexuality education in preventing teenage pregnancy is a way to try and improve the current intervention within the sexuality education offered in the schools. The participants agreed that sexuality education does provide learners with information that could equip them with knowledge of a healthy sexual behaviour. They maintain that this information will be used when they decide to engage in sexual intercourse. However the knowledge participants had which will ultimately decide the learners future was quite limited and it was concerning. They may know the contraceptives that are available but the challenge of accessing them still pose a challenge. The alternatives of accessing contraceptives and the parental involvement may change this phenomenon around.

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## INTERVIEW SCHEDULE

### Interview Protocol

I want to thank you for taking the time to meet with me today. My name is Sinikiwe Sanelisiwe Bhengu. I would like to talk to you about your experiences with your lessons in Life Orientation particularly about the sexuality education section. We are trying to see how the sexuality education has helped you in creating awareness about healthy sexual behaviour in particular and healthy life-style in general. This information will help to capture lessons that can be used in future interventions when it comes to dealing with teenage pregnancy.

The interview should take less than an hour. I will be taping the session because I don't want to miss any of your comments. Although I will be taking some notes during the session, I can't possibly write fast enough to get it all down. Because we're on tape, please be sure to speak up so that we don't miss your comments. All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. Remember, you don't have to talk about anything you don't want to and you may end the interview at any time.

Are there any questions about what I have just explained?

Are you willing to participate in this interview?

\_\_\_\_\_

Interviewee

Witness

Date

\_\_\_\_\_  
Legal guardian (if interviewee is under 18)

## INTERVIEW SCHEDULE

### Inhlolovo Mgomo

Ngithanda ukubonga ngesikhathi senu ukuthi nikwazi ukungibona namuhla. Igama lami ngingu Sinikiwe Sanelisiwe Bhengu. Bengingathanda ukukhuluma nani ngesifundo enisenza lapha esikoleni iLife Orientation, kakhulukazi mayelana neSexuality Education. Esizama ukuthola lapha ukwazi ukuthi iSexuality Education ayasiza yini ukuqwashisa ngokuphathelene ngokuphepha kweziphathelene nocansi kanye nokukhetha nje ukuphila ngendlela enempilo. Lolulwazi luzosiza ekutheni izifundo ezizokwenziwa esikhathini esizayo zikwazi ukumelana nokukhulelwa noma ukukhulelisa kwezingane.

Lenhlolovo izothatha isikhathi esingeqile kwimizuzu engafikile kweyihora. Ngizobe ngiqopha okuzokwenzeka ngalesikhathi ngoba angithandi ukuphuthwa lutho enizokuphawula. Noma ngizobe ngibhala ngalesikhathi, ngekengikwazi ukusheshisa ukuthi ngingabhala yonke into. Ngoba sobesiqopha ngicela niphakamise amazwi khona ngeke sishiye lutho eniliphawulile. Konke enizokuphendula kuzoba imfihlo. Lokho kusho ukuthi enikuphendulayo ngenkathi siqhuba lenhlolovo kuzoba phakathi kwalabantu abantu abaqhuba lolucwaningo futhi soqinisekisa ukuthi ulwazi silufaka kosokuthola ngeke laveze lutho ngawe njengophendulile. Khumbula, awuphoqelekile ukukhuluma uma ungathandi futhi ungayeka noma inini uma ufuna.

Ikhona eminye imibuzo kuko konke loku esengikuchazile?

Uzimisele ukuthatha iqhaza kulenhlolovo?

---

Ohlolwayo

UFakazi

Usuku

---

Obhekelele ingane ngokusemthethweni (uma ohlalwayo enga phansi kwa 18)

## Data collection instrument: Interview Schedule

### Inhlolovo Mgomo- yengane

Date \_\_\_\_\_ (namba)  
yeskole \_\_\_\_\_

### IMIBUZO

#### 1. Questions about the effectiveness of Sexuality education lessons

- a) Ucabanga ukuthi yini inhloso yokuba nesifundo sexuality
- b) Yini oyiqondayo ngokukhulelwa kwezingane ezisafunda isikole?
- c) Ucabanga ukuthi yini eyenza abafundi bezithole bekhulelwe nje?
- d) Ucabanga ukuthi isifundo esiphathelene nokuqwashisa, nokunika kolwazi kubafundi ngezocansi, liyabanika yini ulwazi olubalungisela mhla becabanga ukukwenza ucansi?

#### 2. Knowledge learners have about prevention of pregnancy

- a) Kungabe uyayazi incazelo yokuthi kusho ukuthini ukuzibandakanya ocansini?
- b) Iziphi izibophezelo okumele uzithathe uma usuzibandakanya nocansi?
- c) Ngicela ningitshela ezinye zezinto ozaziyo ezingavimbela ukukhulelwa kwentsha?
- d) Ungakwazi ukuthola usizo lokuvimba ukukhulelwa uma uneminyaka engaki?
- e) Lungatholakala kephi usizo lokuvimbela ukwekhulelwa?
- f) Kulula kangakanani ukufinyelela kulezi zindawo lapho ungathola izivimbeli zokukhulelwa noma ukukhulelisa?
- g) Kumele yini abazali noma okugadile uthole imvume yakhe ukuthi uthathe lezi zivikeli zokukhulelwa or ukwekhulelisa?
- h) Niyaluthola usizo nalokhu ade uzokufuna uma nifika kulezi ndawo
- i) Uyalazi uhlelo oluqhwashisa ngokuzithiba uma kuza ngezokocansi?
- j) Iziphi izimo ogazithola usuwenza ucansi ungazivikelanga?
- k) Ungenza njani uma uzithole usuwenze ucansi ungazivikelanga?

### 3. Izindlela zokuvimbela ukukhulelwa eziqokwa abafundi.

- a)
- b) Nizizwa ngathi lezindlela zokuvikela ukumitha noma ukumithisa siyambisana nempilo oyiphilayoyokuba inagne futhi umfundi?
- c) Yiphi indlela ozwa ngathi ingahambiselana nawe. (awunginikeza isifanekiso)
- d) Uma ucabanga ubani okumele aqikelele ngokuvimba ukukhulelwa kwentsha? Yini ekwenza usho njalo?
- e) Ithini imicabango yenu ngemizamo nezinhlelo zemphakathi yokuvimba kokukhulelwa kwentsha?
- f) Wena ungayisebenzisa yini leyo mzamo? Yini ndaba?

### 4. Imibuzo evalayo

- a) Kukhona ongathandana ukukusicobelela khona njengomfundi othola lesifundo isexuality education?
- b) Ngaphandle kokuthe sakhuluma ngakho namuhla?
- c)

### 5. Isitatimende esivalayo

- Ubabonge ngokuthatha iqhaza kulenhlobo?
- Ubabuze ukuthi bayafuna yini ukubona amakhophi emiphumela
- Qopha noma yini oyibonayo, oyizwayo, nemicabango noma/ nokungenzeka ngalenhlobo

## Data collection instrument: Interview Schedule

### Interview Schedule

Date \_\_\_\_\_ School \_\_\_\_\_

ID \_\_\_\_\_

Pseudonym \_\_\_\_\_

#### Introduction

- Introduce yourself
- Discuss the purpose of the study
- Provide Parental consent, Child/Adolescent Assent and obtain signatures.
- Provide structure of the interview (audio recording, taking notes, and use of pseudonym)
- Ask if they have any questions
- Test audio recording equipment
- SMILE-make the participant feel comfortable

#### QUESTIONS:

##### 1. Questions about the effectiveness of Sexuality education lessons

- a) What do you feel is the main goal of having sexuality education in LO subject
- b) What do you understand about teenage pregnancy?
- c) What do you think makes learners fall pregnant in the first place?
- d) Do you think that sexuality education gives you information that prepares you when you decide to have sex?

##### 2. Knowledge learners have about prevention of pregnancy

- a) Do you know what it means to be sexually active?
- b) What are some of the responsibility of a sexually active person?
- c) Tell me of some of the things you know that can prevent teenage pregnancy?
- d) At what age should you be able to access these pregnancy contraception?
- e) Where can you access those contraceptives?
- f) Is it easy to get the places where you can access the contraceptives ?
- g) Do you have to get your parents' consent to get contraceptives?
- h) Do you get assistance and what you came for when you get to these places?
- i) Do you know of programmes that are running abstinence programs?
- j) What are some of the instances that can lead to having unprotected sex?

k) What would you do when you realise that you have had unprotected sex?

3. Type of prevention measures learners prefer to use.

- a) Do you feel that these preventative measures are suitable for your lifestyle (being young and still attending school)?
- d) What measures do you feel would suit you? (give me an example)
- e) Who do you feel should be responsible for prevention against teenage pregnancy? Why do say that?
- f) What are your thoughts about community initiative programmes that are talking to young teenagers about prevention against teenage pregnancy?
- g) Would you use those initiatives? Why?

4. Concluding questions and statement

- a) Is there anything else you would like to add or share about your experience as the learner who receives sexuality education.
- b) Besides of what we talked about?

5. Concluding Statement

- Thank them for their participation
- Ask if they would like to see a copy of the results
- Record any observations, feelings, thoughts and/or reactions about the interview

## BIOGRAPHICAL QUESTIONNAIRE

Sicela ufunde lesitatimende ngokucophelela utshengise ngaloluphawu (√) endaweni efanele.

### 1.1. Ubulili

Owesilisa	
Owesifazane	

### 1.2. Iminyaka ongena kuyona

12 – 14 years	
14 – 16 “	
16 – 18 “	
18 – over “	

### 1. 3. Ibanga

a) 8	
b) 9	
c) 10	
d) 11	
e) 12	

### 1.4. Uhlanga

a) Black	
b) White	
c) Indian	
d) Coloured	

### 1.5. Ulwimi Lwasekhaya

IsiZulu	
IsiNgisi	
IsiXhosa	
Other (Specify)	

### 1.6. Ulwimi ofundiswa ngalo

IsiZulu	
IsiNgisi	
IsiXhosa	
Other (Specify)	

### 1.7. Uhlobo Lomndeni

Abazali bobabili	
Umzali oyendwa	

<b>Kukhona okugadile</b>	
<b>Okunye(Cacisa)</b>	

## BIOGRAPHICAL QUESTIONNAIRE

Please read each statement carefully and indicate by a tick (✓) in the appropriate space(s) provided below.

### 1.1 Gender

<input type="checkbox"/>	Male
<input type="checkbox"/>	Female

### 1.2 Age Group

12-14 Years	<input type="checkbox"/>
14-16 "	<input type="checkbox"/>
16-18 "	<input type="checkbox"/>
18 and above "	<input type="checkbox"/>

### 1.3 Present grade

a) 8	<input type="checkbox"/>
b) 9	<input type="checkbox"/>
c) 10	<input type="checkbox"/>
d) 11	<input type="checkbox"/>
e) 12	<input type="checkbox"/>

### 1.4. Race

a) black	<input type="checkbox"/>
b) white	<input type="checkbox"/>
c) indian	<input type="checkbox"/>
d) coloured	<input type="checkbox"/>

### 1.5. Home Language

<b>Isizulu</b>	
<b>Xhosa</b>	
<b>English</b>	
<b>Other(specify)</b>	

### 1.6. Language of instruction in school

<b>Isizulu</b>	
<b>Xhosa</b>	
<b>English</b>	
<b>Other(specify)</b>	

### 1.6. Type of family

<b>Both parents</b>	
<b>Single Parent</b>	
<b>Guardian</b>	
<b>Other</b>	

### 1.7 Number of siblings

<b>0</b>	
<b>1– 2</b>	
<b>3 -5</b>	
<b>6 and above</b>	

## Appendix 3: Ethical Clearance Certificate

**UNIVERSITY OF ZULULAND  
RESEARCH ETHICS COMMITTEE**  
(Reg No: UZREC 171110-030)



**RESEARCH & INNOVATION**

Website: <http://www.unizulu.ac.za>  
Private Bag X1001  
KwaDlangezwa 3886  
Tel: 035 902 6887  
Fax: 035 902 6222  
Email: [ManqeleS@unizulu.ac.za](mailto:ManqeleS@unizulu.ac.za)

### ETHICAL CLEARANCE CERTIFICATE

Certificate Number	UZREC 171110-030 PGM 2015/181				
Project Title	Effectiveness of sexuality education in preventing teenage pregnancy in Pinetown district secondary schools				
Principal Researcher/ Investigator	SS Bhengu				
Supervisor and Co-supervisor	Prof DR Nzima		Mrs NN Mbatha		
Department	Educational Psychology & Special Education				
Nature of Project	Honours/4 <sup>th</sup> Year	Master's	x	Doctoral	Departmental

The University of Zululand's Research Ethics Committee (UZREC) hereby gives ethical approval in respect of the undertakings contained in the above-mentioned project proposal and the documents listed on page 2 of this Certificate.

**Special conditions:**

- (1) The Principal Researcher must report to the UZREC in the prescribed format, where applicable, annually and at the end of the project, in respect of ethical compliance.
- (2) Documents marked "To be submitted" (see page 2) must be presented for ethical clearance before any data collection can commence.

The Researcher may therefore commence with the research as from the date of this Certificate, using the reference number indicated above, but may not conduct any data collection using research instruments that are yet to be approved.

Please note that the UZREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the documents that were presented to the UZREC
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

**Classification:**

Data collection	Animals	Human Health	Children	Vulnerable pp.	Other
X					
Low Risk		Medium Risk		High Risk	
		X			

The table below indicates which documents the UZREC considered in granting this Certificate and which documents, if any, still require ethical clearance. (Please note that this is not a closed list and should new instruments be developed, these would require approval.)

Documents	Considered	To be submitted	Not required
Faculty Research Ethics Committee recommendation	X		
Animal Research Ethics Committee recommendation			X
Health Research Ethics Committee recommendation			X
Ethical clearance application form	X		
Project registration proposal	X		
Informed consent from participants	X		
Informed consent from parent/guardian			X
Permission for access to sites/information/participants	X		
Permission to use documents/copyright clearance			X
Data collection/survey instrument/questionnaire	X		
Data collection instrument in appropriate language		Only if necessary	
Other data collection instruments		Only if used	

The UZREC retains the right to

- Withdraw or amend this Certificate if
  - Any unethical principles or practices are revealed or suspected
  - Relevant information has been withheld or misrepresented
  - Regulatory changes of whatsoever nature so require
  - The conditions contained in this Certificate have not been adhered to
  
- Request access to any information or data at any time during the course or after completion of the project

The UZREC wishes the researcher well in conducting the research.



**Professor Nokuthula Kunene**  
 Chairperson: University Research Ethics Committee  
 06 November 2015



## Appendix 4: Letter from the Department of Education



# education

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Department:

Education

**PROVINCE OF KWAZULU-NATAL**

**KWAZULU-NATAL DEPARTMENT OF EDUCATION** POSTAL: Private Bag X 9137, Pietermaritzburg, 3200, KwaZulu-Natal, Republic of South Africa PHYSICAL: 247 Burger Street, Anton Lembede House, Pietermaritzburg, 3201. Tel. 033 392 1004 EMAIL ADDRESS: kehologile.connie@kzndoe.gov.za / Nomangisi.Ngubane@kzndoe.gov.za CALL CENTRE: 0860 596 363; Fax: 033 392 1203 WEBSITE: WWW.kzneducation.gov.za

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Enquiries: Nomangisi Ngubane Tel: 033 392 1004 Ref.:2/4/8/560

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Ms SS Bhengu  
K 667 Sakabula Road  
KWAMASHU  
4360

Dear Ms Bhengu

**PERMISSION TO CONDUCT RESEARCH IN THE KZN DoE INSTITUTIONS**

Your application to conduct research entitled: **“EFFECTIVENESS OF SEXUALITY EDUCATION IN PREVENTING TEENAGE PREGNANCY IN THE PINETOWN DISTRICT SECONDARY SCHOOLS”**, in the KwaZulu-Natal Department of Education Institutions has been approved. The conditions of the approval are as follows:

1. The researcher will make all the arrangements concerning the research and interviews.
2. The researcher must ensure that Educator and learning programmes are not interrupted.
3. Interviews are not conducted during the time of writing examinations in schools.
4. Learners, Educators, Schools and Institutions are not identifiable in any way from the results of the research.
5. A copy of this letter is submitted to District Managers, Principals and Heads of Institutions where the intended research and interviews are to be conducted.
6. The period of investigation is limited to the period from 28 October 2015 to 31 November 2016.
7. Your research and interviews will be limited to the schools you have proposed and approved by the Head of Department. Please note that Principals, Educators, Departmental Officials and Learners are under no obligation to participate or assist you in your investigation.
8. Should you wish to extend the period of your survey at the school(s), please contact Miss Connie Kehologile at the contact numbers below.

9. Upon completion of the research, a brief summary of the findings, recommendations or a full report / dissertation / thesis must be submitted to the research office of the Department. Please address it to The Office of the HOD, Private Bag X9137, Pietermaritzburg, 3200.

10. Please note that your research and interviews will be limited to schools and institutions in KwaZulu- Natal Department of Education.

Pinetown District

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**Nkosinathi S.P. Sishi, PhD**  
**Head of Department: Education**  
**Date: 28 October 2015**

## **ANNEXURE A: PARTICIPANT INFORMED CONSENT DECLARATION**

### **INFORMED CONSENT DECLARATION (Participant)**

**Project Title: Effectiveness of Sexuality Education in preventing teenage pregnancy in the Pinetown district secondary schools.**

**Sinikiwe Sanelisiwe Bhengu (*name of researcher/person administering the research instrument*) from the Department of Educational Psychology, University of Zululand has requested my permission to participate in the above-mentioned research project.**

The nature and the purpose of the research project, and of this informed consent declaration have been explained to me in a language that I understand.

I am aware that:

1. The purpose of the research project is to determine the effectiveness of sexuality education as part of Life Orientation subject in raising awareness about healthy sexual behavior in particular and healthy life-style in general.
2. The University of Zululand has given ethical clearance to this research project and I have seen/ may request to see the clearance certificate.
3. By participating in this research project I will be contributing towards the element in Sexuality Education that is missing that can contribute in reducing Teenage pregnancy. The new knowledge will allow for modification of the current sexuality education. (***state expected value or benefits to society or individuals that will arise from the research***)
4. I will participate in the project by conducting interviews. (***state full details of what the participant will be doing***)
5. My participation is entirely voluntary and should I at any stage wish to withdraw from participating further, I may do so without any negative consequences.
6. I will not be compensated for participating in the research, but my out-of-pocket expenses will be reimbursed. (***Should there be compensation, provide details***)
7. There may be risks associated with my participation in the project. I am aware that
  - a. the following risks are associated with my participation: No risks (***state full details of risks associated with the participation***)

- b. the following steps have been taken to prevent the risks: .....
  - c. there is a nil % chance of the risk materialising
8. The researcher intends publishing the research results in the form of a dissertation and an article in a journal. However, confidentiality and anonymity of records will be maintained and that my name and identity will not be revealed to anyone who has not been involved in the conduct of the research.
  9. I will not receive feedback/will receive feedback in the form of ..... regarding the results obtained during the study.
  10. Any further questions that I might have concerning the research or my participation will be answered by S.S. Bhengu (0714616208).....  
**(provide name and contact details)**
  11. By signing this informed consent declaration I am not waiving any legal claims, rights or remedies.
  12. A copy of this informed consent declaration will be given to me, and the original will be kept on record.

I, **Sinikiwe Sanelisiwe Bhengu** have read the above information / confirm that the above information has been explained to me in a language that I understand and I am aware of this document's contents. I have asked all questions that I wished to ask and these have been answered to my satisfaction. I fully understand what is expected of me during the research.

I have not been pressurised in any way and I voluntarily agree to participate in the above-mentioned project.

.....  
**Participant's signature**

.....  
**Date**

**ANNEXURE B: RESEARCHER'S DECLARATION**

**RESEARCHER'S DECLARATION**

I, .....declare that:

- I explained the information in this document to  
.....
- requested him/her to ask questions if anything was unclear and I have answered them as best I can
- I am satisfied that s/he sufficiently understands all aspects of the research so as to make an informed decision on whether or not to participate.
- The conversation took place in isiZulu / English
- I used/did not use an interpreter

.....  
**Researcher's signature**

.....  
**Date**

## **ANNEXURE D: PARENT AND GUARDIAN'S INFORMED CONSENT DECLARATION**

### **INFORMED CONSENT DECLARATION (Parent or Guardian)**

**Project Title: Effectiveness of Sexuality Education in preventing teenage pregnancy in the Pinetown district secondary schools**

Sinikiwe Sanelisiwe Bhengu from the Department of Educational Psychology and Special Education, University of Zululand has requested my permission to allow my child/ ward to participate in the above-mentioned research project.

The nature and the purpose of the research project, and of this informed consent declaration have been explained to me in a language that I understand.

I am aware that:

13. The purpose of the research project is to see that the sexuality education is effective as an intervention in dealing with teenage pregnancy.
14. The University of Zululand has given ethical clearance to this research project and I have seen/ may request to see the clearance certificate.
15. By participating in this research project my child/ward will be contributing towards the valued information needed to deal with teenage pregnancy.
16. My child/ward will participate in the project by answering questions during the interview session.
17. My child's/ward's participation is entirely voluntary and if my child/ward is older than seven (7) years, s/he must also agree to participate.
18. Should I or my child/ward at any stage wish to withdraw my child/ward from participating further, we may do so without any negative consequences.
19. My child/ward may be asked to withdraw from the research before it has finished if the researcher or any other appropriate person feels it is in my child's/ward's best interests, or if my child/ward does not follow instructions.
20. Neither my child/ward nor I will be compensated for participating in the research. (***Should there be compensation, provide details***) the travelling expenses, lunch since the interviews will be conducted on the weekend when there is no school nutrition program.
21. There may be risks associated with my child's/ward's participation in the project. I am aware that
  - a. the following risks are associated with participation: Some of the questions

may ask questions that may make you feel uncomfortable.

- b. the following steps have been taken to prevent the risks. The learner may choose not to respond to the questions.
- c. there is a 0% chance of the risk materializing

22. The researcher intends publishing the research results in the form of a journal. However, confidentiality and anonymity of records will be maintained and that my or my child's/ward's name and identity will not be revealed to anyone who has not been involved in the conduct of the research.

23. I will not receive feedback/will receive feedback in the form of journal regarding the results obtained during the study.

24. Any further questions that I might have concerning the research or my participation will be answered by the researcher Sinikiwe Sanelisiwe Bhengu cell number 0714616208

25. By signing this informed consent declaration I am not waiving any legal claims, rights or remedies that I or my child/ward may have.

26. A copy of this informed consent declaration will be given to me, and the original will be kept on record.

I, ..... have read the above information / confirm that the above information has been explained to me in a language that I understand and I am aware of this document's contents. I have asked all questions that I wished to ask and these have been answered to my satisfaction. I fully understand what is expected of my child/ward during the research.

I have not been pressurised in any way to let my child/ward take part. By signing below, I voluntarily agree that my child/ward ..... (**insert name of child/ward**), who is ..... years old, may participate in the above-mentioned research project.

.....  
**Parent/Guardian's signature**

.....  
**Date**

## **ANNEXURE D: PARENT AND GUARDIAN'S INFORMED CONSENT DECLARATION**

### **INFORMED CONSENT DECLARATION (Parent or Guardian)**

**Isihloko Socwango: Ukuhlaziya igalelo lwesifundo iSexuality education ekunqandeni ukukhulelwa kwentsha efundayo.**

uSinikiwe Sanelisiwe Bhengu ovela kwi Department of Educational Psychology, University of Zululand ucele imvume yokuthi ngivumele ingane yami / engiyigadile ukuthi athathe iqhaza kulocwaningo oselwushiwo lapha ngaphezulu.

Inqhikithi nenhloso yalolucwaningo kanye nemvumelwano engizivumelayo ukuthi ngichazelwe ngayo ngolwimi engilugqondayo.

Ngiyazi ukuthi:

14. Inhloso yalomsebenzi walolucwaningo ukuthola ukuthi isifundo iSexuality Education lunalo yini igalelo ekulweni nokukhulelwa kwabantwana abasamajongosi.
15. IUniversity Of Zululand inikezile ukuthi yanelisekile ngalolucwaningo oluzokwenziwa ngokubonela ukuthi alulimazani.
16. Ngokubamba iqhaza kulolucwaningo umntwana wami/ engimgadile usiza ekutheni esikhathini esizayo kwazeke ukuthi kubonakale izinto kulesifundo seSexuality Education ezingasiza silwisane nokukhulelwa kwabantwana abasangamajongosi.
17. Ingane yami/engimgadile ozobe ethatha iqhaza ngokuphendula imibuzo yenhlolovo emayelana nalolucwaningo.
18. Ingane yami/ engiyigadile ukuthatha kwayo iqhaza kuzisukela kuyo futhi uma ingane yami/engiyigadile ingaphezulu kweminyaka eyisikhombisa (7) , kuzomele azivumele ukuthatha iqhaza
19. Uma kungenzeka mina noma ingane yami/engiyigadile sifisa ukuphuma noma inini ingane yami/engiyigadile ekuqhubekeni ukuthatha iqhaza singengenxa lokhu ngaphandle kubonakale njengonto embi.
20. Ingane yami/engiyigadile kungenzeka icelwe ukuthi ikhishwe kucwaningo phambi kokuthi luphele uma umcwaningi noma ubani onegunya ozwa ngathi ingane yami noma engimgadile kuyobe kucatshangelwa yona noma ingane yami/engiyigadile ingalandeli imihlahlandlela.
21. Ngeke mina nengane yami/engimgadile sikhokhelwe ngokuthatha iqhaza. Ngaphandle kwemali yokugibelisa nokudla ingane yami/ engimgadile ngoba ucwaningo luzobe lwenziwa ngempelasonto uhlelo lokudla lwesikole luzobe lungekho.

22. Kungenzeka kubekhona ubungozi obungehlela ingane yami/ engimgadile ekuthatheni iqhaza kulolucwaningo. Ngiyazi ukuthi
- ubungozi obulandelayo obuhlangene nalolucwaningo ukuthi: Imibuzo ifuna ukwazi iminigwane ngezinto ezingazwela
  - izinyathelo ezilandayo zithathiwe ukuvimbela ubungozi: umfundi angakwazi ukungaphenduli uma ezizwa engakhululekile futhi ayeke ucwaningo uma ethanda.
  - Kukhona isilinganiselo esi 0% esingaqhamuka.
23. Ucwano luzimisele ukushicilela imiphumela yocwano ngohlelo lwe jenali ezothiolakala emtata mabhuku. Kodwake ukwethembeka kanye nokufihla okuqoshiwe kuzo gcinwa ukuthi kungazeki ukuthi kutholwe kwingane yami/ engimgadile futhi kungatshelwa muntu ukuthi uke wazihlanganisa nocwano.
24. Ngeke ngithole imininigwane/ ngizoyithola imininigwane ngohlobo lwe jenali mayelana nemiphumela yocwano..
25. Noma iyiphi imibuzo engingaba nayo mayelana nocwano noma ukuthatha iqhaza luzophendulwa uSinikiwe Sanelisiwe Bhengu kule namba 0714616208
26. Ngokusayina lemvume engazisiwe ngayo angeke ngifune okungokomthetho, ilungelo noma ukunxesezelwa loku mina noma ingane yami/engiyigadile esingakuthola.
27. Ikhophi yalesivumelwano engazisiwe ngaso izonikezwa mina futhi uqobo lwayo luzogcinwa nokunye okuqoshiwe.

Mina, .....(faka igama **Mzali/umbhekele**) Sengifundile imininigwane engenhla /ngiqinisekisa ukuthi ngichazeliwe ngolwimi engiluqondayo futhi ngiyazi lomqulu umayelana nani. Ngiyibuzile yonke imibuzo ebengifisa ukuyibuza futhi yonke iphendulekile ngokungigcwilisayo. Ngियाqundisisa ukuthi kudingekani enganeni yami/ engiyigadile ngesikhathi socwano.

Angizange ngiphoqeleke nangayiphi indlela ukuthi ngenze ingane yami/engiyigadile ukuthi ithathe iqhaza. Ngokucikica lapha ngaphansi ngizivumela ngokwami ukuthi ingane yami /engiyigadile ..... (faka igama **lengane/omgadile**), .....weminyaka, angathatha iqhaza kulolucwaningo olushiwo lapha ngaphezulu.

.....  
**Mzali/Obhekele signature**

.....  
**Usuku**

**ANNEXURE E: CHILD PARTICIPANT'S CONSENT FORM**

**INFORMED CONSENT DECLARATION  
(Child participant)**

**(Acknowledge reference to Stellenbosch and Fort Hare)**



**Project Title:** *The effectiveness of sexuality education in preventing Teenage pregnancy*

**Researcher's name:** Sinikiwe Sanelisiwe Bhengu

**Name of participant:**

.....

1. Has the researcher explained what s/he will be doing and wants you to do?

YES

NO

2. Has the researcher explained why s/he wants you to take part?

YES

NO

3. Do you understand what the research wants to do

YES

NO

4. Do you know if anything good or bad can happen to you during the research?

YES

NO

5. Do you know that your name and what you say will be kept a secret from other people?

YES

NO

6. Did you ask the researcher any questions about the research?

YES

NO

7. Has the researcher answered all your questions?

YES

NO

8. Do you understand that you can refuse to participate if you do not want to take part and that nothing will happen to you if you refuse?

YES

NO

9. Do you understand that you may pull out of the study at any time if you no longer want to continue?

YES

NO

10. Do you know who to talk to if you are worried or have any other questions to ask?

YES

NO

11. Has anyone forced or put pressure on you to take part in this research?

YES

NO

12. Are you willing to take part in the research?

YES

NO

\_\_\_\_\_  
**Signature of Child**

\_\_\_\_\_  
**Date**



**ACCESS LETTER TO SCHOOLS**

**ANNEXURE E: CHILD PARTICIPANT'S CONSENT FORM**

**Isivumelwano semvumo ocaciselwe ngaso  
(Ingane ethatha iqhaza kucwangingo)**



**Isihloko Socwangingo: Ukuhlaziya igalelo lwesifundo iSexuality education ekunqandeni ukukhulelwa kwentsha esafunda isikole**

**Igama Lomcwaningi: SinikiweSanelisiwe Bhengu**

**Igama lothatha iqhaza  
ocwangingweni: \_\_\_\_\_**

1. Usekutshelile umcwaningi ngokuzoba ukwenza futhi udingeka ukuthi wenzeni??

YEBO

CHA

2. Usekuchazelile yini umcwaningi ukuthi ufunelani uthathe iqhaza?

YEBO

CHA

3. Uyazi ukuthi ucwangingo lufuna ukwenzani?

YEBO

CHA

4. Uyazi yini kukhona okubi okungakwehlela kulolucwangingo?

YEBO

CHA

5. Uyazi ukuthi igama lakho nokushoyo kuzoba imfihlo kwabanye abantu?

YEBO

CHA

6. Kukhona yini imibuzo oke wayibuza umcwangingi mayelana nalolucwaningo?

YEBO

CHA

7. Umcwangingi uyiphendulile yini yonke imibuzo yakho?

YEBO

CHA

8. Uyaqonda ukuthi ungala ukuthatha iqhaza uma ungathandi futshi ngeke kwenzeka lutho kuwena uma unqaba?

YEBO

CHA

9. Uyaqonda ukuthi ungaphuma kucwaningo noma ininuma ungasathandi ukuqhubeka?

YEBO

CHA

10. Uyazi ekumele ukhulume naye uma kukhona okhathazeke ngakho noma oneminye imibuzo ofisa ukuyibuza?

YEBO

CHA

11. Kukhona okuphoqile noma okucindezile ukuthi uthathe iqhaza kulolucwaningo?

YEBO

CHA

12. Uzimisele ukuthatha iqhaza kulolucwaningo?

YEBO

CHA

---

**Signature yeNgane**

---

**Usuku**



## **ANNEXURE F: CHILD PARTICIPANT'S CONSENT CHECKLIST**

### **INFORMED CONSENT CHECKLIST (Child participant)**

**Project Title: Effectiveness of Sexuality Education in preventing teenage pregnancy in the Pinetown district secondary schools**

**Researcher's name: Sinikiwe Sanelisiwe Bhengu**

**ADDRESS: K845 Sakabula Road, KwaMashu ,4359**

**CONTACT NUMBER: 0714616208**

#### **What is RESEARCH**

**Research is something we do to find new knowledge about the way things (and people) work. We use research projects or studies to help us find out more about things such as teenage pregnancy. Research also helps us to find better ways of doing things or helping or treating people.**

#### **What is this research project all about?**

This research is about sexuality education if it is effective as an intervention in dealing with teenage pregnancy in schools.

#### **The duration of the research project?**

*The Research will not be too long . It will take forty (40) minutes not exceeding an hour but we may exceed the time due to unforeseen circumstance, but we will try and keep within the agreed duration.*

#### **Why have I been invited to take part in this research project?**

We want to hear you view about sexuality education as an intervention in dealing with teenage pregnancy in schools

#### **Confidentiality**

*the information we are going to collect from you will only be seen by those who were involved in the study. No other person will have access to your personal information.*

#### **If a sponsor is to be involved**

**Who is doing the research?**

*Identify yourself and explain who you work for and/or why you are doing the project I am a student at The University of Zululand, I'm doing a study to find out more information understand the issue that concerns the department of education through the life orientation which is trying intervene in dealing with teenage pregnancy with sexuality program*

**What will happen to me in this study?**

*I will start by explaining the procedures to allow for the interview to go accordingly. All that will be discussed during the interview must not leave the room. Everyone's contributions are valued. We will have small games so that everyone will relax and can get to know each other better which will then signal the start of the interview. Remember that you are allowed to withdraw at anytime you do not want to do not it anymore.*

**Can anything bad happen to me?**

*There may be questions you may not feel comfortable with, remember you are not forced to answer them.*

**Who else is involved in the study?**

*There is fifteen of you I all together which consist of three grade 8, three grade 9 , three grade 10, three grade 11 and three grade 12. You are coming from the same school.*

**Can anything good happen to me?**

*There is lot information you can get explaining things to you and you also get a chance to hear what other learners about things you have always wanted to know about.*

**Will anyone know I am in the study?**

*. Your participation will be kept confidential*

**Who can I talk to about the study?** *You may contact The researcher Sinikiwe Sanelisiwe Bhengu, cell number 0714616208*

**What if I do not want to do this?**

*You are allowed to refuse to be part of the study regardless that that your parents agreed.*

## **ANNEXURE F: IZINTO EKUZOMELE ZIBEKHONA NGENGANE ETHATHA IQHAZA OCWANINGWENI**

### **IZINTO EZIZOBA KHONA KWIMVUMO ECHAZELEKISIWE (Ingane ethatha iqhaza)**

**Isihloko Socwaningo: Ukuhlaziya igalelo lwesifundo iSexuality education ekunqandeni ukukhulelwa kwentsha esafunda**

**Igama Lomcwaningo: Sinikiwe Sanelisiwe Bhengu**

**Ikheli: K845 Sakabula Road, KwaMashu ,4359**

**Inamba yokuxhumana: 0714616208**

**Yini Ucwanningo?**

**Ucwanningo into eyenza sithole ulwazi olusha nezindlela (kanye nabantu) iinto ezisebenza ngayo. Sisebenzisa ucwanningo lususiza ekutheni okuningi njengozinto ezifana nekukhulelwa kwentsha esafundayo**

**Locwanningo lumayelana nani?**

*Lolucwanningo lumayelana nokuthola ukuthi isifundo iSexuality education iyasebenza ekubhekeleni kokukhulelwa kwezingane ezikoleni.*

**IIsikhathi esizothathwa ilolucwanningo?**

*Ucwanningo ngeke luthathe isikhathi esdei. Imizuzu engu engamashumi amne (40) engeke idlule kwe yihora. Kodwa uma isikhathi seqa ngenxa yokwenzeka okukade kungalindelekile kodwa sizozama kungadluli kwisikhathi esivumelene ngaso.*

**Ngisitholeleni lesimemo sokuthatha iqhaza kulolucwanningo**

*Sifuna ukuzwa uvo lwakho ngesexuality education ngokungenelela ukubhekana nokukhulelwa kwentsha ezikoleni*

**Ukuphepha kweminingwane yakho?**

*Kuko konke esizokuthola kuwe kuzobonwa kuphela abazokwenza ucwanningo. Akekho ongasiye wabanye abasohlweni lwabantu bocwanningo ozokwazi ukuthi abone iminingwane yakho*

**Uma kukhona aabantu abafake uxhaso ngalolucwanningo**

*Akukho bafake uxhaso lwalocwanningo*

### **Ubani uwenza lolucwaningo**

*Mina ngingumfundi waseUniversity of Zululand ngenza ucwaningo ngoba ngifisa ukwandisa ulwazi lokuqonda enye indaba ephethe umnyango wezemfundo ngesifundo seLife orientation esizama to ukungenelela ukubhekana nokukhulelwa kwentsha ezikoleni ngohlelo lweSexuality education .*

### **Yini ezokwenzeka kulocwaningo**

*Sizoqala ngokucacisa ngemigomo ezosilawula okuzokwenza inhlokovo ihambe kahle. Konke esizobe sikuxoxa lapha akumele kuphume ngaphandle. Yonke imibono yomuntu ozebe khona ibalulekile. Sizoba nemidlalo emincane ezosenza sikhululeke futhi sazane futhi isiyisele kwisihloko sosuku. Mese ucwaningi eyaqala ngemibuzo. Ukhumbule njalo ukuthi uvumelekile ukushenxa uma usufisa noma uzizwa ukuthi awusathandi.*

### **Kukhona into embi engenzeka kumina**

*.Kukhona mhlambe imibuzo ongayithola uyizzwa inkwenza ungakhululeki, khumbula awuphoqelekile ukuyiphendula.*

### **Ubani futhi omunye okulolucwaningo**

*Uma seniphelele njengabathatha iqhaza kulolucwaningo niyishumi nanhlanu (15) abathathu (3) garde 8, three(3) grade 9 three(3) grade 10 three(3) grade 11 three(3) grade 12 bonke bangabafundi basekoleni sakho*

### **Kukhona okuhle okungenzeka kumina?**

*Kukhona ulwazi ongachazekisela kulo, uzozwa nawe izimvo zabanye abafundi ngezinto obufisa ukuzazi.*

### **Kukhona ongazi ukuthi ngikucwaningo**

*Ukuthatha kwakho iqhaza kuzogcinwa ngikuthembeka futhi kuzobayimfihlo.*

### **Ongaxhumana naye uma une mibuzo ngocwaningo**

*Ungaxhumana nomcwaningi Sinikiwe Sanelisiwe Bhengu ilena inamba yakhe 0714616208*

### **Kungabanjani uma ngingasathandi ukukwenza lokhu**

*Uvumelekile ukwala ukwenza lolucwaningo phezu kokuba abazali/okobhekele evumile.*

University of Zululand  
PO Box X1001  
KwaDIngezwa  
3886

The Principal  
.....

Dear Ms/Mr .....

### **REQUEST FOR PERMISSION TO CONDUCT RESEARCH**

I am a registered Master's student in the Department of **Educational Psychology and Special Education** at the University of Zululand. My supervisors are **Prof D.R. Nzima and Mrs NN Mbatha**

The proposed topic of my research is: ***Effectiveness of Sexuality Education in preventing teenage pregnancy in the Pinetown district secondary schools.***

The objectives of the study are: among other things

- (a) To determine the effectiveness of sexuality education in preventing teenage pregnancy among secondary school learners in the Pinetown district.
- (b) To establish the type of knowledge learners have about prevention of teenage pregnancy.

I am hereby seeking your consent to conduct interviews with learners at your school. To assist you in reaching a decision, I have attached to this letter:

- (a) A copy of an ethical clearance certificate issued by the University
- (b) A copy the research instruments which I intend using in my research

Should you require any further information, please do not hesitate to contact me or my supervisor. Our contact details are as follows: Sinikiwe Bhengu: email: [teghele@gmail.co.za](mailto:teghele@gmail.co.za) cell: **0714616208**

Upon completion of the study, I undertake to provide you with a bound copy of the dissertation.

Your permission to conduct this study will be greatly appreciated.

Yours sincerely,

**Signature:**

**Name:**

## ACCESS LETTER TO SCHOOLS

University of Zululand  
PO Box X1001  
KwaDlangezwa  
3886

Department of Education  
The District Manager  
.....

Dear Ms/Mr .....

### REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am a registered Master's student in the Department of **Educational Psychology and Special Education** at the University of Zululand. My supervisors are **Prof D.R. Nzima and Mrs NN Mbatha**

The proposed topic of my research is: ***Effectiveness of Sexuality Education in preventing teenage pregnancy in the Pinetown district secondary schools.***

The objectives of the study are: among other things

- (c) To determine the effectiveness of sexuality education in preventing teenage pregnancy among secondary school learners in the Pinetown district.
- (d) To establish the type of knowledge learners have about prevention of teenage pregnancy.

I am hereby seeking your consent to conduct interviews with learners at your school. To assist you in reaching a decision, I have attached to this letter:

- (c) A copy of an ethical clearance certificate issued by the University
- (d) A copy the research instruments which I intend using in my research

Should you require any further information, please do not hesitate to contact me or my supervisor. Our contact details are as follows: Sinikiwe Bhengu: email: [teghele@gmail.co.za](mailto:teghele@gmail.co.za) cell: **0714616208**

Upon completion of the study, I undertake to provide you with a bound copy of the dissertation.

Your permission to conduct this study will be greatly appreciated.

Yours sincerely,

**Signature:**

**Name:**

**a) What do you feel is the main goal of having sexuality education in LO subject**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	R:1 To educate learners about their sexuality and after they become sexual	Create awareness
	or when they start thinking about sex that they must using protection when they have sex.	Use protection
Respondent 2	Since engaging in sexual intercourse is part of life or that how the public refer to it as,	Sex is natural
	I think that educating learners about sexuality , it helps the learners to know that in engaging in sex makes know of the consequences of having sex	Consequences of having sex
	It makes them aware when they are ready to engage in sexual intercourse.	awareness
	Example a 14 year old is not matured enough to have sex but when it happens that they do their bones as I understand it as I do life science.	Sexual immaturity
	Their bones are not ready to carry out a pregnancy whereas a person who is 19 to20 years that person physiologically is ready to carry out a pregnancy.	Sexual maturity
	The 13 year old who engages in sexual intercourse her life is in danger.	Dangers of underage sex
	My knowledge of life science and Life orientation helped me with that information.	Acquired information
Respondent 3	The main goal is to reduce the teenage pregnancy rate that's why we are taught sexuality education.	The reduction of teenage pregnancy
	Adolescence is a tricky stage for teenagers, you go through a lot emotional stuff	Awareness
	and you need someone to talk to about those things and easy wthey you speak to a teacher about those things whereas going at ait alone	Communication
	or speaking to your parent. Because your parent will just wouldn't understand	Having someone to talk to either than parents

	and would tell you that you are still young to be talking about such things.	Someone to understand what they going through
Respondent 4	I think it's to prevent unplanned pregnancy by teens.	Intervention to teenage pregnancy
Respondent 5	I suppose it there to try and reduce teenage pregnancy rate.	Intervention to teenage pregnancy
Respondent 6	I think it is to make us aware that there is pregnancy and about any sexual activity one could find themselves involve in.	Awareness about consequences of sex, mostly pregnancy
Respondent 7	Sexuality education helps us on how to look after ourselves and guide on when we want engage in sexual intercourse about its effect.	Offers guidance on ones sexuality
	I t guides us as well not to get any diseases.	awareness
Respondent 8	Sexuality Education helps you to have knowledge that when you engage in sexual intercourse what results are going to come out of it and obtain.	awareness

**b) What do you understand about teenage pregnancy?**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	It is a pregnancy that happens in the teenage years and it's a pregnancy that is mostly unplanned.	Pregnancy that happens in the teenage years
Respondent 2	Teenage pregnancy is like a fashion because young children like sex They have sex without a condom and they get pregnant.	A fashion trend Having unprotected sex
Respondent 3	Even though teenage pregnancy is unplanned, sexuality education has taught us about which stage that you can get pregnant and at school we get so much information.	Not using information given. Not using information given
	I think teenage pregnancy is due to being careless and wanting to be	Carelessness while

	experimental.	experimenting
	When you are experimenting going around trying out things.	Happens when one is Experimenting
	There is this ideology that if you are a virgin and having sex for the first time that you should not use a condom.	Due to myth of first time encounter one does not get pregnant
	Whereas you know that when you do not use a condom you are going to get pregnant.	False victims to certain ideologies
	So even though it's not a planned pregnancy still it can be blamed on anyone else but the teenager.	unplanned pregnancy by teenagers
Respondent 4	What I understand about this is that they like life and they can succumb to peer pressure.	Peer pressure
	As well as media also can cause teenage pregnancy	Influence of media
Respondent 5	I think they are not well informed about the consequences of teenage pregnancy and that why there is such a high rate.	Learners who are not aware about pregnancy
	They need to be informed about teenage pregnancy.	Learners who are not aware about pregnancy
Respondent 6	They are mostly influenced by their friends and they get pregnant unprepared	Peer pressure
	like they get drunk and engage in sex.	Getting drunk and have sex
Respondent 7	I Think the main cause of teenage pregnancy its these rights that we have.	Abusing Children Rights
	A few months back there was this talk about a new law allows young children can start having sex at the age of thirteen.	Introduction of new laws
	If there is such a law that allow children start to have sex at the age of thirteen	Having sex at a young age
	they are not reducing teenage pregnancy but it is increasing it.	Counteracting laws
	Disease are going to spread, and when start at the age of thirteen they are going to start to experience things and they contract diseases and also	Consequences of unprotected sex

	get pregnant.	
Respondent 8	You suppose protection like condoms or contraceptives.	Not using information on prevention

c) What do you think makes learners fall pregnant in the first place?

Respondent	Responses	Themes
Respondent 1	Because some of the learners coheres each other into having sex	Influence of friends
	and when people they do something they do not think when they see other people but people are not the same.	Influence of friends
	Maybe that person can do something and not get pregnant but when the other tries it	Influence of friends
	and falls pregnant after just doing for the first time and they end up getting pregnant.	Influence of friends
Respondent 2	When learners are not taught of how to behave when they are sexually active.	Not having enough information
	Others can say that its mostly peer pressure that contributes but talking helps.	Peer pressure but talking helps
	Like when you talk to your parent about to behave because emotions and hormones are there.	Emotions and hormones
	You just need to control and put them at the level where you know that whatever you decide to do won't come back and bite you back.	Lack of self-control
	Knowing that I'm doing this and there won't be any consequences that I can't face	Feels invincible
	It's mostly about peer pressure and taking.	Peer pressure
	The person is careless and not looking after themselves and even when their parents tells them	carelessness
	and they don't listen and they say they weren't around during their time and coheres with friends and do stupid things	Not listening and peer pressure
	.	

	Not caring about themselves about it will be like in future.	hopelessness
Respondent 3	I feel that parents should be blame for this because they do not give themselves time to sit down with their children about sex	Parents not communicating with parents
	and show them that if you do like this there is a possible outcome that you can possibly fall pregnant or contract STI.	Teaching about consequences by parents
Respondent 4	Most teenagers who fall pregnant are virgins. The ideology that if have sex as a virgin you do not use a condom is false.	Wrong ideologies
	If you have sex without a condom obviously you will fall pregnant so that ideology makes learners to fall pregnant.	Sex without a condom
Respondent 5	When parents do not speak to their children like when they say you must not have a boyfriend.	Parents not talking to their children
	When you have a 13 year old know that they are having relations	Failing to Facethe reality that children are having sex
	because at that age they are starting to develop feelings, their hormone and they start to be sexually active.	Sexually active driven by hormones
	We may blame parents but at school still we learn and we know how you must protect yourself.	Failure to use the knowledge taught
	Still what makes learners pregnant is that they want to impress because at that time that you want to impress a boyfriend,	Have sex to impress a boyfriend
	boys have strategies of saying I will show her that I love her so that she will open up her legs for me.	Strategies boys use to lure girls
	At the time that you love your boyfriend and he wants your 'cake' , you will say okay fine this person loves me let me just give it to him.	The boy said that he loves the girl
	When you give it to him without protection, you are giving it to him and he is giving it back to you and you find that you are now carrying it in a form of a child.	Sex without a condom
	Stress, because at home your parents are fighting	Domestic violence
	and when the child sees them fighting , what the child will feel is that there could	Alternative solution to

	be something that could make them feel better rather than smoke or drink.	releasing stress
	So they opt to behave like an adult and go be with someone rather than watching my parents fighting, that stress causes that.	Acting mature than their age
	That person will now engage in sex and things turns bad and she finds herself pregnant. She will then ask herself what happened and which will be obvious of what happened.	Having sex while still immature
Respondent 6	It all starts at home, sometimes they do not have control over their children on their activities that they do.	Lack of control from parents
	They go to clubs and find themselves engage in sexual activities and they are not aware of the consequences such as pregnancy.	Going out to clubs and having unprotected sex
	They will now say if my parents had taught me how to behave, live and told us that we are the results of our actions.	Parents not giving information to their children
Respondent 7	Sometimes it happens that you meet up with someone who does not like using it then he will force to sleep with him without it.	Partner refusing to use condom
	In a relationship we understand that is one who is powerful than the other.	Power over relationships
Respondent 8	Powerful meaning he is able to convince the other of what should happen in the relationship.	Power over relationship
Respondent 9	There are people who are very controlling who make sure that what happens is what they have suggested but you can't.	Being controlled by a partner

**d) Do you think that sexuality education gives you enough information that prepares you when you decide to have sex?**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	In Life orientation we learn about different ways of avoiding pregnancy by using contraceptives , you can even go to the clinic to get an injection so that you do not get pregnant.	To use contraceptives to avoid pregnancy
	I would say it gives us enough information. As a guy the information I	Information to use condoms

	have is to use condoms.	when having sex
Respondent 2	Sexuality education does give us enough information but teenage pregnancy is caused because we do not like to listen	Adequate information which learners do not consider.
	and take the valuable information that we get from sexual education We do not value information.	Do not value the information given
Respondent 3	Yes because they give us information on things that we can use so that we do not get pregnant like using contraceptives.	Adequate information
Respondent 4	It does it's just that our problem is that most teenagers we don't like to read and we get a lot of information from reading.	Information given is written and learners do not read
	Most information is vested in books and our problem is that since we do not like to read is that we end up not getting the information that they are trying to give us.	Information is in books and learners do not like to read
	With television, people love entertainment and they do not like to watch programmes that can make a difference in our lives.	
	Sexuality education does give us information adequate information but the problem is that we do not want to take that information.	Learners do not identify with the information
Respondent 5	It does	Adequate information
Respondent 6	I know that when I now decide to be sexually active what would happen if I do not use condoms and if I had used it what would happen.	Adequate information
	It helps me to have knowledge about such information.	Adequate information

## 2. Knowledge learners have about prevention of pregnancy

### l) Do you know what it means to be sexually

active?

Respondent	Responses	Themes
Respondent 1	You cannot go for a long time without having sex.	Not being able to go for a long time without sex
	I think it means that you are now at a stage where you now long to be intimate with someone and you act on it.	Acting on your sexually physical urges
Respondent 2	It all starts at the adolescence stage where your body now wants to experience things that people your age do and you feel pressurised to do them.	Pressurised to give in to experience thing people at your age are experiencing
	You no longer have control of yourself, you just want to do it and you end up involve in things you were not prepared for.	Loss of self-control of wanting to engaging in sex
Respondent 3	It means you are now having sex, and having resources of what you should do not do because now you are going to be facing the results of having sex.	You are having sex and being prepared in knowing what to do

**b) What are some of the responsibilities of a sexually active person?**

Respondent	Responses	Themes
Respondent 1	You must make sure that you use contraceptives	To use contraceptives
	and every three months you go for check-ups for HIV and AIDS so that you don't affect your partner.	Check your HIV status
Respondent 2	You must make sure as you see these things called STDs, STIs and worse HIV the lifelong disease.	Check for STIs STDs and HIV
	Especially the latter, you have to say that	To use

	I'm now sexually active, as we are taught that there are condoms for girls, boys, and contraceptives.	condoms and contraceptives
	There is also a gel that a woman can smear it at the opening and inside her vagina so that she won't be infected with HIV.	Use contraceptives
	The way I see it is that when you are start to be sexually active just use everything that is out there that will protect you because you don't know and you cannot trust a person	Use protection
	Every person present themselves to you as clean only to find that it's the opposite.	Not to be too trusting
Respondent 3	It is to protect yourself by using condoms.	Use condoms
	When you have used condoms, be faithful and have one partner and if you have many sexual partners you might get something .	Use condoms and still remain faithful
Respondent 4	Abstinence because it will help you to not get pregnant because you are still young you are going to fall pregnant	It is to abstain
	and that will mean you have to dropout of school because not all people who fall pregnant have people who will support the girl.	abstain
	There are pills that are common knowledge to everyone can use so that they do not get pregnant.	Use contraceptives

**c) Tell me of some of the things you know that can prevent teenage pregnancy?**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	To totally avoid having sex	abstinence
	Even if you do engage in sex do it safely by using condoms and injections that prevent you from getting pregnant.	Condoms
	and injections that prevent you from getting pregnant.	injections
Respondent 2	There is this thing called ABC which stands for Abstain, Be faithful and Condomise.	Abstaining, being faithful and use a condom

	I cancel because you can be faithful inly to find that your partner is not faithful and being faithful does not prevent teenage pregnancy.	Being faithful does not prevent teenage pregnancy
	So we cancel B whereas A and C is that since you cannot Abstain then Condomise and the gel everything use together mix everything(laughing).	Abstain, use a condom and the gel
Respondent 3	I think that in order to be protected parents have to start from grade 5 learners tell them everything and not hide anything so when they get to a stage when they are and they reach it knowing everything	Give information early to children
	That will prevent teenage pregnancy. Education will prevent learners from getting pregnant.	education
Respondent 4	They must start from primary school teaching learners about teenage pregnancy.	Give information early
Respondent 5	There is this thing of softening the word sex, sex is sex. Not saying you are not supposed to sleep with a boy.	Being frank when giving information no use euphemism
	When you are talking to your child as a parent.	Talking to your children
	Just be candid with your child and tell them that a boy just wants to have sex with you nothing else.	Parents talking to their children
	When this boy is asking you out, he is looking for nothing else from you but sex.	Parents telling their children that boys only want sex
	Use the word as it is 'sex' because children grow up knowing what is sex but now when we grow up we put it in a decent way.	Do not use euphemism be frank
	You just have to tell the child that when a person sleeps with you, this is what they are going to do and this happens.	Being frank
	Not saying "Please my child do not be involve in relationships".	Do not use euphemism
	We know that is impossible, we are going to be in relationships.	Being prepared
	Parents should not even attempt to tell us otherwise.	Parents accepting that children are going to have sex
	You should just accept that okay my child you are now in a relationship and the boy will have	Acceptance by parents

	sex with you.	
Respondent 6	Parents should tell their children what to do when it comes to sex but they do not like how to prevent or avoid falling pregnant or getting infected with HIV.	Parents talking to their children
Respondent 7	Having sex and being just in a relationship are two different thing with teenagers. So when you see that you are now engaging in sexual intercourse and you like dating and being in relationship. Know that is such a thing as a condoms. Buying condoms and buying child nappies are two different things. Nappies are way too expensive than condoms and there are free condoms available at clinics. Use condoms and save yourself from buying nappies.	Understanding what relationships are Knowing what to expect in relationships Knowing about condoms Knowing the demands of having a baby Expensive to have a baby than a condom Use a condom
Respondent 8	You must always have protections, when you have sex you must face the consequences of what may happen and so it's important to use protection because without using condoms.	Use protection
Respondent 9	There are also different types of contraceptive methods like pills, injections and there is plenty more of other stuff. A person who engages in sexual activities they must know that not only a condom is a form of contraceptive that can prevent you from getting pregnant . There are a lot that I have mentioned as well as emergency contraception.	Using different types of contraceptives Knowing different types of preventative measures Knowing about emergency contraceptives

**d) At what age should you be able to access these pregnancy contraceptives?**

Respondent	Responses	Themes
Respondent 1	According to the South African constitution children can access contraceptives at the age of 16 years. But nowadays at any age from age 10 years.	At 16 At 10

		years
Respondent 2	There is belief that children even if they start at 16 years, they are still naïve.	16
	From the way I see it, 13 years. I have been 13 years once and I know what happens when you are thirteen.	From 13
	At thirteen you start noticing handsome boys and start to see that you are also attractive.	13
	From the way I see it, since they can help you when you are 16, they should understand that from the age of thirteen you are now physically developing.	16
	At most time 13 year old are the one who are mostly sexually active.	13
	Boys finding easy to ask the young girls out easily lying to them.	
	So it should start from thirteen years upwards and also 10 year old who are forward and like things.	13
Respondent 3	I think at any age during the adolescence stage, from about thirteen years old.	13
	At any age because we don't know at what age people start engaging in sexual activities, its not that they start at 18 years only	At any age
	and we are talking about teenage pregnancy so teenagers who are involved in sexual activities can start and use contraceptives.	
Respondent 4	Any teenagers from 13 to 19 years old.	13 to 19
Respondent 5	As girls we menstruate at different ages and most people menstruate maybe at age thirteen therefore I think at age thirteen when you have started your menstruation then you can access contraceptives.	13
Respondent 6	I think its twenty	20
Respondent 7	I disagree because learners at 13 years old having sex	13

**e) Where can you access these contraception?**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	You can information from the internet by researching about these contraceptives as well as clinics can give you	Research the internet clinics

	contraceptives like condoms.	
	I'm not saying that condoms are of much help because they say that they are 99% of preventing you from impregnating	Does not trust the condoms
	but what happens to the 1%? Which means even condoms are not of much help.	
Respondent 2	We get information from school because the teachers teach us about contraceptives and even the doctors can give you counselling and tell you about best ways of preventions.	From the doctors
Respondent 3	At school it should be the place mostly where you can access contraceptives. But now you can only get them at clinics and hospitals.	Clinics and hospitals
Respondent 4	I would like to agree with the previous speaker, yes they are only available at clinics but if they be made available at schools it would be much better.	Clinics but prefer if they would be made available at schools
	At schools there are a lot of teenagers and as teenagers all of us go and get our pills, condoms all the contraceptives, you will not be afraid to go and get them.	Prefers school is much more relaxed
	However if you want to go and get them at the clinic, the lady that is your neighbour will see and the place where I come from is small	Apprehensive to receive them at clinic because of stigma
	and everyone will know that you were at the clinic. So it will be much better if we get them from schools.	Stigma attached with receiving from local clinic
Respondent 5	They also need to be made available at clubs because the youth of today like alcohol and having a nice time drinking.	They should be made available at night clubs
	So at clubs they must be made available.	
	Once the alcohol gets into their bloodstream and start developing certain emotions.	
Respondent 6	They must be made available at shops because when they are placed at schools, that will mean they are being encouraged to have sex.	At shop not school because that promotes sex

	They are currently available at shops.	
Respondent 7	At pharmacy	pharmacy
Respondent 8	Public hospital	Public hospital
Respondent 9	Clinics	clinics

**f) Is it easy to get the places where you can access the contraceptives?**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	It is easy because there is no age restriction anybody can get them. I don't see why you can't use them	easy
Respondent 2	It's easy but most people are scared to go to the clinics because of what people are going to say. These people make it difficult otherwise it is easy.	Easy but afraid of the stigma
Respondent 3	It is easy but most teenagers find it difficult because when they get to the clinic they find this old lady sitting and next to her there is a box of condoms. I go to the nurse to ask for condoms, this old lady the way that she will look at me, she could only just be staring at me but through my mind it will be like she is asking herself what do I want these condoms for?	Its easy but scared of the adults at clinic People at the clinic they judge you
	Such a young boy what could he possibly want with condoms. Its even worse for girls because the girl is scared more than a boy.	The judgement is worse for girls
	Its like when you are at a store and you want to purchase condoms its very scary.	Its scary to buy condoms at a store
	For girls it will appear to be too young and naughty to even be seen buying condoms. Girls do not want to be perceived as being more sexually matured.	Girls will appear naughty if buying condoms
Respondent 4	Yes it is because we have public clinics near our communities.	Yes easy access to clinics

Respondent 5	It is easy because we have nearby clinics.	
		Easy
Respondent 6	Though at times you may experience some difficulty when trying to get help because they start judging you .	Difficulty because of judgement
Respondent 7	I do not know but I think at the nurses at our nearby clinic are not very helpful.	Not easy nurses are not helpful
Respondent 8	You do experience difficulty because sometime when you get there is an old nurse old as your mother and you get scared to say why you are there and what you are there for.	Scared of the people you find at the clinic
	You get scared of the way she might think or the way she might perceive you if you tell her about what you are there for.	
	There is difficulty it is not as easy as one would think.	Not easy
Respondent 9	Some other times there is no problems because you get a nurse who has been in a situation that you are in and she is able to understand and is able to talk well with you.	An understanding ear
Respondent 10	I do not think you do experience any difficulty because you do find a nurse that may know or lives in your neighbourhood.	An understanding ear
	I'm not afraid that she may tell my family that she saw me at the clinic asking for condoms.	Afraid that the family may find out

**g) Do you have to get your parents consent to get contraceptives?**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	Although most parents will disapprove but there is nothing you can do but to protect yourself.	Not necessary because it's impossible at times
	Most parents will say you are still young and you cannot be having sex.	
	So getting their consent is impossible.	
Respondent 2	If you have to get your parent's consent, firstly having to tell them is a problem	Scared to get their consent

	saying ‘Yes now I’m having sex, and can I go and get condoms’.	
	There is no way that they will allow that. As children we are scared of our parents, therefore getting their consent is impossible rather they found out on their own.	They will not allow that.
	I will rather face the consequences of that.	No rather face the consequences
Respondent 3	You cannot include your parents because even for parents it’s difficult to take their children to go and get injection for prevention against pregnancy.	You cannot include your parents.
	There are parents that you can talk to that you can get pregnant and a baby is an expense from the time you get pregnant as well as bringing it up.	
	Therefore you end up going with her to the clinic to get help but with others it’s not easy to talk to them.	Its not easy to even talk to them about that
Respondent 4	I disagree with the previous speaker, you have to involve your parents.	Yes you have to get
	They are your parents, and if they do not allow you it’s because they have their reason and they will reason with you.	Yes get parents consent
	Saying why they feel you should not do that but you can also give your own reason of why you doing a certain thing.	Yes get it and make them understand why you want it
	It’s about time that parents and their children try to communicate now	Yes getting their consent will strengthen communication between child and parent
	What if your parent does find out, you will be in a worse situation.	Not telling could worsen relationship between parent and child
	I think it’s important my parent’s consent and I must tell her what I’m doing and just to generally communicate about such things.	Getting consent proves that a child can communicate with parent
Respondent 5	We must get our parent’s consent because by doing that you will be	By getting consent you

	correcting that mistake of parents hiding stuff from their children.	showing them how you want to relate with them
	If you do tell your parent and be able to communicate with them and not hiding things from them.	Get consent showing open relationship to parents
	Let's say you do hide it from them and you take condoms, you sleep with someone and the condom burst and they get pregnant, who will now have to be concerned about that?	Get consent in case something happens
	Its your parent but you went had hidden stuff from them and did not tell them.	
Respondent 6	Yes you have to because everything that happens, you are still under your parents care and you need your parents.	Get consent
	The contraceptive that you are going to use has side effect and your parent needs to consent to that and can withstand anything that can come from that.	You compelled to get consent in-case of side effects
	It may happen that the contraceptive may not agree with your body and something starts happening and your parent can now help you because they would know what is happening.	Get consent
Respondent 7	There is no need to get a consent from your parents, what you can get from your parents is advise because this is your life and it is your body.	No need to get consent
	Therefore all decisions are about you, you can only just take advises from parents and other people.	Not consent but just advice
Respondent 8	I also agree with the last speaker, you can not tell your parent because there are parent that will act crazy and will not understand.	Parents will act crazy when you try to get consent
	We have different parents, there are parents who will approve, but others when they hear about it they can even chase you away from home.	Do not get consent
	They will say you now are able to do things on your own and have a child and tell you to go and be on your own.	
Respondent 9	I think you should involve you parent because when you start having sex your parent can see that now you are having sex	Involve parents

	and it must be them who give you advise that since you have started to do this why we don't go to the clinic and get contraceptives to prevent against teenage pregnancy.	Get parents advise
	Now we do not hide things and things are in the open and there is no reason to hide things from them.	
	They might have an experience of what you going through and so if you tell them they might be able to help you.	Get consent
	The more we hide stuff from them that is when we kill ourselves by taking decision on our own by no consulting with our parents.	Get consent
	So its important to tell our parents, that they maybe able help you.	
Respondent 10	At times you have to and at times not because you are protecting yourself because it can prevent you from studying and it will be too late to sit you down.	Get consent
Respondent 11	I think its wise that you inform someone in your family or mother because it may happen that you can take that injection and it may have a side effect like being dizzy.	Inform your parents
	Your mom may get confused as to why you are suddenly sick all the time but if you inform her she will understand.	
Respondent 12	I think that you should not because other parents will tell you that now that you have engaged in sex you must face the consequences and not to put foreign things in your body.	Do not get consent
	Other parents say that because you have a decision that you now are an adult, what you are doing is done by grown ups.	
Respondent 13	It depends on at what stage you are at and I do not think you should to tell your parents when you are 14 years old and you tell your parents now you wants such things.	Do not tell when you are still young
	They may think that you are still very young to be doing such things which are not right.	
Respondent 14	I do not think it is right to tell them if you still a teenager but only once you are not.	Do not tell when you still a

		teenager

**h) Do you get assistance and what you came for when you get to these places?**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	As a guy when I go to these places I do get assistance maybe I want condoms, yes I do find them. I don't know about girls.	Different perception of genders getting help, yes for boys
Respondent 2	The way teenagers are getting pregnant, I do not think so.	I do not think so when looking at pregnancy rate
	Maybe others are scared, maybe they went and did not get help.	Scared because of past experiences
	Teenagers are getting pregnant out there.	
Respondent 3	At times your partner may not even want to use condoms and that will mean even going to the clinic was just a waste of time.	Partner may not want to use protection even having been given help
	But going to these places you do get help because they can give you an injection and then you will not get pregnant.	Yes you do get help
Respondent 4	At our local clinics, there is no one that you can talk to like counselling you.	You do not get help not even someone to talk to
	Like here at school if we did not have the Learner support agent, there will be no one else to talk to and that's the mistake that the clinics make.	

	You do not get help.	
Respondent 5	Others get help and others don't because when you look outside a lot of teenagers are getting pregnant.	No assistance
	Those who do not get help is because they do not the help or their partners do not want them to go and get help.	No assistance
	Maybe they are scared but they do get help from clinics.	Scared and do not get help
Respondent 6	Getting help from a clinic is supposed to be their primary duty because there are nurses when you go and test for HIV and there is this lady who is always shouting.	No help but get judgement
	You cannot talk to someone who is shouting at you.	No help
	Firstly she is looking at you in a way that says why such a young a child is here and I imagine having to talk to her that will mean I want her to shout at me letting the whole hospital hear.	No assistance but judgement
	Now you cannot speak to someone like that even if you wanted. If they could have people who are calm, people who can listen, people who understand and know what they are doing.	Wrong people work at these places
	There are people who say I'm an adult and that is a child and I can reprimand her.	They reprimand you instead
	Yes that is a child but they must try and be at their level.	No assistance
	Most of the time it's easy for teenagers to speak to their friends rather than their parents.	No assistance
	Parents have this thing that they are parents but with friends they are equals and they are able to open up to each other.	No assistance because they see you as a child
	At clinics you cannot be open because they just start shouting at you.	They shout instead
	It's a common knowledge that nurses at clinic they only shout and reprimand you	
Respondent 7	Yes we do but you get help but the way that people there react and even the nurses the way they look at you, may scare you and you will probably not go back again.	Yes but the stares discourage you from going back.

Respondent 8	We do get help, even though we do not have a good experience but we do see on TV saying you do not have to be scared to go the clinic because of what the nurse will say.	You go there because we see on tv that you do not have to be scared to go for help
	A patient to a clinic other people should not know their HIV status or whether that they are pregnant.	
Respondent 9	At times you do or a times you don't because they have ran out of stock and it hasn't arrived.	At times they run out of stock
	Which means you have to go to another clinic.	
Respondent 10	At other places you get help and if you arrive that they do not have what you want they tell you to leave your numbers so that they can contact you to tell you if the stuff has now arrived.	You get assistance but if un available might tell you to come back some other time

**i) Do you know of programmes that are running abstinence initiatives?**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	The thing is people they do not like to attend these programmes.	yes but people do not attend them
	For instance around the area where I live they had such a programme where they use to teach girls about how they should behave.	They teach teenagers about how to behave
	It's a common knowledge that teenagers are in relationships now and they are helping them to try and prevent getting pregnant.	Helping them not to get pregnant
Respondent 2	Virginity testing may not be a programme of educated people but as you know when you test everyone understands that you are a virgin.	Yes virginity testing
	So it takes real courage to just go and have	

	sex because since everyone knows that I am a virgin again everyone will know I am not one any longer.	
	In that way a lot of people who go for virginity testing motivates them not to just sleep around because they re scared.	
Respondent 3	I do not know of any programmes	No information on programmes
Respondent 4	I also do not know of any programmes	No information
Respondent 5	The ladies that are testers they always say that we should look after ourselves .	Yes
Respondent 6	Yes we do have such programmes	yes
Respondent 7	We do have one where I live and I also go for virginity testing. They test you and tell you to take care of yourself. There are girls who are older than me, I'm 17 years and who are still virgins.	Yes near my area
Respondent 8	There is a programme that I know but sometimes this whole thing has some element of being deceitful  It is all a lie because at times we see a girl who sleeps with a boy and they go to these schools that why I say it is all a lie.	Yes but I'm sceptical about it Yes but girls who sleep around still go to these virginity schools
	There is a school around where I live and we see everything and as boys we talk.	
	As friends we share most of the things and we also know.	
	The boy will admit that the girl refused to sleep with me and he wouldn't lie about it but obviously the girl will deny it.	
Respondent 9	The previous speaker is telling the truth, because they are saying that girls put note in their vagina for the ladies that do the testing not to say anything once they found out they are no longer virgins.	Yes but the girls bribe the ladies that do these tests to lie and say that they are still virgins.
	However that could also be a lie for instance they could say that the girl was sleeping with a boy the previous day and when she goes for testing she still turns out to be a virgin.	
	There is this thing that boys do where they try to lower esteem and the girl starts saying	People start to spread rumours to

	to herself that since everyone believes that I'm no longer a virgin so let me just do it and that's exactly what they want to happen.	break you down to get you to sleep with them
	Me for instance I have been facing a lot of things. In my neighbourhood everyone says I am not a virgin and I have HIV but those very same people who say those things about me come back to court me.	You become a target when you go to these schools
	They want me to tell myself that since everyone talks badly about me that will mean this guy loves me since he took his time to talk to me.	
	I will then sleep with him because this person loves me.	
Respondent 10	This virginity testing thing is said to be a lie because it happens that most people just go to the reed dance.	The programmes are there to give an excuse to go to the reed dance but they are not virgins
	I do not think that all of them go for virginity testing.	
	Near where I stay there are people that go to the reed dance and they know and we know very well they have never been tested.	
	Others sleep with boys and they go for the reed dance	
	At the school they are no longer let you literary open legs to check if you are still a virgin.	
	You agree because you have never slept with a guy before and its your first boyfriend and he tells you that so you end up sleeping without the condom.	These programmes do not prepare you when you decide to have sex and you end up not using protection
Respondent 11	Yes I do, its Love Life, they come to schools to inform learners about sex and other social ills.	Yes love life
Respondent 12	Soul City is a programme on television that teaches us and making us aware about sex, that you may not contract a certain disease, getting pregnant, STIs, STDs and generally warning us about a lot of things about sex.	Soul city
Respondent 13	Soul City, the programme is about teenagers that are pregnant in schools and which shows us that if we are going to children at school this is what will happen.	Soul city
	The programme is able to show us as the	

	youth that when we are in to come to school to be in relationships and see girlfriends.	
	What we should concentrate in our books and it shows us that this is what is happening in our communities.	
	Where a child will not tell the parent, that forces the child to run away and when the child runs away that brings them turmoil in their lives.	
	It is called Soul City because it's about souls.	
Respondent 14	Virginity testing	Virginity testing programme
Respondent 15	They test you if you are still a virgin and then they advise you that it is important to keep yourself as a virgin.	Virginity testing programme
	They tell us that sex is bad because you are going to get pregnant and have a baby.	

**j) What are some of the instances that can lead to having unprotected sex?**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	It may happen that a boy say that since you are a virgin I cannot break you with a condom.	Myths around virginity
Respondent 2	At times when people go to a bar and they drink.	Drinking alcohol
	You meet a girl at the bar and you ask to talk to her, she agrees and then you start kissing.	
	You get so overwhelmed with feelings you take her to the toilet and you sleep with her there.	
Respondent 3	There are girls who say that they have sex with a Choice (government free condoms) because it smells, and all of that.	Not wanting to use government free condoms
	You have come to see me and I only have Choice and you say you do not like it and both of us are really in the mood we definitely end up sleeping without anything because you said you do not like that type of condom.	
	If my aim is to sleep with you I will go ahead but if my aim is to not to sleep with you without a condom I will not go ahead with it.	Sleep without a condom

Respondent 4	It can happen that a boy tells you that you are his steady girlfriend and he can't have sex with you with a condom	As a steady girlfriend you end not using protection
	because I love you and you are my steady girlfriend and you end up sleeping with the boy without a condom.	
Respondent 5	You see when a boy tells you that because you trust him that he doesn't have HIV and you also do not have it, so what should make you use a condom? You should just do it.	Trusting a boy
	They also say "skin to skin" there should be no plastic and also say you need to test something first before you can say it is yours.	Showing ownership by doing it skin to skin
	Those are all boys strategies to try and have sex with you without a condom.	
Respondent 6	Also when I'm in a room with a girl and as a boy I will tell her we can sleep without a condom because I will make sure I do not ejaculate inside of her, she agrees.	Saying that you won't ejaculate inside of the girl
	The only thing that goes through her mind is just that she does not want a baby but through her mind it does not register that I could be sick and have STIs.	
Respondent 7	When you are drunk	Being drunk
Respondent 8	Peer pressure, friends force the person to engage in sex because they have started as well.	Peer pressure
Respondent 9	He is right when he says its peer pressure but the peer pressure happens maybe at a party.	Peer pressure
	. Lets say we are at a party, here at our location we call it "ebhadweni" where people are having fun and its so happens that when you are drunk you forget about protection, a condom.	
	A boy will take you to a room in that party and what he will do have sex with you without a condom.	Sex without a condom at a party
	Therefore the outcome of that is you get	

	pregnant.	
Respondent 10	As we are writing exams, you just take a girl and go with her to your house where you will have sex, don't use protection because the boy will want that but the girl will not want to	Not using protection
	The boy will then ask the girl if she doesn't trust him, if he has HIV or something and the boy gets annoyed.	Sleeping with a boy to prove trust
	The girl wants to fit in because the boy is popular and she wants to impress him so she gives in that way.	Wanting to fit in
Respondent 11	A point of correction, one gentlemen spoke about peer pressure, we need to understand what is meant when we are speaking about peer pressure?	Friends influence you
	It's not about someone forced you to do something.	
	He did say peer therefore your peers give you pressure to do something not that they force you but the things that they do.	
	You want to fit in a group, the things that they do and also want to be like them therefore you are pressured to do the things that they are doing.	You want to fit in
	So when he speaks about friends is like that they force you to have unprotected sex but as you see your friends do such things, you want to be like them then you do what they are doing.	
R12	Also the way I look at it as he was saying, most of the time we as girls, we are scared to express the way we feel when you are with a guy.	Scared to express the way one feel when one is with a guy.
	He said that when you reach that moment when you are about to have sex and then you suggest that you use a condom to protect yourself.	When asking for a condom a guy questions your trust in him
	The boy will then say that you don't trust him and at that time you scared to say yes you don't but you start pretending that you and you give in.	
Respondent	When you are drunk	drinking

13		
Respondent 13	When you are drunk at times you do not find the time to ask or get a condom.	Being drunk
Respondent 14	At times you get tempted by that person and you may find yourself having unprotected sex and there is no time to use a condom.	Being tempted and forget to use a condom
Respondent 15	When you do not have a condom nearby when you have sex.	No access to condoms at time of having sex

**k) What would you do when you realise that you have had unprotected sex?**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	You must go for a pregnancy and HIV test .	Get tested for HIV
Respondent 2	Others use what is called a morning after pills which they get from a clinic or a pharmacy to protect themselves from getting pregnant.	Take morning after pills
Respondent 3	As boys we believe in its called “Esamsholoji” where after you have slept with a girl without a condom, you take Dettol, wash your penis and you are protected, especially when you are circumcised you just wash it with the Dettol you are protected from HIV	As boys wash our penis with Dettol to protect against HIV
Respondent 4	You can take the Morning after pills, but there is what they call a PEP. You are suppose to trust no one like me I trust no one. So if I suspect I have had unprotected sex, I would have to go for PEP within that 24 hours. To make sure Im protected from HIV and pregnancy. Having unprotected sex just not only makes you pregnant but there is HIV and STDs.You just have to go for everything.	Morning after pills and PEP
Respondent 5	Another thing is that after you have slept with a boy, most girls drink disprin with a coke. It is believed to get rid of sperms in your body so that you do not get pregnant	Use Disprin tablets with coke
Respondent	You have to go and check your status HIV	Check HIV

nt 6	and pregnancy status. When you find out that you are pregnant you have to go back to your partner but that will mean you have had an unplanned pregnancy.	status and have a pregnancy test
Respondent 7	Immediately after you have realised that you have unprotected sex, perhaps it will happen that you were drunk and you realised when you wake up the next morning, you have to consult a doctor.	Consult a doctor
	Just go to your doctor or because most people do not have their own doctors, you need to go to the clinic and found out about your HIV and pregnancy status.	
	There is another way of preventing pregnancy even after having unprotected sex and its called an emergency contraception.	Emergency contraception
	Where they give pills and you are making sure that you don't want your future to be ruined.	
	Immediately after you realised that you have had unprotected sex you use those pills and you get back to your normal life.	
Respondent 8	We learned in Life Science that there are pills that when I have engaged in protected sex, I'm now HIV positive, you must consult a doctor within that 24hours	Consult a doctor within 24 hours
	because able to stop the disease from spreading throughout your immune system and with pregnancy there are morning after pills they can be found at pharmacies that will be able stop you from getting pregnant.	Morning after pills
Respondent 9	Having had unprotected sex you don't just check your HIV status or you are pregnant but you also have to check if you have STDs and STIs.	Check pregnancy and HIV status
Respondent 10	Firstly I would go to the clinic and check if I had contracted any disease or if I am pregnant.	GO to the clinic to check for any diseases and pregnancy
Respondent 11	I do not think you can immediately know if you had contracted HIV but what I would do is get someone to advise you .	Get someone to advise you
	or the doctor	See a doctor

Respondent 12	I would wait maybe for month until the time you had to start menstruation and if you see that you are not starting then you can go to get help	Wait for a month to check if not menstruating then go for help
	At that time they can be able to pick up if you have HIV or that you are pregnant.	
Respondent 13	Also others can take morning after pills after they had sex which they can get from a chemist.	Morning after pills

**3. Type of prevention measures learners prefer to use.**

**a) Do you feel that these preventative measures are suitable for your lifestyle (being young and still attending school)?**

Respondent	Responses	Themes
Respondent 1	Where you use injections I do not like it because it makes your body to be lethargic and you turn to retain water.	No they are not
	Most of these things you will end up not being able to have children in the future.	
Respondent 2	I prefer the implant, where you are protected for three years against pregnancy therefore you do not have to go to the clinic all the time every month.	Implant you do not to worry about
	You do not have to worry about remembering because its already there.	
	Saying that your body gets sluggish and it retains water , all of those thing are just allergies.	
	Firstly before you take that contraceptive, you first have to know what is it that you are allergic to so that you will be able to know which one is best for your type of body.	
Respondent 3	I do not like the injection because as a boy when you sleep with a girl water just comes out of her vagina when you have not done much.	I do not like injections as a boy
Respondent 4	I prefer to use condoms, it has never burst but most boys says it does.	I prefer condoms

	I think it depends on how you put it on which will contribute to it bursting.	
	I prefer a condom.	
Respondent 5	Not all of them because people are still in school so they do not have money to buy contraceptives but condoms are easily accessible at clinics and they use them mostly	Condoms are convenient
	I prefer condoms	
	I don't think that they are good because pills have chemicals, things in them that addictive.	Pills are addictive
	Children should not consume things that are addictive and people who use pills use them as a contraceptive method when they are sexually active.	
	The person will find themselves with those addictive chemicals in their body, which is wrong for a person who is still a learner.	
Respondent 6	Others are, others are not example like the injection that girls use where every month you suppose to go through your menstruation cycle, you suppose to bleed but this injection you are given sometimes is for two or three months.	Injections end up having bad effects
	When you take the injection you do not go through your menstruation cycle the period that the injection is still in your body and it prevents you from getting pregnant.	
	Sometimes it can affect you because the blood that is suppose you to leave your body, will stay somewhere in the body and it will chose where and it affects you in any different way.	
	Lets say you you have used this injection for seven years and this blood that is suppose to leave your body is not, it builds up and the time when it does you over bleed and you may not survive that.	
	I think using injection is not the right one to use.	
	What is better is using pills after you have had sex or after because the injection the blood that stays in your body is building something that at some point will end up affecting you.	
Respondent	Abstinence	abstinence

7		

Respondent 8	I am still young most of those things are not right for me	I do not feel any of them are right for me
Respondent 9	There is this thing like a match stick that they insert in your arm which helps for not getting pregnant.	implant
Respondent 10	Others say the implant is not good because after three weeks you start bleeding (menstruation) endlessly.	Implant cause endless menstruation
Respondent 11	When they insert it they tell you that you how long you shouldn't have sex and if you go the time they stipulated then you start getting such complication	You still need correct use implants correctly

**b) What measures do you feel would suit you? (give me an example)**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	Abstinence	abstinence
Respondent 2	If you feel that you cannot abstain opt for the implant because you do not have to do it every month and people do not have to see you. You will just do it after every three years	implant
Respondent 3	Implant	implant
Respondent 4	Implant	implant
Respondent 5	Implant would agree with me	implant
Respondent 6	Condom	condoms
Respondent	Abstain	abstain

7		
Respondent 8	It is not to rush to have sexual intercourse	abstaining
Respondent 9	Virginity testing	Virginity testing
Respondent 10	Abstinence because it encourages you not to engage in sex which will put you into trouble and you will end up all alone and the boy is no longer bothered with you. You are now having to bring up and take care of the baby on your own.	abstinence
Respondent 11	Condoms because even the girl can give it to the boy.	condoms
Respondent 12	Emergency contraceptives are the best.	emergency
Respondent 13	They are right but I heard that if you forget to drink it you get pregnant. I would say it must be used by someone who is not forgetful.	Pills but you mustn't be forgetful
Respondent 14	You can use them all the time but once you do forget using them you get pregnant.	Pills but do not be forgetful
Respondent 15	I prefer condom because it prevents STDs, HIV/AIDS and Pregnancy at the same time.	condoms
Respondent 16	Implant	implant
Respondent 17	Condoms(laughing)	condoms
Respondent 18	With injections you bleed for a long time , with implant my aunt said if you go to shops they set the detectors off  , with implant my aunt said if you go to shops they set the detectors off  Lets say I did not say at home and then it goes off, what is my mother going to say,have I stolen something and now I have to start explaining.	With injections you bleed for a long time  Implant set off metal detectors

e) **Who do you feel should be responsible for prevention against teenage pregnancy? Why do say that?**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	Teenagers who are sexually active because the consequences are there.	Teenagers who are sexually active
	Even though they do affect the parents but they mostly affect the teenagers the most.	
	Boys do not have much of the problem, it's the girls that suffer the most	
	It's the girls that have to make sure that you even carry the condom for the boy and that you even have your own condom.	Mostly girls
	Plastic to plastic because if you do not prevent you are the one who is going to get pregnant.	
	You are the one who is going to give birth and it is being said giving birth is painful.	
	You are going to bring up that baby and you can't carry on with school and you will have to stay home and breast feed the baby.	
Respondent 2	We as teenagers because its you who is going to suffer especially girls. Boys will not be around they will be out there having fun and it will be girls who will be feeling the pain.	Girls
Respondent 3	Teenagers have to be responsible because you can't hold your parent responsible.	teenagers
	Firstly she does not know when you are going to sexual relationships and you are withholding information from your parents they will not be able to help you	
	So you need to be responsible because it's you who is going to suffer if you do not prioritise yourself by saying this is what I'm going to and this is how I am going to protect myself.	
	So you need to be responsible.	
Respondent 4	Health facilities, hospitals, clinics because they have to make sure that contraceptives are made available to the public.	Health centres
Respondent 5	We a teenagers especially girls, boys go to the clinic and get the condoms. At the clinic they would say we gave out condoms and the boy goes, sleep with the girl and he does not use the condom.	girls
	You are not forced to use it but at the clinic you	

	did take it but you just look at it and don't use it and sleep with girl without having used it.	
Respondent 6	Mostly its girls and the reason I say that is because girls will be the ones at the end who will get hurt because the boy is just there to have sex and obviously once he is done he is done he will just leave.	girls
	I could be there because I'm visiting and I find myself a girlfriend, we have sex and forget to use a condom.	
	I will leave and she will be left alone, pregnant. So girls should be responsible because it backfires on them.	
Respondent 7	It should be girls because it's them that are mostly affected because she will be pregnant, still at school which she will have a couple of months that she will have to miss from school.	girls
	She will miss the learning time, the knowledge she would have gain in school and the whole year she will be staying home not studying.	
	Meanwhile the boy is free, where you get pregnant, have to bring up the baby and you do whatever to try and raise the baby.	
	That will take probably a year or two and the years of your life are being wasted.	
	The boy does not deny that he impregnated you but on the other side he is still living his life and carrying on with school and doing all the things he wished to do with his life is able to do.	
Respondent 8	The people who are having sexual intercourse are people who are in a relationship, who love each other, its not like people who just met up in the street.	Both the boy and girls
	They need to be faithful to one another, the guy needs to make sure that the girl does not get pregnant and the girl.	
	But both of them should not just expect the girl to make sure she does not get pregnant because if she is not able to she will then get pregnant.	
	Both partners need to help each other.	
Respondent 9	Point of correction to the previous speaker, as a learner is that there is no such thing as love among young children.	The boy
	Love is for grown ups, if there is someone that says they love you while you are in school, that person is just playing with you. All that he wants	

	is sex, there is no love in children specially among learners.	
Respondent 10	I agree with him because when there is the two of you in a relationship there is a motive behind it.	The boy
	. Most of the time the girl is the one who has most love in the relationship and she gives you all of it.	
	But what happens as a boy it could be just a crush and the time goes you will end up having sex with her.	
	Once you have had sex with her and had a good time with her, he will not want to stick around.	
	Meanwhile the girl still loves you, you are no longer interested and that's where the problem starts where you now want to love each other and the fact that as children we do not know what love is.	
	We are sexually active early for our age.	
Respondent 11	I say that there is love, the problem is we do not know how it works.	
	We have love as children, it is just that we mix everything up and when we find ourselves in trouble of things that happen in love relationship then we fail to stand for them and then we break ending up believing that there is no love because we failed to stand for problems that are in relationships.	
Respondent 12	We all do not know what love is lets just stick to the topic.	
Respondent 13	The community should not be responsible for children not to get pregnant	The community
Respondent 14	The parents should be responsible, make sure that their children do not get pregnant and try by all means although you cant protect a child for 24hours but they should try.	parents
Respondent 15	The way that parents could try to prevent pregnancy is that most of the time they do not want to give their children information.	parents
	They should be the first educator in their children's life and explain everything that will encounter.	

Respondent 16	As adults they have gone through a lot of things.	parents
	So if the parents tell their children about things that might happen and when they go to school they are going to be told the same thing.	
	They will be conscientious about it and begin to live it learners need to be informed.	
Respondent 17	I agree with him if he says the parent must try because when your parent tells you something rather than be told by a mere stranger like a teacher.	parents
	In my mind there will be that what is this person saying because they are not even my parent.	
	The parent must not be afraid to tell us things, they just leave us not intentionally but they are just scared.	
	Our parents should start being open to us and get used to telling us things no matter what those things are.	
	So that when other people we will be able to listen to them.	
Respondent 18	To add to that as my sister had said, is that if your parent loves you and taking care of you in whatever way possible and they tell you everything that's where you are able to get information	parents
	You learn a lot of things like going to church and there it's obvious they always say that if you commit a sin knowing is a sin that's a sin.	
	You will also be conscious that what I'm doing is wrong because I have been told daily and it's stupid to do something after being told that it is wrong.	
Respondent 19	It's the person who decides that they are now going to have sex.	The one who decides is going to engage in sex
	The person must think of the consequences they are going to face after having unprotected sex, you must know few days or months after having sex there will be consequences and will you be able to face them.	
	So people must decide and make choices that influence good life processes.	

Respondent 20	Both the girl and the boy because its them that are going to be having sex and its not their parents.	Both boys and girls
	They are the ones who have taken that decision.	
Respondent 21	They have been taught and they now know because the parents can tell you but you on the side you are doing your own things	Boy and girl
Respondent 22	I can say it's the government can open organization in townships and hire people who are going to work on bringing awareness that if you are taking this step these are the guidelines in how to go about it.	government
	The government is not doing enough.	
Respondent 23	Right now the government is allowing that if you have a baby you can receive a grant.	The teenagers
	He shouldn't do that because that is going to make them use protection because they will know they will not get anything to support their children	
Respondent 24	There should not give a person who is still a teenager a social grant so that they know that when you fall pregnant you will no support.	The teenagers
Respondent 25	Government is spoiling children that if a person gets a baby at a young age that you are going to get a social grant and be helped.	The teenagers
	If the government did not do that maybe a person will think that if I get a child, how will I support that baby.	
Respondent 26	I will like to disagree with the both of them, grant is not to bring up the baby but from knowledge social grant is for supporting just a few.	Girl she suffers the most
	Not all people that receive a grant like when you earn you do not get it.	
	Teenagers should get it because they are not working because a guy impregnates a girl and then she is disowned at home.	
	When she is disowned where is she going the money if the government does not issue the grant.	

Respondent 27	Government is increasing teenage pregnancy because if you are pregnant you are allowed to continue with schooling of which other learners can see that if I do get pregnant there will be no problem because I will still continue with my studies.	Girl because she suffers the most
Respondent 28	According to the constitution of South Africa there is a right that say every child has the right to learn.	Girl because she suffers the most
	According to the previous speaker should they be refused to go to school which will mean they must violate her right?	
Respondent 29	Every child has the right to learn not a mother because when you get pregnant you become a mother and you teaching children to do what you have done.	The girl because she suffers the most
	When you are pregnant you not yet a mother, you are still pregnant, only once you give birth.	
	What I want to say is that learner is still allowed because they haven't given birth, unless the had said once they have given birth even then they are still violating her right.	
Respondent 30	Lets say I'm kicked out of school and I am not receiving grant, How am I going to support my child?	The girl because she suffers the most
	I do not see it necessary for a child not to go to school because she is pregnant.	
	What about those who have been raped?	
Respondent 31	Grant promotes teenage pregnancy	both
Respondent 32	Going to school pregnant promotes teenage pregnancy because they know they are going to carry-on with school and you only going to be at home once you are 8 months pregnant	both
Respondent 33	Others of cause need to study and carry-on with building their future because it must have	both

	been a mistake because if it was a mistake, what must they do?	
Respondent 34	There is no mistake in sex because both of you have agreed to it.	both
Respondent 35	Lets say I was raped and I have been chased away from school, what then?	

**f) What are your thoughts about community initiative programmes that are talking to young teenagers about prevention against teenage pregnancy?**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	I would say they try even though they do try it's up to teenagers to say they do what they have been advised.	They are trying
	Do they even bother to go because when you go there you will find that there are only four people.	
	Even those four are just there to check what's going on not because they are sincerely interested to listen to what is being said.	
	They are there to check what's going on and just leave.	
	It's no use really because if the person hasn't really spoken to themselves and said that this is what they want to do, no one can do anything.	
	Everything is in the mind, everyone thinks thing through their own way, they don't want any irritants they want to go and do things their own way.	
	When they run into trouble only then do come back say you did warn me but I did not listen.	
Respondent 2	I would say they do try and they should keep on trying because they can encourage and motivate the youth to stop the things they are doing.	They are trying
	They should carry-on helping us as the youth.	
	We also should make an effort to attend these meetings.	
	When they have these meetings there are just a few people that attend we have to try to go and listen to what they have to say.	

Respondent 3	Even though those few do come even one or two come its better those to be there hear than not to be able to reach anyone.	They are helpful
	It is very helpful to those who are interested	
Respondent 4	Community programmes do help but they lack somehow, they should try new things.	They are helpful but they should try new things
	For example virginity testing is outdated and there is no trust and confidence in virginity testing.	
	They have to try other things as adults put their minds together to see what they can come up with because virginity testing is out.	
Respondent 5	I think the effort that community is not making enough as much as they try to tell people that there are consequences of a person who gets pregnant at an early stage.	Not enough effort
	We don't see the much difference because we see at school the rate of learners getting pregnant is increasing so they are not solving this issue of pregnancy.	
Respondent 6	From the things that we have been told as teens every day we are daily engaging and talking about things and mostly it's about social issues and the person knows that when I do this what might happen.	They are making an effort
	So most people are not using their mind as they should they do things even though they may know their outcomes but they carry-on anyway.	
Respondent 7	The teachers seriously need to teach the learners principles of respect to be instilled back to our own lives that if we do such things, where are we going to be in the coming future?	Not enough effort from teachers in teaching values
	How about those coming generations, how are they going to know and acknowledge if we are failing as teenagers to control ourselves.	
	What's going to happen when we ourselves reach our parents age, it will mean that we will also be going to lack.	

	Even the country won't be able to sustain their issues.	
Respondent 8	Virginity testing	Virginity testing school are making enough effort
Respondent 9	Most parents take their children for virginity testing	Virginity testing school are making enough effort
Respondent 10	Others who understand that a child has started to engage in their thing, do take the child to clinic to go and prevent.	
Respondent 11	As I am from the farm, the way I can describe it is that the picture you get from parents is that if a child is going to get pregnant while young they will chase her away.	Not enough effort because parents still chase their children away
	To the person who has not gotten pregnant will get a lesson that if I get pregnant this is what will happen that I will be chased away from home.	
Respondent 12	Teenagers are supplied by whole lot of things and they should help themselves by knowing that they are engaging in such things of which they are not supposed to be doing in the first place.	The schools are doing enough
	Teachers especially LO they help us a lot because they are always emphasising abstinence.	
	She also teaches us on prevention as well as to abstain and prevention.	
Respondent 13	Sometimes people are told but they do not listen	They are making enough

		effort
Respondent 14	She tells us to use condoms, prevent because when she is telling us all this, others have already started having sex.	Teachers are making enough effort

**g) Would you use those initiatives? Why?**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	I use them especially virginity testing because it helps us in being successful in life and to have a bright future.	Virginity testing because I want to be successful in life
	We should use it and take it as part of our lives.	
Respondent 2	I do not agree with virginity testing because it may happen that you can be confused and end up sleeping with a boy and the whole country will see that you are no longer a virgin because you were with them but now you wont be able to go with them knowing you have done something.	Not virginity testing
Respondent 3	I would use these initiatives, because truthfully a child is an expense. Firstly most of the teenagers come from poor backgrounds.	I would use them because a child is expensive
	I for one I have to use it because I wont be able to handle suffering not at my age.	
	Firstly when you bringing up a child, you have to buy nappies and all the things that goes with bringing up a child including a nappy rash(laughing).	
	So not using them will put me into trouble.	
Respondent 4	I cannot handle suffering.	Yes because I cannot handle suffering
Respondent 5	I will use virginity testing because you just have to mind yourself and just ignore everybody else.	Virginity testing because you just live your life

	This person had sex and they are no longer virgins.	
	Use them because you know yourself and you have to take care of yourself.	
Respondent 6	I do not agree with virginity testing, because if you are a virgin its something that should be between you and your parent than to show everybody.	Will not use virginity testing because you do not have to broadcast it to everyone
	When you are no longer a virgin you will have to pretend that you still are because people know that you are still.	
Respondent 7	I do not agree with virginity testing because you have to know yourself that I'm still a virgin and now I'm ready to have sex and this boy will take my virginity.	Not virginity testing because you end up becoming a target
	As boys we have different skills of getting a girl to sleep with you.	
	I will try my skill on a girl and another boy will follow but one of us will at the end be able to win the girl over.	
	Once one of us manages to sleep with you and the whole country will now know that you are no longer a virgin.	
Respondent 8	Yes I would use them because it's the most important thing that I have to do without it there is nothing I can do and I will just fall apart and I become nothing in the future.	I will my future depends on it
	We are compelled.	
Respondent 9	I would use them too, because I what I believe in is that the circumstances of our background must never define our lives.	I will I believe in is that the circumstances of our background must never define our lives.
Respondent 10	I would use them because not to say everyone in this generation want to listen but the coming generation maybe they will be able to take this information and use it well.	I will use it to be a good role model
	They must not quit on this and they must	

	continue doing it.	
Respondent 11	Because I'm now having sex I would use pills because I know how dangerous others are and because I wouldn't have a problem in my body.	Yes I will use them because I want to finish school
	They are not risky which will allow me to finish school.	
Respondent 12	As a black person I must destroy that perspective that says skin to skin but maybe to implement that person I will be having sex with use a Femi don and I use a condom in that way she can't get pregnant.	I will use them because I want to change peoples perspective of black people
Respondent 13	I will go to the clinic to get condoms.	Yes I will use them
Respondent 14	I prefer virginity testing because that would make me happy when people see how well I'm looking after myself.	Virginity testing because people will see how well I'm taking care of myself
	. Lets im from Durban and now I get to go to KwaNongoma where Im going to meet people.	Get to meet other people
	Where they are going to give you more information of how to better take care of yourself.	Get information from different people

#### 4. Concluding questions and statement

c) Is there anything else you would like to add or share about your experience as the learner who receives sexuality education.

Respondent	Responses	Themes
Respondent 1	Sexuality education is not enough, you need your parents. It all comes down to family values, when you talk with your parent, you just know that my mom will not approve of this because at home this is what we believe	Sexuality education needs to be supported by parents

	in	
	So if you are going to go according to the sexuality education that you are taught in LO, that will not be adequate for you in the future.	
	It wont be sustainable you also need your family values	
Respondent 2	Teenage pregnancy is something that will not change but we can limit it.	Teenage pregnancy cannot be eliminated but limited
	It like when a boy beats a girl up for sleeping around that will not change anything because our fathers and mothers they could not change it now who are we?	
	What can do is to try and reduce it by communicating with your parent and they must tell you as well ways of preventing pregnancy.	
Respondent 3	Teenage pregnancy will not end instead it's an on-going problem because the youth today are materialistic.	Teenage pregnancy will not end because teenagers are materialistic
	What would help is up-to an individual, what do you want in life and that will curb teenage pregnancy.	Teenage will be curbed if individuals know what they want in life.
Respondent 4	As important as it is to speak to parents but it's not all of us that has parents for instance you stay with your sister , one when its 22:00 she goes out, you wake up its midnight another one is gone and you left alone.	Its not easy when you do not have parents and rely on your siblings who themselves are still young
	You also see that I might as well go at 1AM. But if you know what you want like when they all leave and to do what its none of my business.	
	What I want is to carry-on with my studies.	
	What teenagers like to say and use it as an use is " I'm pregnant because at home we	

	are poor therefore I rely on my boyfriend to help me” .	
	We are poor most of us and we know poverty and if a person gets pregnant because they are poor there should be a whole lot of us who are pregnant with 5 children already.	
	Being poor and being pregnant those things go hand in hand because you now have this child, where are you going to find the money to buy nappies and all the things the child needs and these children get sick and you say it's because I'm poor.	
	I have a sugar daddy because I'm poor, what is stopping me from using a condom so that I do not get pregnant and avoid accumulating more problems	
	Let's not poverty as an excuse and you desire to sleep without a condom just do that and not blame that on being poor.	
	If the sugar daddy does not want a condom, tell him to try someone else	
Respondent 5	I think for us to get adequate information in life, everything that we need to know, we know that most information is vested in books.	Teenagers must seek information to guide them through life.
	We are always being told that. I have recently found this information that says only 1% of people read books in South Africa which shows that people do not like to read.	
	If they are not interested in reading they will lack information on things. I've also heard that only 5% of people in South Africa actually read books and those are parents that read books to their children.	
	Which simply means that our future is non-existence because which means for us to have information we only have to know about it through formal education.	
	AS Mandela said Education is the most powerful weapon one can use to change the world.	
	So black people especially do not like to read and we will be ignorant.	
	What they like is entertainment, when they watch television its only for entertainment like watching cartoons, movies and mostly uneducational stuff.	
	Sensible and important programmes like Doctor Phil usually talks about important	

	stuff and Steve Harvey and Doctor Oz, they talk about important things.	
	Entertainment television is of no use of no consequences and it does not help us in anyway.	
	So for us to be informed, learn we must read.	
	Somebody once said that if you want to hide something from a black person you must write it in a book because they don't like to read books.	
	A black person does not like books and as we are aout to close school people will only look at books when the schools open.	
	They only look at books at school and when they are at home they do not bother.	
	We will not have a great future if we do not read and most of the things that we spoke about here some of the people here were hearing about it for the first time like contraceptives methods.	
	People do not read but there is plenty of information everywhere and they just do not want to read.	
	What I can say is that please lets try to love reading even though we may feel that we do not like to but lets force ourselves to read so that we can have great future.	
Respondent 5	Learners should not be engaging in sexual intercourse even those things that meant to prevent pregnancy are not good for your body .	Learners should not be engaging in sexual intercourse because even the contraceptives cannot be trusted.
	I would be happy that as teens we do not rush things that are done by adults because it can affect your body .	
Respondent 6	Teenagers should decrease drinking alcohol because it is another cause teenage pregnancy and diseases.	Teenagers should stop consuming alcohol which leads to unsafe sex
	When you are drunk you do not think about protection, even the next day, you do not immediately think you should go test.	

Respondent 7	Parents should work with teachers because the child is taught about this at school and parents feel that when talking to a child but only to find out that a child has already engaged in sex.	Parents should work with teachers
	The child need that as a parent you talk to your child and make them aware and help them about what they should do.	
Respondent 8	Parents should try to understand the situation that times have changed, the way that they grew up then is not the same as we are growing up now.	Parents should be more understanding
	A child now their situation is not the same like how the parents when they were their age were like.	
	Parents must try and understand and try to teach us more.	
	If a child is not at school they are at home so when they get information at school they also get it at home and that can make them wiser in choosing what they should do.	

**b) Besides of what we talked about?**

<b>Respondent</b>	<b>Responses</b>	<b>Themes</b>
Respondent 1	Government should decrease rights that they afford to children, there is too much of them because rights spoil children .	Children have too many rights that are destroying them at the end
	A child will go out there do what they like and turn around and tell you that they have rights and that they know whatever they do the government will support her.	
	Parents can't even hit their children because they know that their children have rights.	
	Children continuing with school should not be allowed only those who were raped.	
Respondent 2	Lets those are pregnant are chased out of school, so those who were raped now everyone will know that those learners still at school were raped.	Learners cannot be chased out of school because they are pregnant

Respondent 3	It will be unfair because they are also pregnant its just that they got pregnant under different circumstance and everyone will know what happened to them.	Leaners cannot be chased out of school because others got pregnant under different circumstances
	Other children will not understand the situation and start blaming them about it. All of them should be allowed to school.	