

**THE EFFECTS OF UNPLANNED PREGNANCY ON FEMALE STUDENTS OF  
THE UNIVERSITY OF ZULULAND**

**BY**

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**A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE  
REQUIREMENTS FOR THE MASTERS DEGREE IN (COMMUNITY WORK)  
IN THE SOCIAL WORK DEPARTMENT (FACULTY OF ARTS) AT THE  
UNIVERSITY OF ZULULAND.**

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**DATE OF SUBMISSION: NOVEMBER 2008**

## **TABLE OF CONTENTS**

### **CHAPTER 1**

<b>CONTENTS</b>	<b>PAGE NUMBERS</b>
1. Scope of the study	1
1.1 Introduction	1
1.2 Background information	2
1.3 Statement of the problem	2
1.4 Objectives of the study	3
1.5 Motivation of the study	3
1.6 Significance of the study	3
1.7 Literature review	4
1.8 Research methodology	4
1.8.1 Sampling procedure	4
1.8.2 Sample size	4
1.9 Data presentation, analysis and interpretation	5
1.10 Ethical considerations	5
1.11 Conclusion	5

### **CHAPTER 2**

#### **LITERATURE REVIEW**

2. Literature review	6
2.1 Introduction	6-7
2.2 Conceptual framework	7
2.2.1 Unplanned pregnancy	7-8
2.2.2 Contraceptives	8-9
2.3 Modern contraceptives	9
2.3.1 Barrier methods	9
2.3.2 History of condoms	10
2.3.3 Types of condoms	11

2.3.3.1 Latex condoms	11
2.3.3.2 Polyurethane condoms	11-12
2.3.3.3 Novelty condoms	12
2.3.3.4 Advantages of condoms	12-15
2.3.4 Intra-uterine devices (IUD)	15
2.3.5 Oral contraceptives	15-16
2.3.6 Side effects of Oral contraceptives	16
2.3.7 Contraceptive injections	16
2.3.8 Emergency contraception (EC)	17
2.3.9 Sterilization	17-18
2.3.10 Termination of pregnancy (TOP)	18-19
2.3.11 Sexually transmitted infections (STI)	19
2.4 Contraceptives, Abstinence and unplanned pregnancy	19-20
2.5 Parents, School, and Sex Education	20
2.6 Birth control versus Abstinence and Sex Education	20-21
2.7 Young people and HIV and AIDS	21-22
2.8 The state of HIV and AIDS prevention among University students	22-24
2.9 Precursors of unplanned pregnancy among University students	24
2.9.1 Early independency	24
2.9.2 Lack of information	24
2.9.3 Problem-solving behaviour	25
2.9.4 Peer group influence	25
2.9.5 Poor self image	25
2.9.6 The influence of the media	25-26
2.9.7 The attitude of the community	26
2.9.8 The use of contraceptives	26-27
2.10 The Health Belief Model (HBM)	27-29
2.10.1 Individual perceptions of female that could influence the The non-utilization of contraceptives	29-30
2.10.2 Factors that could influence female students' non-utilization Of contraceptives	30

a) Age	30
b) Race	31
c) Gender	31
d) Social psychological issues	31
e) Cultural/traditional factors	32
2.11 The effects of unplanned pregnancy	32
2.11.1 School drop-out	32
2.11.2 The consequences of Dropping out	33
2.11.3 The economic consequences	33
2.11.4 Social consequences	33-34
2.12 Consequences of Early childbearing	34
2.12.1 Socioeconomic consequences	34-35
2.12.2 Educational consequences	35-36
2.12.3 Health related consequences	36-37
2.13 The emotional effects of unplanned pregnancy	37-38
2.14 The physical effects of unplanned pregnancy	38-40
2.15 The risk of using alcohol and drugs among teenagers and young Adults	40-43
2.16 Variables affecting female students likelihood of initiating and Maintaining actions to use contraceptives	43
2.16.1 Perceived benefits of contraceptives utilization	44
2.16.2 Perceived barriers to the utilization of contraceptives	44
2.16.3 Accessibility and affordability of contraceptives	45
2.17 Ways to prevent HIV and AIDS, STI's and unplanned pregnancy	45-47
2.18 Conclusion	47

**CHAPTER 3**  
**RESEARCH METHODOLOGY**

3. Research methodology	48
3.1 Introduction	48
3.2 The aim of the study	48
3.3 Research technique	48-49
3.4 Participants	49
3.5 Sample procedure	49
3.6 Measuring instrument	50
3.7 Scoring	50
3.8 Data analysis, interpretation and presentation	50
3.9 Conclusion	50

**CHAPTER 4**

**DATA ANALYSIS, INTERPRETATION AND PRESENTATION**

4. Data analysis, interpretation and analysis	51
4.1 Introduction	51
4.2 Demographic characteristics	52
4.3 Results presentation	53-74

**CHAPTER 5**

**SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUSION**

5. Summary of findings, recommendations and conclusion	73
5.1 Introduction	73
5.2 Restatement of the problem	73
5.3 Restatement of the Objectives of the study	73
5.3.1 The Objectives of the study	73-75
5.4 Findings and conclusion of the study	75
5.4.1 Summary of the findings of the study	75-76
5.4.2 Conclusion	76
5.5 Recommendations	77
6. References	79-81
Appendix	82-87

## **LIST OF TABLES**

Table 4.1: Demographic characteristics

Table 4.2: Respondents and the partner still having an intimate relationship

Table 4.3: Does unplanned pregnancy strengthens the relationship with the partner

Table 4.4: Respondents opinion about termination of pregnancy

Table 4.5: Have felt being neglected by the family

Table 4.6: Respondents presently using any contraceptives

Table 4.7: Does unplanned pregnancy make you feel good about yourself

Table 4.8: Respondents perception about utilization of contraceptives

Table 4.9: Respondents opinion which age group is at risk of experiencing unplanned pregnancy

## **LIST OF FIGURES**

Figure 4.1: Respondents consideration of termination of pregnancy

Figure 4.2: Responses about whether or not use of alcohol and drugs has an impact on unplanned pregnancy

Figure 4.3: Respondents use of any contraceptives before unplanned pregnancy

Figure 4.4: Responses on whether unplanned pregnancy makes respondents differ from their peers

Figure 4.5: Responses on whether friends were supportive during unplanned pregnancy

Figure 4.6: Respondents social and emotional effects of unplanned pregnancy

Figure 4.7: Responses on stigma in being pregnant before marriage

Figure 4.8: Respondents consideration of being infected or affected with HIV and AIDS during unplanned pregnancy

Figure 4.9: Does unplanned pregnancy cause any financial constraints in your family

Figure 4.10: How many children do you have been they planned

Figure 4.11: Is unplanned pregnancy resulted fro rape

Figure 4.12: Have studies been affected the unplanned pregnancy

Figure 4.13: Have heard of the DNA test

Figure 4.14: Would go for the test to be sure of the child's paternity

## **APPENDIX**

### Appendix A: Interview schedule (Questionnaire)

## **DECLARATION**

I, Nothando Nokuthula Gama hereby declare that this document is my own work and that all the sources used have been acknowledged by means of complete references.

.....  
Nothando Nokuthula Gama

.....  
Date

## ACKNOWLEDGEMENTS

I would like to express my sincere appreciation and gratitude to numerous people without whose contribution, support, guidance and encouragement the completion of the dissertation would not have been possible.

- ❖ Firstly, the almighty God for the strength, guidance, support and wisdom to complete this study, without him I would not be possible.
- ❖ To my Supervisor, Dr R.T Buthelezi for her guidance, supports, motivation and inspiration throughout the course of this study. SHENGE, SOKALISA, Dr N.H Ntombela and Mrs S.J Magagula for their guidance and motivation.
- ❖ To my Mother, Father and my two Sisters for emotional support, financial support, encouragement, inspiration and motivation throughout the course of the study and to my special friend Nozipho who also encouraged and supported me throughout my studies.
- ❖ To my Boyfriend, Sbongiseni Majola for his emotional support, encouragement, unconditional love and most of all for believing in me.
- ❖ Finally, to my research respondents who made it possible for me to collect data through their willingness and co-operation.

## **DEDICATION**

This Dissertation is dedicated to my late Grandmother, Elizabeth Shange (MaGumede) for her parental guidance and undying love for the family.

## **ABSTRACT**

The study investigated the effects of unplanned pregnancy on female students at the University of Zululand. The sample consisted of 22 female students whose ages range from 15-26+. Female students who are sexually active were more likely to use no contraceptives, which puts them at a high risk of unplanned pregnancy. Some are influenced by their partners regarding birth control or they forget to use contraceptives altogether. University students engage in sexual intercourse, generally with multiple partners.

The University of Zululand female students are faced with the problem of unplanned pregnancies, which is very high. It has become imperative, therefore, to get some answers to the questions as to why some fall pregnant and say it was unplanned and some do not know who impregnated them. The researcher wanted to examine perceptions of the effects of unplanned pregnancy on female students; to examine long term or on-going effects that female students might experience after termination of pregnancy or miscarriage, and to investigate the level of knowledge related to contraceptives and other means of preventing unplanned pregnancy.

The findings show that it is the young adults (15-19) years of age that are mostly affected by unplanned pregnancies. Racial group are the blacks, those who are not married, are mostly experiencing unplanned pregnancy. There are a few people who are using contraceptives; this also indicates that there is lot that needs to be done in educating people about the use of contraceptives.

# Chapter 1

## 1. Scope of the Study

### 1.1 Introduction

Female university students are given many options by health care professionals in the use of contraceptives; it is of concern that most pregnancies in campuses are unplanned. The question is, it is because students may lack information about the use of contraceptives? Female students who have knowledge about contraceptives tend to be more satisfied with contraceptive use and in most cases; they plan their pregnancies by using contraceptives.

Female students who are sexually active were more likely to use no contraceptives, which puts them at a high risk of unplanned pregnancy. Some are influenced by their partners regarding birth control or they forget to use contraceptives altogether.

Assessing the level of a woman's knowledge regarding birth control, followed by a careful explanation of the side effects of a contraception choice, may reduce the rate of unplanned pregnancy. Counselling the male partner or sexually active men regarding contraceptive options may be equally important in reducing the high rate of unplanned pregnancies (Babbie, 2004:20).

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careful explanation of the side effects of a contraception choice, may reduce the rate of unplanned pregnancy. Counselling the male partner or sexually active men regarding contraceptive options may be equally important in reducing the high rate of unplanned pregnancies (Babbie, 2004:22).

## **1.2 Background information**

According to University statistics (2006) the majority (60%) of today's University students engage in sexual intercourse, generally with multiple partners. While many of these sexually active female students use contraceptives, some do not use them at all. The University of Zululand Health Centre revealed that in 2006, 40% of the women were not using any contraceptives at the time they were seeking the pregnancy test and some were failing to use contraceptives properly or not using contraceptives at all. It is not surprising that 12% of University of Zululand students report either experiencing or being involved in unplanned sexual intercourse (Wallman, 2007:34), which led to unplanned pregnancies.

## **1.3 Statement of the Problem**

The University of Zululand female students are faced with the problem of unplanned pregnancies, which is very high. It has become imperative, therefore, to get some answers to the questions as to why some fall pregnant and say it was unplanned and some do not know who impregnated them. The purpose of the study was essentially, to describe the female students' perceptions of the effects of unplanned pregnancy while enrolled full-time in an institution of higher learning.

#### **1.4 Objectives of the study**

**The following are the objectives of the study**

- a) To examine perceptions of the effects of unplanned pregnancy on female students
- b) To examine long term or on-going effects that female students might experience after termination of pregnancy or miscarriage.
- c) To investigate the level of knowledge related to contraceptives and other means of preventing unplanned pregnancy.

#### **1.5 Motivation of the Study**

The motivation for the researcher has come from a thorough observation of female students on the campus. There are a number of reported cases of unplanned pregnancy and some only had one-night stands-where you find that a person is sexually involved with someone she has just met for one day. Others have been rejected by their partners and been on a rebound so they engage in the one-night stand.

#### **1.6 Significance of the Study**

The research assisted in providing information useful in eliminating the high rate of unplanned pregnancy on campus mainly at the University of Zululand. The study will also assist the victims to be able to disclose information about their experiences. Lastly, it will help in addressing problems faced by the victims. Furthermore, the findings from this study will be significant for several groups, including student affairs professionals, counsellors or psychologists, and those interested in woman's issues. Student affairs

practitioners may use the results of this study to better understand the needs of female students who experience unplanned pregnancy. More knowledge about this population's needs and challenges may enable universities to respond appropriately to their needs.

### **1.7 Literature review**

The literature reviewed includes both primary and secondary sources of information obtainable from libraries, the internet and record centres.

### **1.8 Research Methodology**

The research design was explorative and descriptive. The research methods were both qualitative and quantitative. The tool for collecting data was an interview schedule in face to face interviews. It comprised close-ended questions, and open-ended questions the latter would further clarify the respondents' views.

#### **1.8.1 Sampling Procedure**

The researcher has used non-probability sampling method in the form of purposive sampling procedure.

#### **1.8.2 Sample Size**

The researcher interviewed 30 participants to represent a larger group of population. The sample was comprised of past and current victims, who had experienced the effects of unplanned pregnancy. The participants were female students of University of Zululand of different ages, from 15-26 + years.

### **1.9 Data Presentation and Analysis**

The collection of data was presented and analyzed in the form of descriptive statistics. Responses were analyzed to determine frequencies, percentages and relationships among variables. For the open-ended questions, responses are organized into themes and then discussed.

### **1.10 Ethical considerations**

The full explanation and the purpose of the study were provided to respondents so they could give their consent to participate in the study and to foster full co-operation of participants. Ethical commitment with regard to informed consent, confidentiality and anonymity through the process was maintained. The names of respondents were not used in the study.

### **1.11 Conclusion**

In this chapter an overview of the study is outlined. The following aspects have been discussed, the background information of the study, statement of the problem, objectives of the study, motivation, significance of the study, literature review, research methodology, sampling procedure, sample size, data presentation and analysis and ethical considerations.

## **Chapter 2**

### **2. Literature Review**

#### **2.1 Introduction**

This chapter discusses the literature review undertaken on female use of contraceptives. According to Pilot and Hungler (1997:645), a literature review involves the systematic identification, location, scrutiny and summary of written material that contains information on a research problem. Pilot and Hungler (1997:643) further state that a literature review refers to an extensive and systematic examination of books, publications and articles relevant to the research. The purpose is to explore theory and research that has developed about the topic being studied, identify the definition of concepts and variables already established, examine elements of research used by others, such as designs, methods, instruments and techniques of data analysis that may prove useful in the proposed project.

The purpose of the literature review in this study was to obtain information on female students' utilization of contraceptives. This would familiarize the researcher with the topic and help to identify gaps and weaknesses in the literature in order to justify the new investigation. The researcher discovered what was known and what remained to be done in the field of study, what could be replicated and which findings might be compared and contrasted in the proposed study.

According to Uys and Basson (1991:20) the researcher should see the problem within a broader perspective and evaluate findings and their significance more effectively. The

literature review revealed that considerable research had been done on females and contraceptives but not specifically in the University of Zululand. The literature review is discussed with reference to the three components of the health belief model (HBM), namely individual perceptions, modifying factors, and variables affecting the likelihood of initiating action, conceptual framework, causes of teenage pregnancy, the effects of unplanned pregnancy, the risk of using alcohol and drugs, modern contraceptives, termination of pregnancy, and ways to prevent HIV/AIDS, STI's and unplanned pregnancy, are also focused on (Babble, 2004, 6).

*The following discussion focuses on the definition of the key concepts/terms used in the study.*

## **2.2. Conceptual Framework**

For the purpose of the study the conceptual framework was discussed.

### **2.2.1 Unplanned Pregnancy**

McBurney & White (2007, 157-158) state that, it is extremely difficult to draw a clear line between those pregnancies that are planned and those that are unplanned. It is difficult to arrange a pregnancy to order. The average fertile couple trying for a child may take three or four months to conceive, and many couples go through a stage where they are not exactly planning to have a child now, but at the same time they are not exactly doing everything in their power to prevent it either. Field ( 2000: 125) indicates that women who use the contraceptive pill are often advised to switch to a barrier method of contraception, such as a diaphragm or condom, three months before they intend to start 'trying' for a child.

Barrier methods are inherently less effective and if the couple has difficulty using them, and happens to be highly fertile it is quite possible that the pregnancy intended for three months hence arrives sooner than planned. Technically this scenario could also count as “Unplanned pregnancy”. Other similar situations may arise. For example, what about the situation where one partner wants a child, but the other is reluctant? A woman may assert her maternal ambitions by frequently 'forgetting' to take her contraceptive pill thereby becoming pregnant 'accidentally on purpose'. She may always insist that she conceived *unintentionally, never admitting that she took chances that she would not have taken had she been committed to avoiding pregnancy*. Men can just as easily manipulate things so that risk situations occur. He may 'forget' to buy condoms, insist if they have sex he will withdraw before ejaculation and then get 'carried away', or he may deliberately engineer situations where unprotected sex is likely. Sometimes these manoeuvres are quite conscious and deliberate, at other times they are unconscious and not even recognized by the people who perpetrate them (Debby, 1992: 45).

An unintended pregnancy is a pregnancy that is either mistimed or unwanted at the time of conception. It is a core concept in understanding the fertility of populations and the *unmet need for contraception*. *Unintended pregnancy is associated with an increased risk of morbidity for women, and with health behaviours during pregnancy that are associated with adverse effects*. For example, women with an unintended pregnancy may delay prenatal care, which may affect the health of an infant. Women of all ages may have unintended pregnancies, but some groups, such as teens, are at a higher risk (Williams-

Wheeler, 2005:89). The average ages at the University range from 16- 22 years in undergraduate educational levels. A closer look at contraceptives is imperative in understanding planned and unplanned pregnancy

### **2.2.2 Contraceptives.**

Contraceptives are devices or medications designed to prevent pregnancy by either suppressing ovulation, preventing sperm from passing through the cervix (Furedi, 1996:101).

Barrier methods of contraceptives include methods that physically and chemically prevent pregnancy by blocking the passage of sperm into the uterine cavity (Kasner & Tindall (1995:47) cited by Story (1999:25). All barrier methods are used locally within the male or female genitalia . Condoms, spermicides, diaphragms and cervical caps are types of barrier methods. Male and female condoms are the mostly used barrier methods available in the public care services. A condom is a contraceptive sheath worn by the male or inserted into a woman's vagina to protect both partners against sexually transmitted diseases (STI's) and pregnancy.

### **2.3 Modern contraceptives**

The following modern contraceptives are discussed: barrier methods, oral contraceptives, injections and condoms.

#### **2.3.1 Barrier methods**

Barrier methods help to prevent both pregnancy and STI's, including HIV and AIDS. Female student failed to use condoms effectively to prevent unplanned pregnancies (Dubois-Arber, 2000:208).

### **2.3.2 History of condoms**

According to Renato (1997:120) condoms act as a mechanical barrier; they prevent pregnancy and reproductive tract infections by stopping sperm from going into the vagina. They should be placed on the penis before it enters a partner's vagina. Condoms are made of latex (often called "rubbers"), polyurethane (plastic), or natural membranes (often called "skins" and made from the intestine of sheep). Polyurethane condoms may be used by couples when either partner is allergic to latex. Condoms are one of the only methods of contraception that are also effective for use with oral sex, sex toys and anal sex. *Condoms resemble a long thin deflated balloon. Male condoms are considered to be between 85-98% effective. Among typical couples, about 15% will experience an accidental pregnancy in the first year. If condoms are used consistently and correctly, about 2% will become pregnant over the course of an entire year.*

The study conducted at the University of the states reveals that condoms help to prevent both pregnancy and STI's, including HIV and AIDS. Female student failed to use condoms effectively during sexual intercourse to prevent unplanned pregnancies (Lawrence & Brasfield, 2003:147).

The Egyptians have been pioneers in the use of condoms for protection against sexually transmitted diseases. The first historical mention of use of condoms (in the form of a linen sheath) dates back to as early as 1000 BC! Paintings and ancient writings hint at the possibility of condoms being used also in Europe, especially Rome around 100- 200 AD. Perhaps the spread of syphilis, a sexually transmitted disease across Europe around the 1500s prompted for the invention of the condom. A simple sheath made out of linen was

claimed to prevent spread of the infection. Such sheaths were soaked in a chemical solution and later allowed to dry, paving the way for incorporation of the first spermicides on condoms. The use of condoms for contraception is nothing more than an Extrapolation of condom functionality

The Word 'condum' was first used in a poem composed at around 1706. The invention of the condom is still controversial. Several reports suggest that the device is named after Dr. Condom who lived during the reign of Charles II. Condoms made out of animal intestines were available around 1700 AD. However, cost concerns limited the wider usability of this simple device (Goldzieher, 1993: 3)

### **2.3.3 Types of condoms**

As it is rightly said, 'Prevention is better than cure', it is safer to use a condom to prevent sexually transmitted diseases, more specifically AIDS. It is agreeable to use a simple but effective condom for contraception rather than going in for an abortion at a later stage. A considerable variety of condoms is now available. A male condom is a sheath or covering that is fitted over the man's penis. It is open at one end and closed at the other end (Darrow, 2001:267).

#### **2.3.3.1 Latex condoms**

These condoms are made up of latex rubber. This type of condom is now available at very low rates in most countries. This can be used only with a water-based lubricant and not with oil-based lubricants such as Vaseline or Cold cream. Some people might be

allergic or sensitive to latex condoms. Such individuals can resort to polyurethane condoms (Darrow, 2001:268).

### **2.3.3.2 Polyurethane condoms**

Polyurethane is a type of plastic. It is much thinner than latex rubber, making it more sensitive. Hence it offers a superior advantage in terms of the feel and appearance to most of the users. It can be used with both water and oil- based lubricants, and is generally expensive when compared to the latex condoms.

The data on the efficiency of condoms is controversial. The golden rule therefore is to use the condom appropriately to maximize the benefits (Paul & Hayes, 2002:421).

### **2.3.3.3 Novelty condoms**

These are special condoms meant for fun and enjoyment and do not confer any protection against HIV and AIDS or other sexually transmitted diseases. They do not prevent pregnancy either. These are labelled 'FOR NOVELTY USE ONLY'. Caution has to be excised while purchasing such types of condoms (Darrow, 2001:269).

### **2.3.3.4 Advantages of condoms**

- a) Proper and consistent use of condoms prevents transmission of sexually transmitted diseases (AIDS HIV, Syphilis).
- b) Reliability is high if used appropriately.

- c) Availability of different shapes, sizes and types of condoms. There is one for every body.
- d) Ease of purchase of a condom at pharmacy supermarket, departmental stores. There is no need for a prescription and is even provided free of cost in health centres and family planning clinics.
- e) Condoms are easy to use, and very little practice is needed.
- f) It can be used during each act of intercourse whereas birth control pills have to be taken for a prolonged period.
- g) *Enhances responsibility and mutual understanding between the partners.*
- h) Use of condoms is devoid of any side effects and is much cheaper when compared to other forms of birth control. They have the potential not only to prevent unplanned pregnancy, they also help to:
  - i) Prevent STI's, including HIV and AIDS, as well as pregnancy, when used correctly with every act of sexual intercourse.
  - j) Protect against conditions caused by STI's- pelvic inflammatory disease, chronic pain, possible cervical cancer in women, and infertility in both men and women.
  - k) They prevent STI's during pregnancy.
  - l) Condoms are suitable for use after childbirth.
  - m) *Are safe because no hormonal side effects are incurred.*

- n) Can be discontinued at any time.
- o) Offer occasional contraception with no daily upkeep.
- p) Are easy to keep on hand in case sex occurs unexpectedly.
- q) Can be used by persons of any age.
- r) Can be used without consulting a health care provider.
- s) Are usually easy to obtain and sold in many places.
- t) Enable a man to take responsibility for preventing unplanned pregnancy and disease.
- u) Increase sexual enjoyment because there is no need to worry about pregnancy or STIs.
- v) Help prevent premature ejaculation.
- w) A female condom is controlled by a woman.
- x) Condoms can be acquired without prescription and are obtainable from local clinics, hospitals or bought from pharmacies, supermarkets or sex shops. Female condoms might not be readily available from health care services and are relatively expensive (Watkins & Siegal, 1998:24-26).

The following disadvantages of condoms should be indicated to condom users in order to adhere to correct practice (Hatcher: 2004; 45).

- a) Unless the woman puts it on as a part of foreplay, condom application may

interrupt sex.

- b) Condoms require some practice to learn how to use.
- c) Condoms can break or tear when they interact with sharp objects such as scissors, rings, fingernails, teeth, piercing, and other sharp objects.
- d) You can't use oil based lubricants such as Vaseline, sun tan oil, or Crisco with latex condoms! These products weaken the latex, and can cause condoms to tear.
- e) Some men cannot maintain an erection while wearing a condom.
- f) The man must pull immediately after ejaculation. If the male becomes flaccid before withdrawal, accidental pregnancy or infection may occur.
- g) Some people are sensitive (or allergic) to latex or find the smell very unpleasant. They must use polyurethane condoms: Durex-Avanti, Trojan-Supra or Reality Female Condom.
- h) Buying, negotiating use, putting on, and getting rid of condoms may be embarrassing.
- i) Condoms decrease enjoyment of sex for some couples by causing decreased sensation for either partner. Recently, however, many manufacturers have released condoms that allow for greater sensation.

Health care providers must teach all students about the advantages and disadvantages so that they can use condoms correctly at all times. Leaflets or guidelines on how to open a condom, including the steps of using it effectively, should be included in all condoms

packs. All health care providers should be willing to demonstrate condoms use to every client.

#### **2.3.4 Intra-uterine devices (IUD)**

An IUD is a small device that is put into a women's uterus (womb) by a specially trained health worker. An IUD can prevent pregnancy for at least five years. It does not prevent Sexually Transmitted Infections (STI/HIV and Aids). If a women or her partner has multiple sex partners, the IUD should not be the method of first choice unless condoms are also used, to protect against STI/HIV transmission (Real magazine, 2008: 450).

#### **2.3.5 Oral contraceptives**

The Combined Oral Contraceptive Pill (COCP), often referred to as "the Pill", is a combination of an estrogen (oestrogen) and a progestin (progestogen), taken by mouth to inhibit normal fertility. Combined oral contraceptives were developed by Gregory Goodwin Pincus, John Rock, and Min Chueh Chang. They were first approved for contraceptive use in the United States in 1960, and are still a popular form of birth control. They are currently used by more than 100 million women worldwide and by almost 12 million women in the United States. Usage varies widely by country, age, education, and marital status: one quarter of women aged 16 - 49 in Great Britain currently use the Pill (combined pill or mini-pill), compared to only 1% of women in Japan (Paul & Hayes, 2002: 360).

Women who use oral contraceptives swallow a pill daily to prevent pregnancy. There are

very effective in preventing pregnancy when taken regularly every day, and are safe for most people. There are two types of oral contraceptives: combine oral contraceptives (COCs) and progesterone-only pill (POPs). COCs contains both synthetic progesterone and oestrogen whereas POPs contains only progesterone.

Oral contraceptives have been proven to be effective in controlling pregnancy when taken correctly and consistently, that is, at the same time every day, and do not interfere with sexual intercourse. Some female students preferred using contraceptive pills because they were familiar with pills and they continued to menstruate regularly while using contraceptive pills ( Sabogal & Catania,1996: 300).

### **2.3.6 Side effects of Oral Contraceptives.**

The possible side effects are: vaginal discharge, changes in menstrual flow, breakthrough bleeding, nausea, vomiting, headaches, changes in the breasts, changes in blood pressure, loss of scalp hair, skin problems and skin improvements. The insert included with each pill packet usually has a more extensive list of recognized side effects (Sabogal & Catania, 1996: 231).

### **2.3.7 Contraceptive injections**

There are two types: Nur-Isterate, which is given every two months (8 weeks) and DMPA (Depo Provera or Petogen) which is given every three months (12 weeks). This form of contraception does not prevent Sexually Transmitted Infections (STI) and HIV and AIDS ( Sabogal & Catania,1996: 230).

### **2.3.8 Emergency contraception**

This method can be used by women who want to prevent pregnancy because they have had unprotected sex, been raped or they suspect that the contraception they used during sexual intercourse did not work properly. Emergency contraceptive pills can be taken 72 hours (three days) after unprotected sex to prevent unwanted pregnancy, but the earlier the pills are taken the better they work. Pills are free of charge at clinics and hospitals and can also be bought without prescription at pharmacies.

An IUD can also be inserted within five days of unprotected sex to prevent unwanted pregnancy. If it is too late for these emergency contraceptive methods, and an unwanted pregnancy is suspected, a Termination of Pregnancy (TOP) is available as a last resort. TOP is legal in South Africa (Shoupe & kjos, 2006:140).

### **2.3.9 Sterilization**

This is a permanent contraceptive method for both women and men. Any person 18 years or above who is capable of consenting may be sterilised at his or her request. Counselling should be given before the procedure. It is a short and simple operation that does not affect one's sex life, other than giving peace of mind about unwanted pregnancy. A booking for sterilisation can be made at the local clinic. Counselling is provided and a request form will need to be signed. The operation is free of charge at some community health centres and hospitals at every level (primary, secondary and tertiary). The doctor who does the operation will ask the client to sign a consent form.

The operation for females is called a tubal ligation. The fallopian tubes that carry the eggs

from the ovaries to the uterus (womb) are tied or blocked. The eggs are prevented from becoming fertilised by the sperm and pregnancy is prevented.

The procedure for males is called a vasectomy, which is usually done while the man is awake, using local anaesthetic, or a general anaesthetic. One or two very small openings are made in the skin near the testicles. The vas deferens (sperm tube), which carries sperm from each testicle, are cut and tied. The operation is not immediately effective and another contraception method is needed for three months after the operation, or for the next 15-20 times that the man has sex. A confirmatory test (sperm count) is necessary to ensure that the sperm is cleared from the tubes.

Sterilisation does not prevent Sexually Transmitted Infections (STI/HIV/Aids). As with all contraceptive methods, there is a small risk of failure (Sabogal & Catania, 1996:250)

### **2.3.10 Termination of pregnancy (TOP)**

Termination of pregnancy or TOP is a term used to describe abortion. TOP ends pregnancy before birth takes place. TOP is a special procedure that can only be carried out by a trained health worker in a government approved clinic or hospital (Carolyn, 1990:25). Any women (irrespective of age) can get a legal abortion for an unwanted pregnancy according to the Choice of Termination of Pregnancy Act no 92 of 1996. Pre- and post- TOP counselling that is not prescriptive should be provided. Parental or partner's consent is not required. Women are advised to go for safe, legal abortions rather than "backstreet" abortions that are likely to endanger their health and their lives. Also see Contraception (Family Planning) for emergency contraception.

To get a free abortion, the request for a TOP must be made at a primary health care clinic, where the pregnancy will be confirmed, counselling provided, an appointment made, and a referral letter be given to a facility where the procedure can be performed. Not all health workers are willing to be involved in this service, but they are obligated by law to inform the client of her rights and must refer the client to a health worker or facility where she can get the service.

The service can also be accessed via a General Practitioner (GP) but a consultation fee will be required. Marie Stopes Clinics and private hospitals also provide the service for a fee.

Any girl or women can ask for a TOP in the first three months (12 weeks) of pregnancy. It is important to act quickly if an unwanted pregnancy is suspected.

If you are three to five months (13-20 weeks) pregnant, a different set of rules apply for TOP. The doctor, in this case, will carry out the TOP only if:

- a) There is a risk to the physical or mental health of the woman or foetus.
- b) Having the baby will cause major social or economic problems for the mother.
- c) The woman is pregnant from rape or incest.

The service, however, must still be requested at primary Health Care Centres (Hatcher & Nelson, 2004:89-100).

### **2.3.11 Sexually transmitted infections**

Makhubele (2004: 20) defines sexually transmitted infections as venereal infections.

which are infectious since they are passed from one person to another through coitus or other intimate contact. Sexually transmitted infections include gonorrhoea, Chlamydia, genital herpes, syphilis and HIV/AIDS (Baker 1999: 439).

#### **2.4 Contraceptives, Abstinence and Unplanned pregnancy**

The type of sex education received by teenagers and young adults has come under the microscope. Some have criticized sex education programs for their focus (or lack thereof) on either abstinence or birth control as a way to prevent unplanned pregnancy and abortion. Birth control and unplanned pregnancy are a sensitive topic for many, but a recent study has tried to analyze the connection between abstinence and contraceptive sex education, and the likelihood of experiencing an unplanned pregnancy (Musick, 1993: 41)

#### **2.5 Parents, School and Sex Education**

Women and men can receive sex education and information about birth control from a variety of sources. These include parents, school programs, doctors, clinics, friends, books and the Internet. Women are more satisfied as well as less likely to experience an unplanned pregnancy if they received sex education from a variety of sources.

Singh(,2000:56-57). inparticular states that the majority of young people preferred getting information about sex from their friends, as well as other informal sources as opposed to schools and clinics, for example Satisfaction proved to be an important consideration, and seems to be connected to fewer unplanned pregnancies.

## **2.6 Birth Control versus Abstinence and Sex Education**

The debate about sex education with a focus on either abstinence or contraception has been highlighted by critics. More specifically, the question arises: what type of education system can prevent unplanned pregnancies and abortion?

Women who received no education about abstinence or birth control from parents and schools were the most likely to have an unplanned pregnancy. In contrast, those who received sex education that either focused on abstinence only, or equally focused on *abstinence and contraception in school* were least likely to have an unplanned pregnancy or abortion.

In addition, the study looked at the relationship between religion and sex education. The results suggest that women who are not affiliated with a religion such as Christianity, Islam, Judaism, Hinduism or Buddhism were more likely to experience an unplanned pregnancy. This may be due to the type of education received from religious parents; for example, parents of respondents of Christian affiliation were more likely to teach their daughters about abstinence ([www.epigee.org/birth control education.html](http://www.epigee.org/birth%20control%20education.html)).

## **2.7 Young People and HIV/AIDS**

Unplanned pregnancy may not only result in an unwanted child but may have an impact in reducing STI and HIV and AIDS. *looking at young people and HIV and AIDS.* According to Miles & Huberman (2000: 65) they stated that today's young people are the AIDS generation. They have never known a world without HIV. Millions already have died. Yet the HIV and AIDS epidemic among youth remains largely invisible to adults

and to young people themselves. Stopping HIV and AIDS requires comprehensive strategies that focus on youth.

Of the over 60 million people who have been infected with HIV in the past 20 years, about half became infected between the ages of 15 and 24. Today, nearly 12 million young people are living with HIV and AIDS. Young women are several times more likely than young men to be infected with HIV. In nearly 20 African countries 5% or more of women ages 15 to 24 are infected. Such statistics underscore the urgent need to address HIV and AIDS among youth.

The Physical, psychological, and social attributes of adolescence make young people particularly vulnerable to HIV and other sexually transmitted infections (STI's). Adolescents often are not able to comprehend fully the extent of their exposure to risk. Societies often compound young people's risk by making it difficult for them to learn about HIV and AIDS and reproductive health. Moreover, many youth are socially inexperienced and dependent on others. Peer pressures easily influence them often in ways that can increase their risk.

In addressing the epidemic, recent declines in incidence of HIV and AIDS in a few countries, are accompanied by signs that young people are changing their risk-taking behaviour, give hope. AIDS today is widely seen as a social crisis as well as a problem of individual behaviour.

Young Adults who are sexually active and/or use injection drugs are at risk of HIV infection. Since the beginning of the HIV epidemic the average age of infection has decreased. Although young adults are better informed of how HIV is transmitted, there is

ample evidence to suggest that youth do not always protect themselves or others. Sexually transmitted disease rates are generally falling, but are still highest among youth. Unplanned pregnancy, multiple sexual partners and sexual activity without protection are still common. Alcohol and other drug use are highest among youth and are associated with a risk of acquiring HIV (Singh, 2000:98).

## **2.8 The State of HIV and AIDS Prevention among Youth**

Young people are the key to the management of the HIV and AIDS epidemic. Preventing HIV transmission among youth will be a determining factor in the course of the epidemic for decades to come. Persistent HIV prevention efforts are required to keep youth well informed of the modes of transmission and means of protection from HIV infection. While this information is necessary, it is not sufficient to protect youth from infection. *Young people also require guidance and assistance in understanding their personal values in developing skills to protect themselves, and in recognizing how their social environments can help support them in making decisions.* Parents, schools, public health and the professional community have an important role. The AIDS epidemic is complex, and thus only a combination of approaches can succeed. It is increasingly clear, however, that youth must be at the centre of strategies to control HIV and AIDS.

According to Luker (1996: 185), there must build support for AIDS prevention, until more leaders speak out about the AIDS crisis among youth and give it top priority for fighting with HIV and AIDS.

Offering education and communication, young people need help to become aware of risks for HIV and AIDS and how to avoid them. Education and communication programs

must go beyond merely offering information to fostering risk-avoidance skills as well, such as delay of sexual debut, abstinence, and negotiation with sex partners. HIV and AIDS education should be before children become sexually active.

Addressing cultural and social norms, many traditions and cultural practices increase risks for young people more than adults and for young women even more than young men. Efforts to involve communities and to change social norms are as crucial as efforts to reduce individual risk-taking (Luker, 1996: 172).

Promoting condoms for dual protection, condoms are the only contraceptive method that can protect against HIV as well as against pregnancy. Condoms should be widely accessible, and their use promoted among sexually active people of all ages.

Making services youth-friendly. to serve young people better. health care providers must do more to make young people feel welcome and comfortable. Services, including treatment of STIs and voluntary HIV counseling, testing, and referral, should be provided confidentially and sensitively.

Reaching out. programs need to reach out to street children, sex workers, and other vulnerable youth, including the millions of young people orphaned by AIDS. Most programs for youth work better when young people help plan and run them. Programs must also find more effective ways to reach parents and other adults who can influence young people's lives (Luker, 1996:190).

## **2.9 Precursors of Unplanned pregnancy among University Students**

Many factors cause unplanned pregnancy. Although one specific cause may be identified, research relating to these causes indicates a concomitant of factors leading to young person's pregnancy.

### **2.9.1 Early independence**

When a young person moves out of their parents' home at a very early age, direct parental control ceases and identification with the peer group increases. A natural fading out of the sexual values that were taught by their parents takes place, and they are replaced with a more liberal sexual value orientation. In such conditions sexual intercourse is practiced, with resultant pregnancy (Zama, 1991: 45).

### **2.9.2 Lack of information**

Sex is the topic that is least spoken about by members of a family. Teenagers who experience physiological and other changes often find it difficult to discuss these experiences with their parents and siblings. In need of information, they turn to their peers for guidance or seek information from books, magazines articles, videos and the like. Not all information obtained from these sources is correct or satisfies the curiosity of the teenager. This increases the chances of teenagers experimenting with sex, the outcome of which is sometimes an unplanned pregnancy (Brent, 1992:12).

### **2.9.3 Problem-solving behaviour**

An unknown percentage of young female intentionally fall pregnant. By falling pregnant

they hope to find a solution to their problems, be they real or imagined. By falling pregnant with a certain male's child, the young female hopes that he will marry her. Others may find it impossible to live in the same house-hold as their step-parents and by falling pregnant they hope to achieve independence away from their homes. The rebellious teenager may intentionally or unintentionally fall pregnant because she seeks release from her frustrations and anger by indulging in sexual activity (Parrot, 2004:257).

#### **2.9.4 Peer group influence**

The peer group is the most important socialization agent next to the family. The peer group is also a primary source of information about sex. Besides the fact that this information may be incorrect, peer pressure on the teenager to indulge in sex because everyone does it or not to feel out, may be the direct cause of an unplanned pregnancy (Corbin, 2006:352).

#### **2.9.5 Poor self-image**

Doweiko (2006:80) stated that during adolescence the teenager seeks to build an esteemed self-image. It is through interaction with significant others that a self-image is created. If the interaction between the teenager and the significant others is positive, the teenager will develop a positive self-image. Teenagers who constantly have to prove their worth or endure continuous ridicule, or experience an identity crisis, may seek attention outside the home. Such attention-seeking behavior often ends in illicit sexual unions through which the teenager tries to prove his or her worthiness.

### **2.9.6 The influence of the media**

Barry (1993:45) indicated that much research has been done undertaken about the influence of the mass media on the individual. Today, the teenager has greater opportunity to view sexual activity on national television than before. Sexually arousing material, be it on film, in print or set to music, is freely available to the teenager. Often such information is presented out of the context of the prescribed sexual norms of that society. This influences the teenager to internalize antisocial sexual behavior or to experiment with illicit sexual activity, with resultant pregnancy. Together with peer pressure, the influence of the mass media has a powerful triggering effect on the teenage to indulge in illicit sex. The media also has an influence on attitudes of people.

### **2.9.7 The Attitude of the community**

Both modern and developing societies are becoming increasingly complex. Norms and values are in a state of change. often creating confusion among interacting individuals. Like most norms and values, the norms and values regulating sexual behavior change with time are creating confusion in those who want to conform to them. There is a discrepancy in what is conveyed about sex by the parents, religious leaders and teachers. and what is experienced by the teenager as happening in the community. In the midst of this confusion, teenagers resort to experimentation, often with resultant pregnancy (Bezuidenhost, 2002:29).

### **2.9.8 The use of Contraceptives**

Bezuidenhout (2002:30-31) further stated that much disinformation exists about sex and the use of contraceptives. The result is that available contraceptives are not used or they are often used incorrectly. It is a known fact that sexually active persons, more often than not, first indulged in sexual activity without the use of contraceptives. Similarly, a visit to the general practitioner or the family planning clinic for guidance takes place only after they have been sexually active for some time.

There are theories that could lend light to the issues underlying non-utilization of contraceptives. One of these is the Health Belief Model.

### **2.10 The Health Belief Model (HBM)**

This model focuses on rational decision making as the sole basis of engaging in health promotion behaviour. As (Bandura, 1997) states, effective behavioural control is not solely achieved by will. It requires social and cognitive skills but also a strong belief in one's ability to exercise personal control. According to this view, for health intervention to be effective, it should instill into people the convictions that they have the capacity to alter their behaviour by insisting on the use of condoms and to deal constructively with risk situations to which they are exposed. Intervention must provide instruction and practice in doing so.

The AIDS risk reduction model according to (Coates, 1999), was developed specially for HIV related risks act, which incorporated all of the above concepts. It encourages motivation to act safely and skills to implement safe acts that must be acquired and

practiced. This model is based on the premise that to avoid disease, individuals must perceive that their sexual behaviour places them at risk for HIV infection; reach a firm decision to make behavioural changes and to take action. Skills training are needed for behavior change. Support maybe sought from self-help strategies (pamphlets, reading material and lectures, informal support, family, friends or professional helpers, physicians, mental health professionals and Clergy). The increase in funding for research in AIDS needs to be complemented by a structure that co-ordinates work across the federal agencies, non-Governmental organizations and promotes development of theory based interventions.

Despite the use of the health belief model, some disappointments have begun to appear in the AIDS literature. For example. the relationship between belief in the H.B.M. and condom use over three years amongst a large sample of 16-19 year olds. They found the belief in H.B.M. including perceived Susceptibility to HIV infection, perceived severity of HIV and perceived effectiveness of condoms in preventing infection, accounted for 10% of condom use.

This led to the authors to concluding that many other factors not specified in the H.B.M. also influence condom use. It becomes clear that to be effective. the approach will have to be extended firstly to street youth who are able to exercise little control over their sexual partners or the nature of their sexual experiences.

According to (Bandura, 1997). for AIDS prevention programs to be effective, it must address socio-economic and social cultural realities that impose restraints on the scope of

behaviour control amongst individuals in these groups. Interpersonal expectations, social norms and situational survival pressures, contain the degree to which the threat of the AIDS virus can be salient and the extent to which rational decisions or trained skills can be put into practice.

Secondly, by emphasizing cognitive processes, too little emphasis is placed on moral and emotional domains involved in AIDS related issues. As mentioned, current STD campaigns are ineffective as they enhance roles of those elements by inducing high levels of fear and by compounding perception of risk, with immoral behaviour. It is inappropriate when directed to individuals, for whom sexual behaviours are one way of surviving pressing and personal circumstances.

The effects of unplanned pregnancy will be further discussed under three approaches within the health belief model.

### **2.10.1 Individual perceptions of females that could influence the non-utilization of contraceptives**

Story (1999: 35) emphasized that some females might perceive contraceptives to be irrelevant or even harmful and these perceptions could result in unplanned pregnancies. Unplanned pregnancies could have serious implications for the physical, psychological and social well-being of females and even for their nuclear as well as extended families. Females should therefore be knowledgeable about contraception and different contraceptives, to enable them to make informed decisions about their own as well as their children's future. Adequate information about contraceptives could help females to

realize that effective utilization of contraceptives can successfully postpone pregnancies until they have completed their schooling and or are financially capable of caring for their children. Numerous factors could contribute to the many female adolescent pregnancies in the University level. However, female students require knowledge to be able to make informed decisions and to evaluate their attitudes and beliefs about contraceptives (Williams-Wheeler, 2005:72).

In a study in United State of America Clinton (1990; 90) cited by Story (1999) found that 23% of the females indicated that pregnancy was caused by girls seeking to prove their fertility. This perception might encourage females to engage in unprotected sexual intercourse and avoid using contraceptives so as to prove their fertility. Thus the desire to prove their fertility may have influenced some females' non-utilization of contraceptives. Males also want to prove their virility and do insist girls prove their "love" or commitment to them.

Watt (2001:226) found that the belief that condoms are difficult to use and interfere with sexual pleasure was perceived as a barrier to the use of condoms. Females were ashamed to use contraceptives, 49% feared parental reaction should their contraceptive use be discovered and 43% did not trust contraceptives at all. Thus females' attitudes of shame for using contraceptives, fear for parental disapproval and distrust in the efficacy of contraceptives all pose possible barriers to females' utilization of contraceptives to prevent unplanned pregnancies.

## **2.10.2 Factors that could influence female students' non- utilization of contraceptives**

The modifying factors that could influence female students' non-utilization of contraceptives includes demographic factors, such as age, gender and, and cultural / traditional beliefs and practices.

### **a) Age**

The ages of female students could be important in identifying the high risk age groups in order to make concerted efforts to provide such age groups with appropriate health education opportunities. Female students might not use contraceptives out of ignorance and the unavailability of contraceptives. The female students' age might influence their decision to engage in sexual intercourse and contraceptive non- utilization. Belfield (1998:31) cited by Story (1999:19) states that if sexual and relationship education is started at an early age, prior to females' sexual debut. such knowledge could help female students to delay their first sexual encounters.

Female students need knowledge about contraceptives before sexual activities commence in order to prevent unplanned pregnancies and reduce the number of female pregnant students on campus. Thus sex education needs to be considered.

### **b) Race**

The Oxford dictionary ( 2001: 128) cited by Story(1999:20). defines race as each of the major division of humankind, based on particular physical characteristics: racial origin or

the qualities associated with this; a group of people sharing the same culture, language, etc. The literature review revealed no racial factors, specific to race, which could contribute to female students' non-utilization of contraceptive (Bernard,2000: 56).

### **c) Gender**

There might be gender differences in sexual knowledge, attitudes and behavior among students of the University. Female and male students *might need interventions* that could improve their sexual knowledge and skills, clarify attitudes and beliefs, and enhance discussions and negotiation skills (Watt: 2001:227). Both female and male students should receive the same information about contraceptives and reproduction. Male students should be able to control reproductive opportunities by using male condoms to prevent unwanted pregnancies. However, the present study focused only on female students. *Gender differences related to the balance of power in a paternalistic society may cause women to have lesser control over their reproductive health* (Pate & Rimza. 2001:1)

### **d) Social psychological issues**

McBurney (2001:320) states that social values, beliefs and practices influence decision-making about the use of contraception. Some beliefs are beneficial and others are not. Female students are influenced by socio-psychological variables in deciding about initiating sexual relations and contraceptives use, possibly allowing their individual perceptions to be greatly influenced by their peers influence and expectations. These female students are still adolescents, and adolescence is a time of increased need for

acceptance and support from others (Nass & Fisher, 1998:90).

**e) Cultural/ traditional Factors**

Ethnic background, socio-economic class, educational level, religious affiliation and local community standards are interrelated factors in shaping females' sexual ideas and behaviors. Female students are from different cultural backgrounds, religious or traditions that might be influenced by different factors, or by the same factors but to different extents. This affects their decisions to use contraceptives or to arrange marriages (Windal, 1997: 59).

Many educated females tend to fetch greater bridal wealth (known as "lobola" in many South African traditional cultures), which may encourage parents to support their daughters' schooling, and perhaps their return to school following childbirth. However, encouraging their daughters to use contraceptives in order to complete their schooling prior to childbearing could be problematic for many parents, especially those living in traditional communities. Cultural/traditional factors could pose a problem to females' utilization of contraceptives, leading to unplanned pregnancies (Nass & Fisher 1998: 86). In the Zulul culture the "hlonipha custom does cause health professionals to be judgemental in helping young people, in a way that you can find the person failing to disclose information pertaining sexual activities and to ask questions about the use of contraceptives and the health professional might be judgemental towards that particular person.

## **2.11 The Effects of unplanned pregnancy.**

There are a variety of effects emanating from the consequences of unplanned pregnancy, particularly while still at the University.

### **2.11.1 School drop-out**

The U.S Department of Education (McMillen, Kaufman, & Whitener, 1996) defined a school drop-out as a pupil who leaves school before is/her program of study is complete, before graduation, without transferring to another school. Students who die during the course of study are not considered to be drop-outs, and their numbers are not reflected in drop-out statistics. Before this definition of the terms, there was no consistent criterion for counting drop-outs (McWhiter, 2004:97).

### **2.11.2 The Consequences of Dropping Out**

Dropping out of school has a significant impact on the life of the individual. However, the costs go far beyond individual consequences. The practice of dropping out of school has serious economic and social repercussions for the larger society as well (McWhiter,2004: 100).

### **2.11.3 The economic Consequences**

The individual who drops out of school is at an economic disadvantage. Unemployment and underemployment rates are high among school drop-outs. They earn low salaries over their lifetimes than those who graduated. The economic consequence of the drop-out problem includes loss of earnings and taxes, loss of social security, and lack of qualified

workers (McWhiter, 2004:101).

#### **2.11.4 Social Consequences**

Students who leave school before completing their program of study are at a disadvantage in other ways as well. Dropping out of school often has an impact on an individual's psychological well-being. Most drop-outs later regret their decision to leave school. Such dissatisfaction only intensifies the low self-esteem typical of potential drop-outs. Dissatisfaction with self, with the environment, and with lack of opportunity is also associated with lower occupational aspirations among young people (Drop-out's Perspective, 1998), cited by McWhiter (2004:102).

Paul & Hayes (2002:18) indicated that, when school drop-outs are unemployed or earn less money than their graduated peers, their children also experience negative consequence because they live in lower socioeconomic conditions. Proportionately few of these homes provide the study aids that children of graduates can expect to have. Parents who are poor are less likely to provide no-school-related activities for their children than parents of higher socioeconomic status. Further, low wages require parents who are drop-outs to work such long hours that it is difficult for them to monitor their children's activities. As school drop-outs have lower occupational aspirations than their graduated peers, they also have lower educational expectations for their own children.

#### **2.12 Consequences of Early Childbearing**

When a young female becomes pregnant, her physical, social, educational, and career

development is significantly altered. An unwanted child has consequences for the mother's socioeconomic status, her educational attainment, her health, and her family development (Berg, 1994: 21) cited by McWhiter (2004).

### **2.12.1 Socioeconomic Consequences**

A young female who decides to keep her baby is likely to suffer consequences in the form of substandard housing, poor nutrition and health, unemployment or underemployment, and end to her schooling, inadequate career training, and financial dependency (Robinson, Watkins-Ferrell, Davis-Scott, & Ruch-Ross, 1993) cited by McWhither (2004). She is substantially more likely to live in poverty than a married mother who is older. Furthermore, the average family income of a female who gave birth at 16 or younger is approximately one-fourth that is earned by families where the mother is on her late 20's (Moore, Myers, Morrison, Nord. Brown. &Edmonston. 1999:30).

A truncated education, which frequently accompanies a teenage pregnancy, exacerbates the problem. Young mothers with limited education do not develop the skills, resources, and experience necessary to overcome their poverty and the pervasive sense of powerlessness that usually accompanies it. Most young girls who carry their pregnancies to term decide to keep their babies, cementing the link between adolescent childbearing and poverty: unlike their more affluent sisters, when poor girls make bad choices, engage in risky behavior, become pregnant, and keep their babies, they are more likely to close doors that can never be reopened. Those who come of age in poverty are given very little margin of error in negotiating the tasks of adolescence. Breaking this cycle and fostering young women's productive participation in society is critical to their adolescent parental

role, their children, and society as a whole (McWhiter, 2004: 140).

### **2.12.2 Educational Consequences**

Adolescent pregnancy is associated with low achievement scores and low vocational aspirations. Clearly, youth at risk for becoming parents are also at risk for dropping out of school and are more likely to be unemployed or underemployed throughout much of their lives, especially if they are minority youngsters. According to the study at USA, the adolescent mothers were three times more likely to drop out of school than mothers who delayed childbearing until they were in their 20's (Dubois, 1996:412). In recent years, the proportion of young mothers with high school diplomas has increased, in large part because many school districts now provide alternative high school or school programs for student mothers. However few high school mothers attend college, and less than 1% complete a college degree (Moore, 1992).

The educational problems faced by adolescent parents are frequently carried over into the next generation. A disproportionate number of the children born to young mothers show more emotional and behavioural problems while growing up (Thomson, Hanson & McLanahan, 1994; Zill, Morrison, & Cioro, 1993). These children also have more erratic attendance records, lower grade point averages, lower scores on standardized achievement tests, and lower college expectations (Astone & McLanahan, 1991). These consequences have clear implications for school policy. As young people continue to deliver children at the current rate, school systems are confronted with a burgeoning group of children who are themselves at risk for intellectual and social deficits. Ultimately, educators and society are forced to cope with the special needs of the children

of young mothers (McWhiter, 2004:140-141). The Minister of Education highlighted that, those who become pregnant while still schooling should be given maternity leave.

### **2.12.3 Health-Related Consequences**

Pregnant young mothers commonly experience poor nutrition, poor health, and limited access to and use of medical and health services. Prenatal, perinatal, and postnatal problems are more common among them than older mothers, and more of their babies die, likely because they seek prenatal care infrequently in their first trimester. The younger the mother, the higher the incidence of anaemia, toxemia, infection of the urinary tract, STI's, uterine dysfunction, cephalopelvic disproportion, and other complications of labor and delivery (Stevens-Simon & White, 1991). These problems are compounded for teenagers who live in poor socioeconomic conditions. In comparison with older women, younger girls also have problems with premature delivery and are at greater risk of very long labour.

Children of teenage mothers also have serious health problems. For example 15 year old mothers are twice as likely as older mothers to have low-birth weight babies and the baby is three times as likely to die in the first eight days of life. Low birth weight has been related to a number of developmental difficulties and learning disabilities (McWhiter, 2004: 141).

### **2.13 The Emotional Effects of unplanned Pregnancy**

Whatever your choice, you will experience a wide range of emotions. It is important to remember that there is no "right" way to feel. Your emotions may be very similar to or

different from others who have experienced unplanned pregnancy.

**Abortion:** Some women experience feelings of guilt, remorse, shame, anger, and sadness following an abortion. Having these feelings does not necessarily mean that you made the "wrong" choice. Rather, these feelings probably indicate that you are experiencing normal grief and distress about all of the things you have been through. There is no time-frame for these feelings. You may find that feelings of sadness come after months or years following an abortion. Some women do not experience negative emotions, but do report relief, happiness, and resolution. These feelings may be coupled with the realization that abortion was the right choice for you and the most frequent post-abortion emotions are a combination of relief and sadness.

**Adoption:** If you choose to give the baby up to adoptive parents, you will experience a wide range of emotions, including relief, happiness that you've helped another person become a parent, sadness that you may never know the child, and remorse that you are unable to be a parent at the current time. The pregnancy may be difficult for you, as you are aware of the developing foetus, while trying to avoid an intense emotional bond that may make adoption more difficult. The broad range of emotions from happiness to grief is usual, and you will likely feel both positive and negative emotions throughout your pregnancy and following the adoption.

**Raising the child:** If you choose to become a parent, you will need to plan for both financial and emotional support. Since your pregnancy was unplanned, you have much less time for planning than individuals or couples who have been trying to get pregnant. You also have the additional task of adjusting to the idea of parenting, which you may

not find easy. You may need to explore options for external support, including your family, partner, and local social service agencies. If you choose to work or go to school, you will also need to plan for childcare, which is usually expensive. Emotional support is also needed, as giving birth and raising a child are obviously extremely time-consuming and often exhausting tasks. You may also experience rapidly shifting emotions, including fear, happiness, ambivalence, anger, sadness, and joy. These emotions may be very intense and are complicated by the body changes and hormone fluctuations during pregnancy (Jakobsen & Rise, 1997: 56-57).

#### **2.14 The Physical Effects of Termination of pregnancy**

William-Wheeler, (2005:90-91) states that an abortion, be it of any kind is a difficult feeling for an individual, both at a physical as well at a mental level. So, it is but obvious to have some of repercussions after undergoing an abortion.

Some of the physical side effects which women face up to two weeks are:

- (i) Abdominal pain and cramping;
- (ii) Nausea ;
- (iii) Vomiting ;
- (iv) Diarrhoea;

The duration of these side effects vary from individual to individual. Also there could be other types of side effects which would vary from person to person. There are a host of them, few of which have been listed here:

**Haemorrhage** - There exists the possibility of Haemorrhage due to bleeding or other such factors

**Infection** - The person could be prone to infections which are an outcome of the procedure. Perforation of the uterus

**Crying/sighing** - Owing to the mental trauma which the mother goes through, she could be found crying for long period in a bid to overcome the shock and grief.

- (i) Insomnia;
- (ii) Loss of appetite;
- (iii) Weight loss;
- (iv) Exhaustion;
- (v) Nervousness;

The ones mentioned above are found to be occurring more commonly. But that does not relegate other forms of side effects which exist. In fact, these side effects are specific and depend on several factors such as the individual, the social stigma and other such factors.

Thus there exist other kinds of side effects pertaining to the body. Some of them among the lesser known side effects are:

- (i) Extremely heavy bleeding, more than your usual period
- (ii) Excruciating stomach or back pains
- (iii) Discharge that has an awful odour.

Apart from the physical side effects, a procedure takes its toll on the individual's mind. The individual also goes through a host of emotional turmoil which could lead to:

- (i) Lower self-esteem and confidence
- (ii) Denial
- (iii) Isolated and lonely feelings
- (iv) Relationship difficulties
- (v) Emotional numbness
- (vi) Feeling agitated and angry more often
- (vii) Pain during sex
- (viii) Disrupted sleeping patterns or insomnia
- (ix) Fear of others finding out
- (x) Eating disorders
- (xi) Depression
- (xii) Drugs or alcohol abuse
- (xiii) Suicidal feelings or attempting suicide

### **2.15 The Risk of Using Alcohol and Drugs among Teenagers and Young Adults**

- a) The use of alcohol and drugs play a significant role in risky sexual behavior, including unwanted, unintended, and unprotected sexual activity, and sex with multiple partners. Such behavior increases the risk for unplanned pregnancy and for contracting sexually transmitted diseases (STI's), including infection with HIV, the virus that causes AIDS
- b) Increases the risk of physical and sexual assault.
- c) Is associated with academic failure.

- d) Is associated with illicit drug use.
- e) Is associated with tobacco use.
- f) Can cause a range of physical consequences, from hangovers to death from alcohol poisoning.
- g) Can cause alterations in the structure and function of the developing brain, which continues to mature into the mid- to late twenties, and may have consequences reaching far beyond adolescence.
- h) Creates secondhand effects that can put others at risk. Loud and unruly behavior, property destruction, unintentional injuries, violence, and even death because of underage alcohol use afflict innocent parties. For example, about 45 percent of people who die in crashes involving a drinking driver under the age of 21 are people other than the driver. Such secondhand effects often strike at random, making underage alcohol use truly everybody's problem.
- i) In conjunction with pregnancy, alcohol abuse may result in fetal alcohol spectrum disorders, including fetal alcohol syndrome, which remains a leading cause of mental retardation.
- ii) Is a risk factor for heavy drinking later in life, and continued heavy use of alcohol leads to increased risk across the lifespan for acute consequences and for medical problems such as cancers of the oral cavity, larynx, pharynx, and esophagus; liver cirrhosis; pancreatitis; and hemorrhagic stroke (Mott & Marsiglio, 1995:95).

Alcohol and other drugs can affect judgment and lead to risk taking in people of all ages, but the consequences are often especially severe for teens. Each year, alcohol use is involved in more than 35 percent of all fatal teen car accidents. But substance abuse also impairs teens' ability to make judgments about their sexual behaviour. As a result, their risk increases for unplanned pregnancy, sexual assault and sexually transmitted diseases (STI's).

One-quarter of sexually active high school students report using drugs or alcohol during their most recent sexual experience, and 13 percent of young people say they did something sexual while using drugs or alcohol that they would not have done if they were sober. In fact, many young men and women say they used alcohol-or were even drunk-when they had their first sexual experience. And many of these same young people say they were so drunk that they could not properly use birth control, especially condoms. The more young people drink the less they use condoms. Young people that had five or more drinks were three times less likely to use condoms than other young people.

Males are nearly twice as likely to mix alcohol or drugs with sex (31 percent compared to 19 percent of females), but young women face greater threats. Not only do young women risk an unplanned pregnancy, they are more likely to be the victim of an alcohol or drug-related sexual assault or an incurable STI. Nearly 40 percent of high school boys said it is acceptable to force sex if a girl is stoned or drunk (Chimere-Dan; 1996:4-9).

For both adolescents and young adults, men and women, there is a strong relationship between drug and alcohol use and multiple sex partners. Multiple sex partners and reduced condom use can be a deadly prescription for HIV and AIDS and cervical cancer;

again, young women face the greatest risk. During year 2000 White House report says that half of all new HIV infections occur in people less than 25 years of age. In young people, two out of three new HIV infections were in females. Because of the way their bodies are built, females are more likely to be infected with HIV during sex. Being infected with another STI also increases the risk of HIV. To make matters worse, drug and alcohol use also weaken the immune system.

Risky behaviours like smoking, using drugs, drinking alcohol and early sex tend to occur among the same young people. Boys who start drinking or smoking at a young age are 40 percent more likely to also start having sex at a young age. The risk doubles for girls. For them, use of alcohol or cigarettes increases the risk of early sex by 80 percent. Teens need facts and skills to make healthy decisions and avoid serious, lifelong consequences. Saying "no" to drugs and alcohol is the first step. The only sure way to avoid unplanned pregnancy and STI's is not to have sex!

When teens are sexually active, the best protection against unplanned pregnancy is using the most effective birth control method appropriate to one's personal health and lifestyle. For most teen girls this is the pill or the injection (Depo Provera). But neither of these methods protects against STI's. Condoms are the best defence against sexually transmitted diseases, including HIV and AIDS. That is why every sexually active teens need to use a condom every time, and that can be difficult to do when you are drunk (Dubois-Aber, 2000: 209-210).

## **2.16 Variables affecting female students' likelihood of initiating and maintaining actions to use contraceptives**

Perceived benefits and barriers have an impact on adolescents' decision to initiate and maintain the utilization of contraceptives to avoid unplanned pregnancy.

### **2.16.1 Perceived benefits of contraceptive utilization**

Female students should be informed about the benefits of contraception. Fathalla (1997:64) cited by Story (1999:34) states that contraception is the woman's power to control her fertility and be able to complete her education, maintain gainful employment and make independent marital decisions. The use of contraceptives saves women's lives and improves their health by allowing them to prevent unplanned pregnancies. Lives are saved from high risk pregnancies or unsafe abortions. Effective use of condoms can prevent maternal deaths, cancers and STI's, including HIV and AIDS.

By delaying childbearing, through the use of effective contraceptives, female students would be acting in the interest of their future children because infant mortality rates are reportedly higher for babies born to adolescent mothers than for babies born to women in their twenties or thirties. Contraceptive use saves children's lives by allowing individuals and couples to delay and space births thereby providing greater opportunities for emotional support from the parents for each child. In addition, the parents are able to provide for each child's physical needs and so help each child to attain his/her maximum potential in life. Contraceptive use also helps men to provide better lives for their families with less emotional and financial strain than with having to provide for a large family. Contraceptives provide parents with the freedom to choose when to have children and

how many children to have at what intervals.

### **2.16.2 Perceived barriers to the utilization of contraceptives**

Often, the major barriers young mothers encounter that influence their non-utilisation of contraceptives are negative staff attitudes at clinics as well as the accessibility and affordability of contraceptives.

### **2.16.3 Accessibility and affordability of contraceptives**

Access to health care services for young ones also affects the utilization of contraceptives. Distances from the nearest clinics and payment for transport sometimes prevent adolescents from traveling to health care services for contraceptives and information. Most female students are financially dependent on their parents who might be unable to pay for transport to clinics. Richter (2000:98) stresses that according to the principles of primary health care, a health service be accessible to its users. The service could be within a reasonable geographic distance and be functional in terms of the needs of adolescents. Accessibility could also be improved by rendering services on Saturdays. Contraceptive services could be located at schools, clinics or community centre accessible to anyone. Reproductive health care services at government institutions are free of charge but to improve access to adolescents, the services could be accessed by everyone, irrespective of sex, age, creed, colour, marital status, disability or any characteristics that puts individuals at a disadvantage. Services could be provided in a respectful, non-judgmental and unbiased way.

## **2.17 Ways to Prevent HIV and AIDS, STI's and Unplanned Pregnancy.**

There are various ways which need to be built into strategies to educate and develop life skills for the young adults who are potential victims of unplanned pregnancy and its other consequences.

**i) Avoid excessive one night stands.** These are the riskiest kind of sexual encounters.

And, once you've mastered the art of Variety, the sex in one night stands in inevitably worse than sex in a relationship.

**ii) Always use a condom until you can trust your partner.**

**iii) Carry condoms with you at all times.** This is because when you have no condoms on you, the temptation to go bareback can sometimes be too much. Also, do not carry condoms in your wallet, as they can tear.

**iv) Use condoms properly.** Condoms are very effective when used right...but the problem is, a lot of people don't use them right. The key here is lubrication in the right amounts. Put a small amount of lubrication inside the condom when you use it otherwise, the condom may tear from friction.

**v) Get tested once every six months.** It is a pain, yes, but it is worth it. You will be able to confidently tell your partners that you do not have HIV and AIDS.

**vi) Avoid anal sex with partners unless you trust them enough to have unprotected sex with them.** Anal sex is much riskier than regular sex for STI transmission. It can be great, but be sure that you are both clean before you do it.

**vii) Before going off condoms with your partner, make sure that you see the STI test**

**results.**

**viii) Use a condom that fits you well.** This is important, because condoms that do not fit well will have a tendency to either slip or tear. Shop around, and try all the major brands before you settle on the one that is best for you.

**ix) For pregnancy protection, get your partner on a form of birth control that does not have to be taken daily like the pill.** The injection, the patch, the Nuva-Ring, IUD these are all better alternatives than the pill because they cannot be forgotten. The pill can and will be forgotten and young people must try to use injections.

**x). Be as safe as you can, but do not live in fear.** Yes, STI's and pregnancy can happen, but if you follow the above nine steps the risk will be very, very small (Paul & Hayes, 2002:56-59).

## **2.18 Conclusion**

This chapter discussed the literature review regarding unplanned pregnancy and this chapter forms the core of the study. The following chapter outlines the method used to conduct the study.

## **Chapter 3**

### **3. Research Methodology**

#### **3.1 Introduction**

This chapter outlines the research design used by the researcher to collect data. This includes sample selection, instrumentation, data collection procedures, and data analysis procedures. According to Sarantakos (2005) cited by Biyane (2007:20), the research entails two major stages: one is the stage of planning, and the other is the stage of execution. During the first stage, the researcher constructs a design, a plan of the research, and during the second they collect and analyze the data. The design explains in some detail how the researcher intends to conduct the study, namely how the question asked in each research will be addressed. It indicates the data collected as well as the methods, procedures and instrument used in the study (Sarantakos, 2005).

According to Diekmann (1995), there are many forms of research design. some focus on the process of data collection only. While others extend their boundaries to cover data analysis.

#### **3.2 The Aim of the study**

The major aim of the study was to describe the female students' perception of the effect of unplanned pregnancy while enrolled full-time in an institution of higher education.

### **3.3 Research technique**

Research design provides the glue that holds the research project together. A design was used to structure the research, to show how all of the major parts of the research project- the samples or groups, measures, treatments or programs, and methods of assignment - work together to try to address the central research questions.

Qualitative research method was used in this study. Miles & Huberman (2000) says *qualitative research is a method of collecting, analyzing, and interpreting data by observing what people do and say.*

According to Collins (1999:10) qualitative research refers to the meanings, concepts, definitions, characteristics, metaphors, symbols, and descriptions of things, and it is much more subjective and uses very different methods of collecting information, mainly individual, in-depth interview and focus groups. Qualitative research generates rich, detailed and valid (process) data that contribute to in-depth understanding of the context.

### **3.4 Participants**

The total number of 30 participants was used in this study. The participants were female students with the age ranging from 15- 26+ years. All the participants were drawn from the University of Zululand. All South African racial groups were represented in the study.

### **3.5 Sample Procedure**

The sample was drawn from the female students of the University of Zululand. Purposive sampling method was used in this study. Nueman (1997:45) defines *purposive sampling*

as the type of non-probability sampling in which the researcher uses judgments in selecting respondents who were considered to be knowledgeable on the subject area to be researched. The selection procedure took only a week and non-probability sampling was utilised.

Purposive sampling is the technique that is targeted and specifies pre-established criteria for recruiting the sample. The need for purposive sampling is dependant on the research question (DiClemente & Peterson, 2000:45).

### **3.6 Measuring instrument**

The structured interview schedule was used to collect data from the participants. Goldestein (2002: 23) emphasized that survey questionnaires are the most commonly used method of data collection in the social sciences; so common, that they quite often are mistakenly taken to be the method of social research. Interview schedules provide a way of gathering structured and unstructured data from respondents in a standardized way either as part of a structured interview or through self-completion. Often the data collected can be represented numerically and can thus be analyzed using statistical techniques. The interview schedule used in this study was in English and consisted of 22 questions.

### **3.7 Scoring**

The data collected was scored by the researcher. Information on scoring is reported in chapter 4.

### **3.8 Data analysis**

To analyze the data collected, frequencies of responses were tabulated for the total sample and will be analyzed to determine frequencies, percentages and relationships among variables and Statistical package of Social Science (SPSS) was also used to analyze the data.

### **3.9 Conclusion**

This chapter explains the method used to conduct the study. The aim and sample used are briefly discussed. The procedure used to collect, score and analyze data was outlined.

The following chapter discusses the results obtained from data collected.

## Chapter 4

### 4. Data Presentation, Analysis and interpretation

#### 4.1 Introduction

In this chapter the researcher presents and analyses the data collected on Female students of the University of Zululand about the effects of unplanned pregnancy. The data was collected through interview schedule as per Appendix A.

Tutty et al (1996:90) cited by Dlamini (2001:48) states that the central purpose of analyses in qualitative studies is to sift, sort and organize the masses of information acquired during collection in such a way that it addresses the original research problem.

The quantitative data is presented using frequency tables, graphs and pie charts, and the qualitative data is presented in a form of themes discussions.

**Table 4.1: Demographic Characteristic**

<b>Demographic characteristics</b>	<b>Frequency (n)</b>	<b>Percent %</b>
<b>Age-Group</b>		
15-18	10	36
19-25	9	32
26 +	11	29
<b>Race</b>		
Black	20	67
White	0	0
Coloured	2	7

Indian	8	27
<b>Marital Status</b>		
Single	27	90
Married	1	3
Widowed	2	7
Separated	0	0
<b>Faculty</b>		
Arts	7	23
Education	6	20
Science	11	37
Commerce & Admin	6	20
<b>Religion</b>		
Christian	22	73
Islam	7	23
Other	1	3
<b>Education Level</b>		
First Year	3	10
Second Year	6	20
Third Year	8	27
Fourth Year	5	17
Post Graduate	7	23

This table shows that the age group which is mostly affected by unplanned pregnancy is 15-18 by thirty six percent (36%), the racial group are the blacks by sixty seven percent (67%), the marital status are those who are single by ninety percent (90%). the faculty is science by thirty seven percent (37%). the religion is Christians by seventy three percent (73%), the educational level that is mostly affected are the third year students by twenty seven percent (27%). As the group that is mostly affected by unplanned pregnancy is

young people of 15-18, this means that there is a lot that needs to be done. Because this young people's unplanned pregnancies may be caused by the lack of information about the use of contraceptives, parental guidance and peer pressure and single mothers should be told to make use of available contraceptives to prevent unplanned pregnancy.

1. Have you considered termination of pregnancy

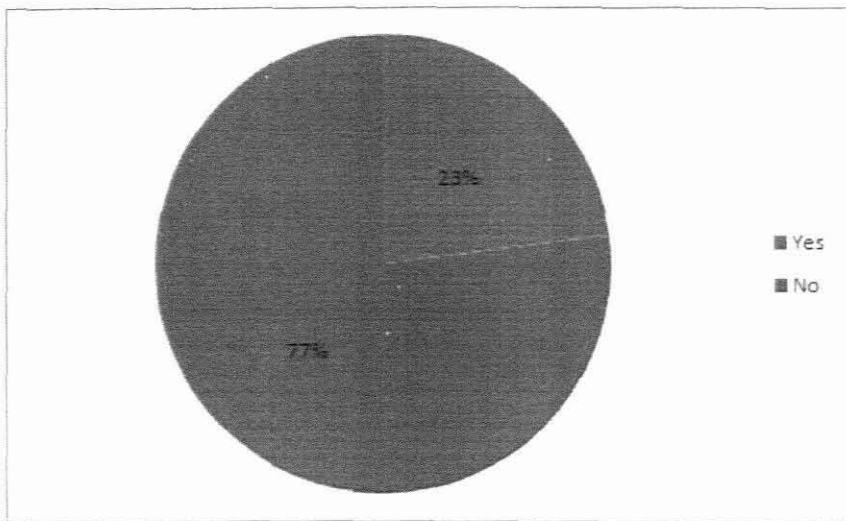


Figure 4.1: Respondents consideration of termination of pregnancy

The figure 4.1 indicates that, the respondents who have considered doing termination of pregnancy is twenty three percent (23%) and those who have not considered doing termination of pregnancy is seventy seven percent (77%). These seventy seven percent (77%) shows that the rate of unplanned pregnancies is very high and the number of children who will be deserted by their young mothers will increase and malnutrition and low-birth weight will also increase. The population of South Africa is also increasing and

the rates of poverty as unplanned pregnancies occur mostly to single mothers.

2. Use of Alcohol and drugs has an impact on unplanned pregnancy

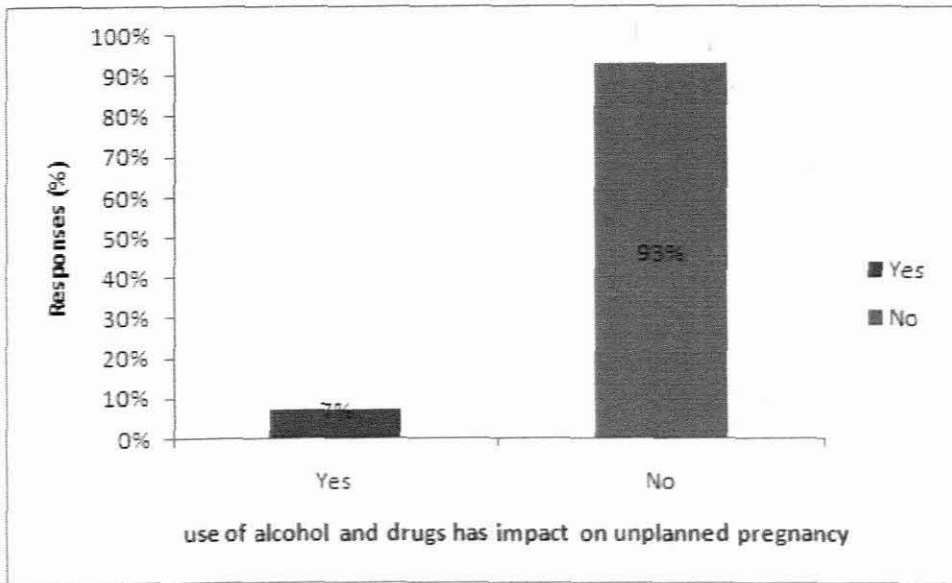


Figure 4.2: shows use of alcohol and drugs has an impact on unplanned pregnancy

As the majority of University students are young adults, most of them consume alcohol and use drugs, but it is interesting to note that only seven percent (7%) of unplanned pregnancies attributed to use alcohol and drugs. They are ninety three percent (93%) of the students their pregnancies are not the result of using alcohol and drugs. These figures may show that not all the unplanned pregnancies are the result of alcohol and drugs, some fall pregnant when they are sober. These figures further illustrate that, the rate of female students who are using alcohol and drugs is not high on campus. The shame associated

with using alcohol and drugs may be making the respondents from being open on this one.

3. The respondents and the partner are still having an intimate relationship

Table 4.2: Respondents and the partner are still having an intimate relationship

<b>Response</b>	<b>Frequency (n)</b>	<b>Percent %</b>
Yes	23	23
No	7	77
Total	30	100

Table 4.2 revealed that seventy seven percent (77%) of the respondents who are not still an item with their partners after unplanned pregnancy. The twenty three percent (23%) shows the respondents who are still an item with their partners. These table revealed that there are many children who are raised by single mothers at the expense of their families as the father of the child has just vanished, leaving the young mother responsible for everything pertaining the parenthood. This will affect the young mother's future plans for instance; the plan of going back to school after the birth of the child will not be accomplished. because other young people / mothers are the Orphans with no one to look to.

4. Respondents' use of contraceptives before the unplanned pregnancy.

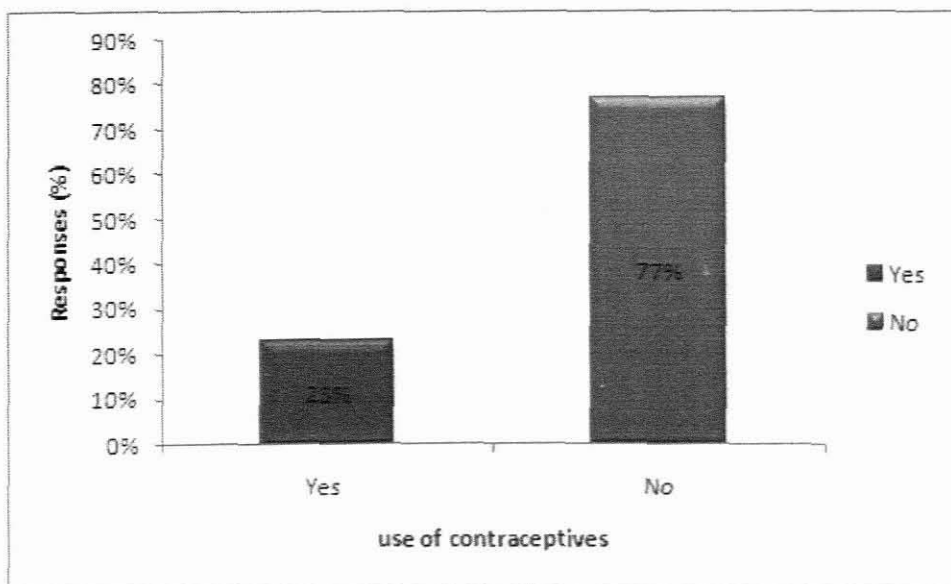


Figure 4.3: respondents use of any contraceptives before

The percentage of respondents who use contraceptives before they experience unplanned pregnancy is twenty three percent (23%) and the respondents who have not used any contraceptives are seventy seven percent (77%). Considering the fact that, the respondents are still students at an institution of higher education; this shows clearly that the majority of female students are not using any contraceptives. They can be easily infected with HIV and AIDS and other related diseases because they do not even use the condoms. Babbie, (2004:20) also argued that female students who are sexually active were more likely to use no contraceptives, which puts them at a high risk of unplanned pregnancy. Some are influenced by their partners regarding birth control or they forget to use contraceptives altogether.

5. Unplanned pregnancy makes respondents differ from their peers.

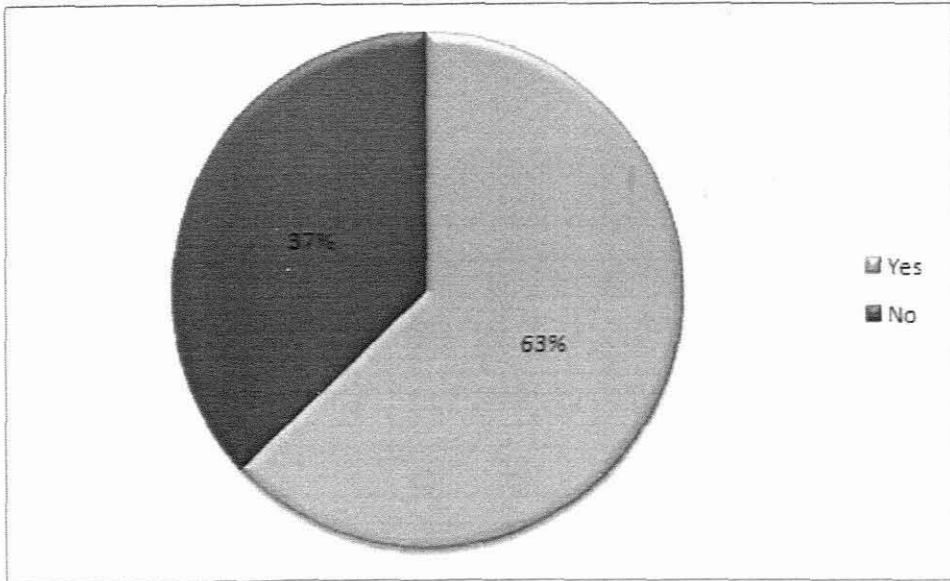


Figure 4.4: Unplanned pregnancy makes respondents differ from their peers

The sixty three percent (63%) which is the majority of respondents who agreed that unplanned pregnancy makes them differ from their peers, and only thirty seven percent (37%) who says it does not makes them differ from their peers. The unplanned pregnancy makes them differ in such a way that some loose their friends because they are pregnant, and some will perform poorly academically during unplanned pregnancy as they are the victims of unplanned pregnancy they are discriminated by their peers and some discriminate themselves from their peers because of low self-esteem.

6. Unplanned pregnancy strengthens the relationship with partner

Table 4.3: Unplanned pregnancy strengthens the relationship with partner

<b>Responses</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
Yes	13	47
No	16	53
Total	30	100

This table illustrates that forty seven percent (47%) of respondents agreed that unplanned pregnancy strengthens the relationship with partners, and fifty three percent (53%) unplanned pregnancy does not strengthens the relationship with partners. This shows that unplanned pregnancy comes with many changes in life and in a relationship, and others ended up breaking with their partners and even committing suicide.

7. Were friends supportive during unplanned pregnancy

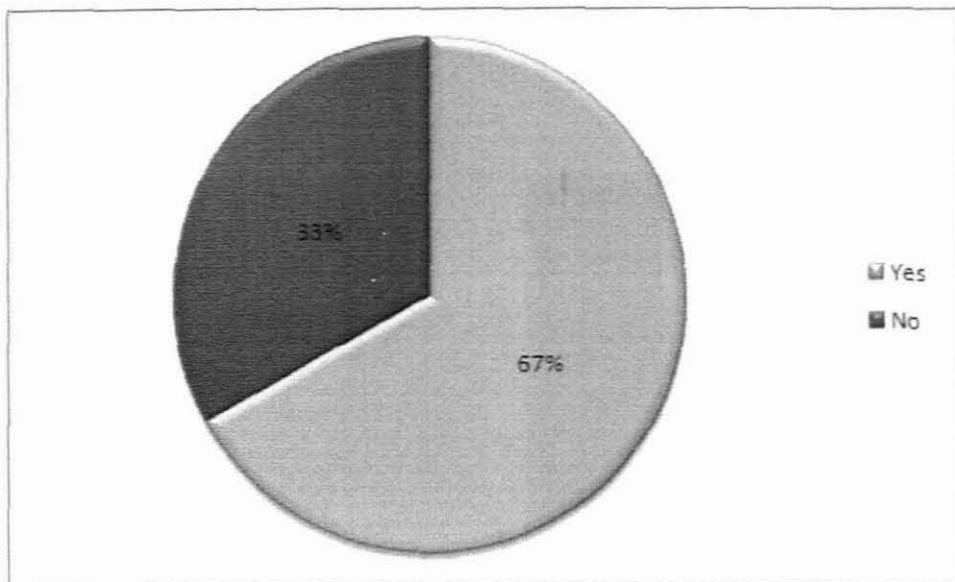


Figure 4.5: Friends supportive during unplanned pregnancy

This pie chart shows that sixty seven percent (67%) of the respondents were supported by their friends during unplanned pregnancy and only thirty three percent (33%) did not receive any support from their friends. Friends are the source of strength if somebody is in need of support through difficult times, the sixty seven percent (67%) of the respondents supported by their friends' means that the number of children who are deserted will decrease, because if a friend cares about her friend she can be able to look after the child.

8. Social and Emotional Effect of unplanned pregnancy

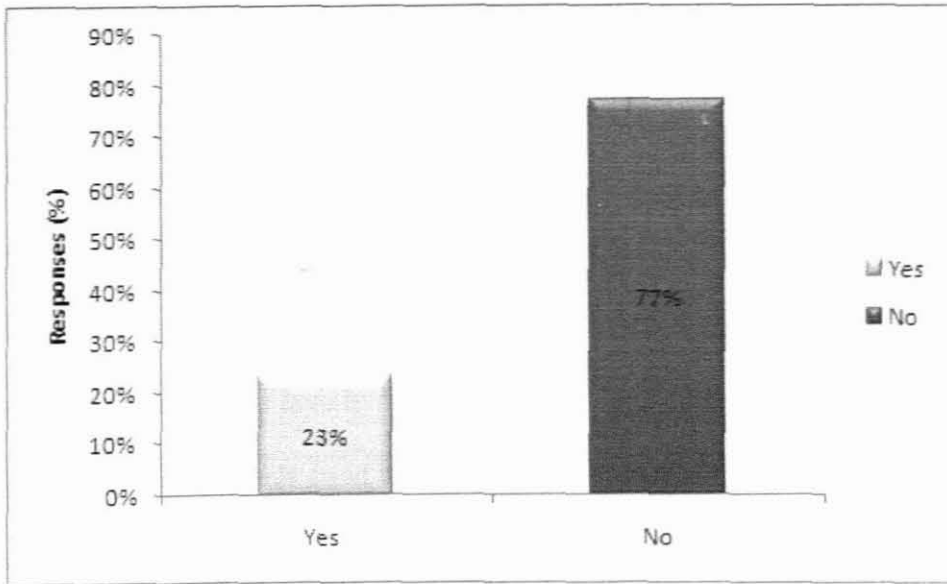


Figure 4.6: social and emotional effect of unplanned pregnancy

The above figure indicates that twenty three percent (23%) of the respondents who have been socially and emotionally affected by unplanned pregnancy and it is seventy seven percent (77%) of those who have not been affected by social and emotional effects of unplanned pregnancy. This shows that, the victims have their way of dealing with problems without being affected.

9. Respondents' opinion about termination of pregnancy

Table 4.4: Respondents' opinion about termination of pregnancy

<b>Respondents Opinion</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
Should be undertaken in cases of unplanned pregnancy	9	30
Should be undertaken only if it is done once in a life time	1	3
Should be undertaken if the couple do not want a child	3	10
Should be undertaken if the pregnancy is through rape	2	7
Should be undertaken if there is no one to provide for the child	2	7
It is bad because no-one is here by mistake	1	3
It is good, if the person feels good about it	2	7
It is good if the person is not ready for motherhood	1	3
It is not good at all	3	10
It should be the decision of one self	1	3
It is not a good idea if you want to keep the child	3	10
It is good but at some state it is bad	1	3
There should be an age restriction for doing T.O.P	1	3
Proper counseling should be given before doing T.O.P	1	3
<b>Total</b>	<b>30</b>	<b>100</b>

The above table shows the respondents opinion about the termination of pregnancy. Given the above figures, the respondents did not disclose any information on whether they have done termination of pregnancy or not.

10. Respondents opinion about stigma attached to pregnancy before marriage

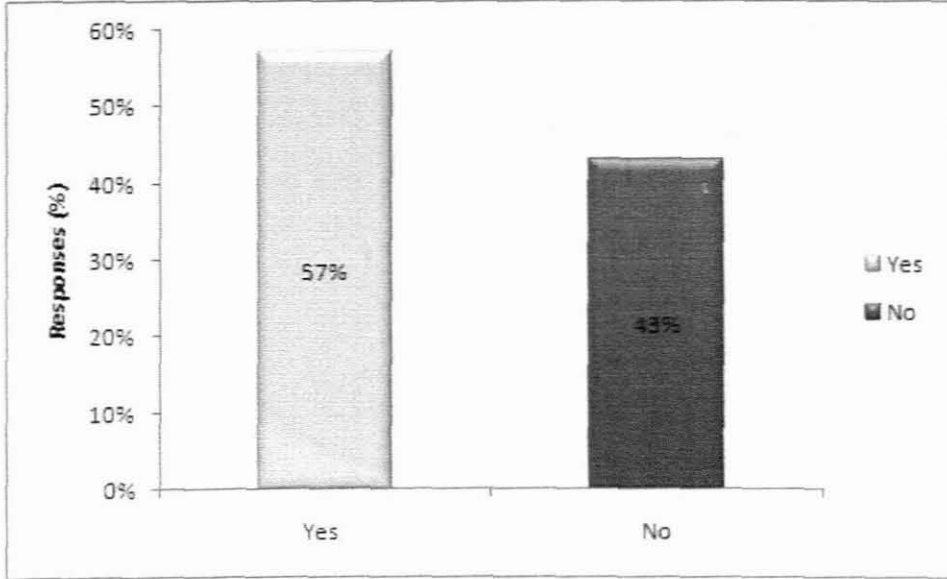


Figure 4.7: stigma in being pregnant before marriage

The fifty seven percent (57%) of the respondents there is a stigma in being pregnant before marriage and forty three percent (43%) says there is no stigma in being pregnant before marriage. The fifty seven percent (57%) also shows that, the chances of getting good opportunities are very slim, for instance getting married to a good husband, being involved in relationship with some one else, and even to get a good job will sometimes be affected, as most students are from poor families.

11. As you experience unplanned pregnancy, have you considered the fact that you can be infected or affected with HIV and AIDS?

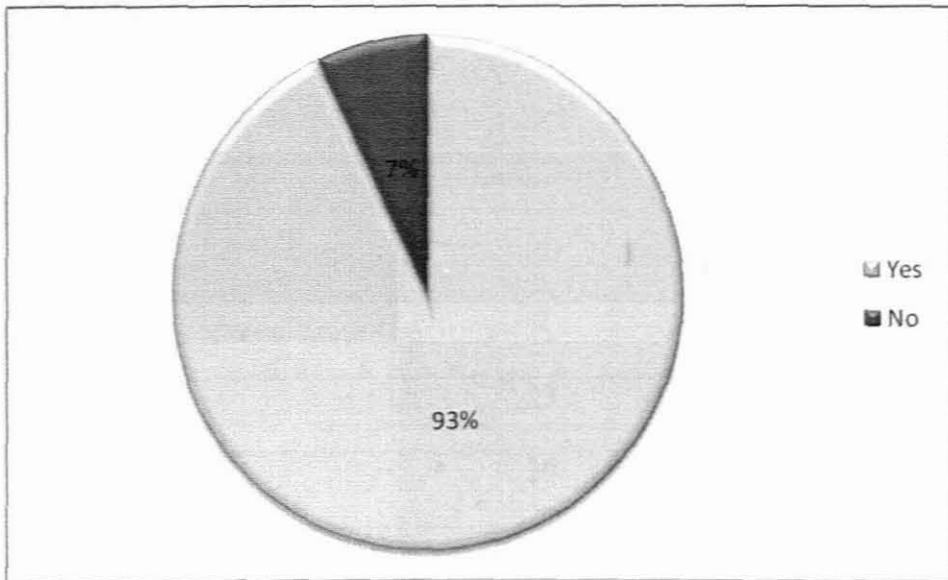


Figure 4.8: Consideration of being infected or affected with HIV and AIDS during unplanned pregnancy

The ninety three percent (93%) of the respondents are quite aware that, they can be infected and affected by HIV and AIDS during unplanned pregnancy, and seven percent (7%) did not consider the fact that they can be infected or affected. The ninety three(93%) of the respondents shows that, there is a lot of awareness that have been done to educate people about HIV and AIDS and to make them aware that AIDS is a real killer whether you are old or young.

(Singh, 2000:98) emphasized that in addressing the epidemic, recent declines in incidence of HIV and AIDS in a few countries, are accompanied by signs that young people are changing their risk-taking behaviour. AIDS today is widely seen as a social crisis as well as a problem of individual behaviour

12. Have you ever felt that, you have been neglected by your family? If yes, how?

Table 4.5: Have felt being neglected by the family

<b>Response</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
Yes	7	23
No	23	77
Total	30	100

The above table indicates that twenty three percent (23%) have felt that, they have been their families and seventy seven percent (77%) did not feel neglected. The twenty three percent (23%) shows that some people are not taken care of by their families may be it can be that parents are angry about what their child has done or there is no one left in the family.

13. Does unplanned pregnancy cause any financial constraints in your family?

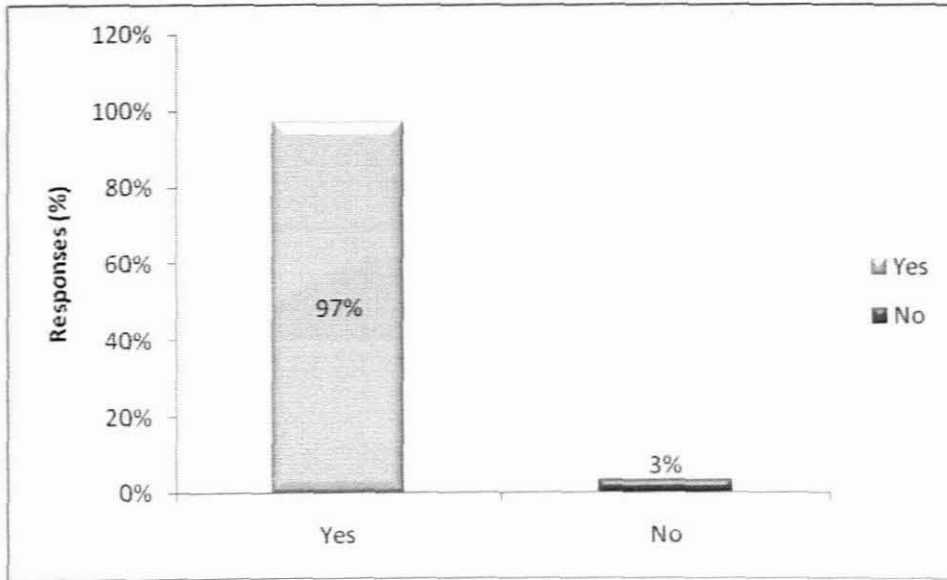


Figure4.9: Does unplanned pregnancy cause any financial constraints in your family

Figure 4.9 illustrate that many households experience financial constraints during unplanned pregnancy about ninety seven percent (97%) of respondents, and three percent (3 %) do not have any financial problems. The high percentage is reached because many people who experience unplanned pregnancy are not working as students. They all depend on their parents for financial support of their children, only the few whose children are supported by their biological fathers

Moore Myers & at al, (199:30) cited by McWhiter (2004) also agree that the young female is substantially more likely to live in poverty than a married mother who is older. Furthermore, the average family income of a female who gave birth at 16yrs or younger is approximately one-fourth than that is earned by families which the mother is on her late 20's (Moore, Myers, Morrison, Nord, Brown, &Edmonston, 1999:30).

14. How many children do you have, been they planned?

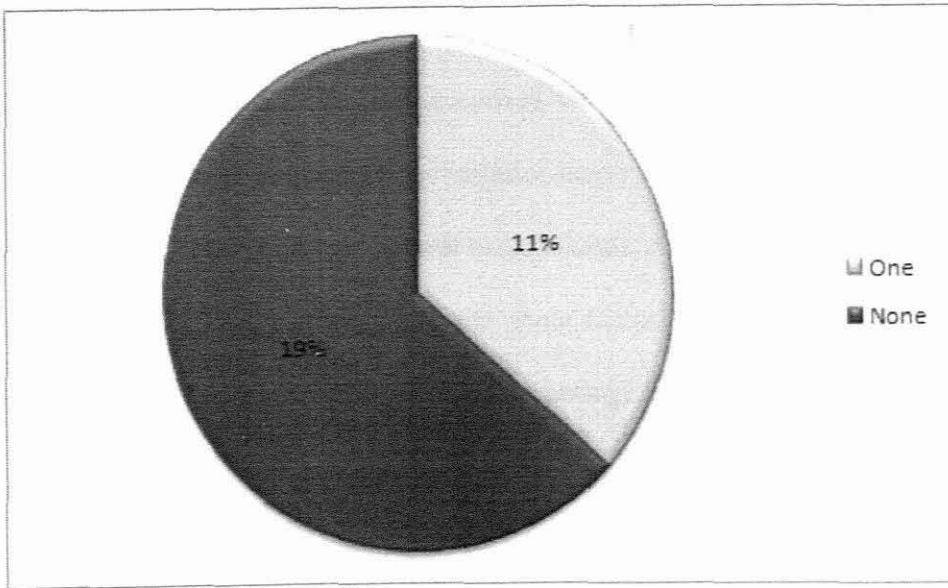


Figure4.10: How many children do you have, been they planned

Figure 4.10 indicates that eleven percent 11% of respondents have one child and nineteen percent (19%) have none.

15. Are you presently using any contraceptives now?

Table 4.6: Are you presently using any contraceptives

<b>Response</b>	<b>Frequency</b>	<b>Percent</b>
	<b>(n)</b>	<b>(%)</b>
Yes	10	33
No	20	67

<b>Total</b>	<b>30</b>	<b>100</b>
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Table 4.6 shows that sixty seven percent (67%) of respondents who are not using contraceptives and thirty three percent (33%) of respondents are using contraceptives. This can increase the high rate of unplanned pregnancies and of people who are infected with HIV and AIDS, and other related diseases. If they are using any contraceptives, mostly students prefer to use oral contraceptives which is a pill, they do not like to use injection because of its disadvantages for instance heavy bleeding.

Female students are from different cultural backgrounds, religious or traditions that might be influenced by different factors, or by the same factors but to different extents. This affects their decisions to use contraceptives or to arrange marriages (Windal, 1997: 59).

16. Is your unplanned pregnancy resulted from rape? If yes have you reported the rape case? If not why?

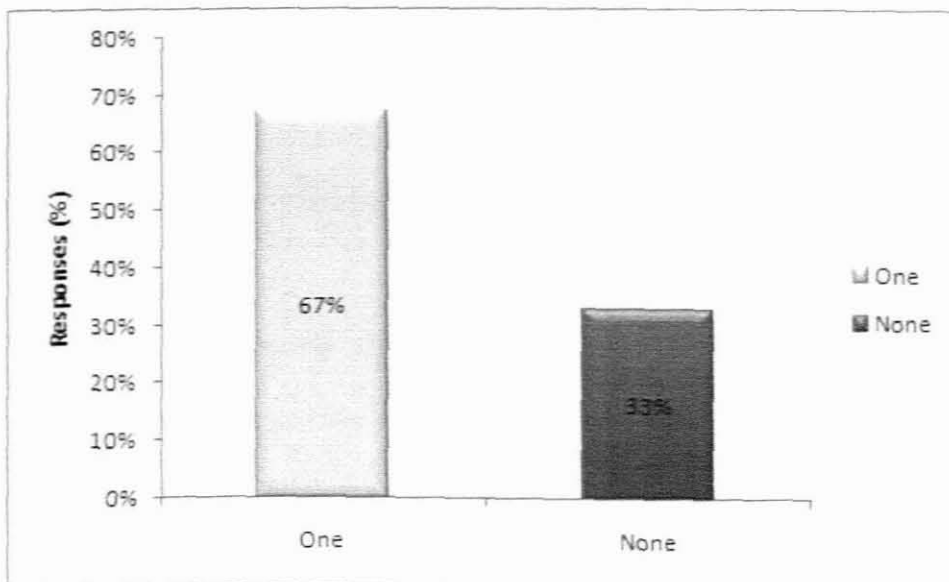


Figure4.11: Is your unplanned pregnancy resultant from rape

This figure illustrates that sixty seven percent (67%) of the respondents whose unplanned pregnancy is resulted from rape and only thirty three percent (33%) pregnancies which are not through rape. The sixty seven percent (67%) did not report their cases of rape because of the stigma and some did not even told their relatives about rape.

17. Have your studies been affected by your unplanned pregnancy? If yes how?

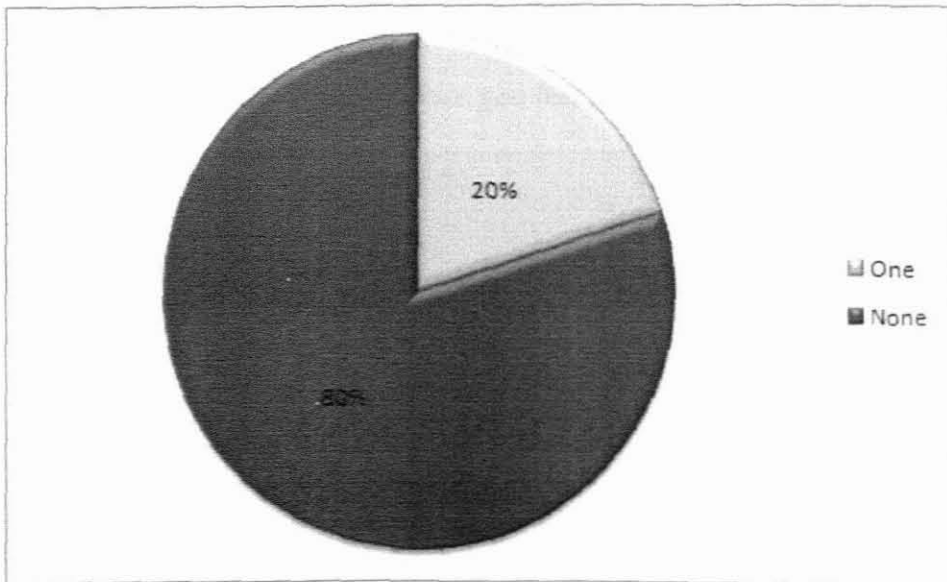


Figure 4.12: Have your studies been affected by your unplanned pregnancy?

Most students are academically affected by unplanned pregnancy only twenty percent (20%) who is not affected and the eighty percent (80%) of the respondents are affected by unplanned pregnancy. Being pregnant when you are still studying comes with many challenges, and that includes University drop-out or poor performance at the University.

The consequences of this would be that of getting low income jobs, because of lack of education. Also the rate of poverty will be high among these people who drop-out of the University because of unplanned pregnancy.

Berg (1994: 21) cited by McWhiter (2004) indicates that when a young female becomes pregnant, her physical, social, educational, and career development is significantly altered. An unwanted child has consequences for the mother's socioeconomic status, her educational attainment, her health, and her family development.

18. Does unplanned pregnancy make you feel good about yourself?

Table 4.7: Does unplanned pregnancy make you feel good about yourself?

<b>Responses</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
Yes	9	30
No	21	70
Total	30	100

The responses on this question make it clear that many students are not proud about being pregnant, while still enrolled at higher learning institution. About seventy percent (70%) of students who do not feel good about themselves and only thirty percent (30%) of students that feels good about unplanned pregnancy.

This figure shows that there are those, who still have the conscience when they have done wrong.

19. What are your perceptions of the utilization of contraceptives?

Table 4.8: What is your perception about the utilization of contraceptives?

<b>Respondents perception about utilization of contraceptives</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
Contraceptives have disadvantages and advantages of using them	1	3
Contraceptives like condoms protect people from HIV and AIDS and STI's	3	10
Good because they prevent unwanted pregnancies	1	3
Good for future planning	3	10
Good if the person feels good about it	5	17
It is not good to use contraceptives	1	3
They make family planning easier	6	20
It should be decision of one self	1	3
They should not be given to somebody who do not want them	1	3
They try to minimize the high rate of unplanned pregnancies	4	13
<b>Total</b>	<b>30</b>	<b>100</b>

Story (1999: 35) emphasized that some females might perceive contraceptives to be irrelevant or even harmful and these perceptions could result in unplanned pregnancies. Unplanned pregnancies could have serious implications for the physical, psychological and social well-being of females and even for their nuclear as well as extended families.

20. Which age group is at risk of experiencing unplanned pregnancy?

Table4.9: Which age group is at risk of experiencing unplanned pregnancy?

<b>The Age group at Risk of experiencing Unplanned pregnancy</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
15-19	9	30
20-25	7	23
26-30	8	27
32-40	6	20
<b>Total</b>	<b>30</b>	<b>100</b>

The above table shows that most teenagers have a high rate of unplanned pregnancy because they are exposed in so many things like the use of drugs and alcohol, they have multiple sexual partners and they do not use contraceptives properly.

The female students' age might influence their decision to engage in sexual intercourse and contraceptive non- utilization. Belfield (1998:31) cited by Story (1999:19) states that if sexual and relationship education is started at an early age. prior to females' sexual debut, such knowledge could help female students to delay their first sexual encounters.

21. Have you heard of the DNA test?

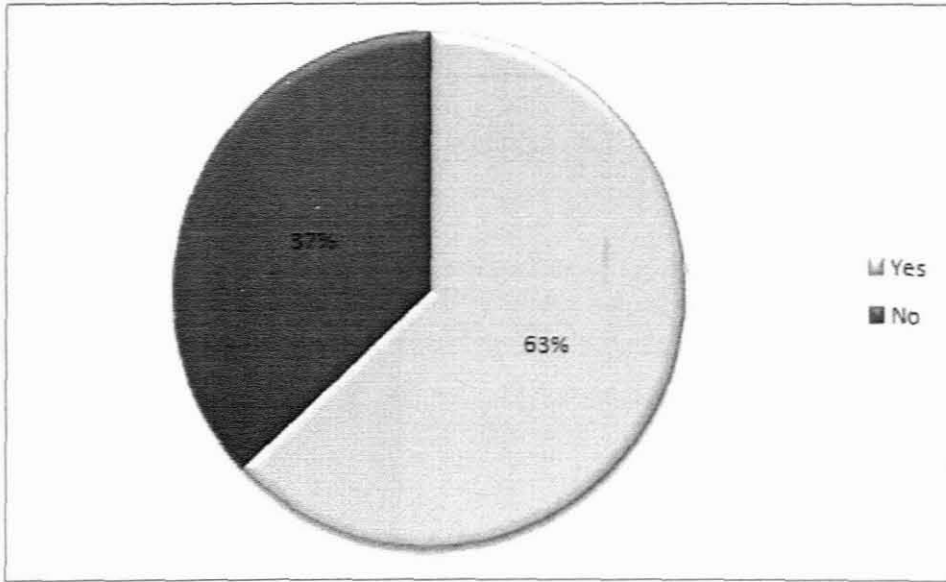


Figure 4.13: Have heard of the DNA test

The majority of sixty three percent (63%) have the knowledge of the DNA test and thirty seven percent (37%) do not have the knowledge about DNA test and this indicates that the number of children without fathers will decrease because people are knowledgeable about the paternity test.

22. If you did not know who impregnated but suspect someone would you go for the test to be sure of your child's paternity?

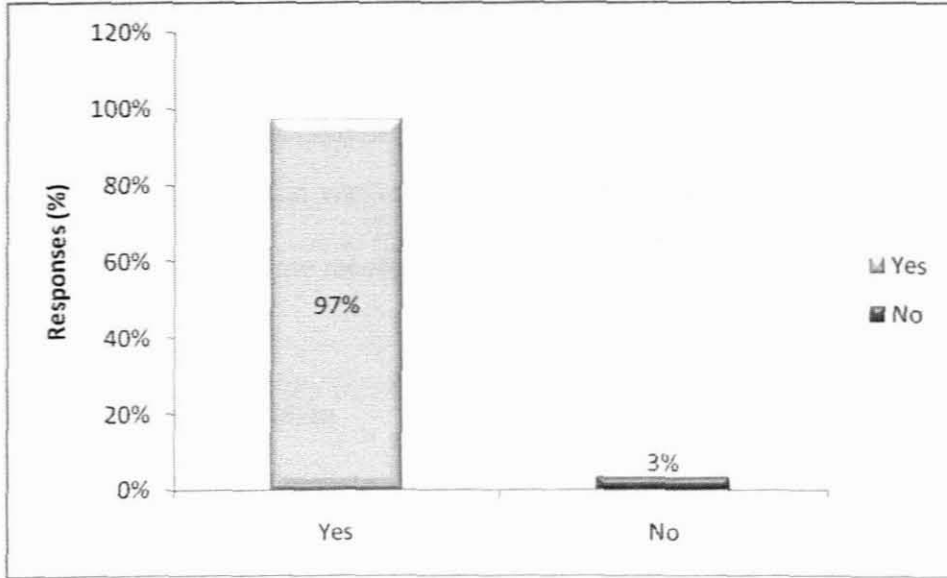


Figure 4.14: Would go for the test to be sure of the child's paternity

The ninety seven percent (97%) of respondents would go for the DNA test to be sure of the child's paternity and three percent (3%) would not consider doing the DNA test, despite not knowing the child's paternity.

## **Chapter 5**

### **5. Summary of Findings, Recommendations and Conclusion**

#### **5.1 Introduction**

In this chapter the summary of findings, recommendations and conclusions that have been drawn from the data that was collected using the interview schedule are outlined.

This chapter concludes with the recommendations that the researcher made.

#### **5.2 Restatement of the Problem**

The University of Zululand female students are faced with the problem of unplanned pregnancies, which is very high. It has become imperative, therefore, to get some answers to the questions as to why some fall pregnant and say it was unplanned and some do not know who impregnated them. The purpose of the study was essentially, to describe the female students' perceptions of the effects of unplanned pregnancy while enrolled full-time in an institution of higher learning.

#### **5.3 Restatement of the Objectives of the study**

##### **5.3.1 The Objectives of the study were:**

###### **a) To examine the effects of unplanned pregnancy on female students**

The findings show that the female students are affected socially and emotionally by unplanned pregnancy. The use of alcohol and drugs also has an impact on unplanned pregnancy, but not that much as the results indicates that it is only 7% of female students who use drugs and alcohol and the victims of unplanned pregnancy. Some female

students feel that unplanned pregnancy makes them differ from their peers, as they need to prepare for motherhood.

The findings further indicate that students are academically affected, due to unplanned pregnancy. They are also faced with a stigma of being pregnant before marriage. This stigma will close the doors for them; they would not get even the good husbands.

Paul & Hayes (2002:18) indicated that, when school drop-outs are unemployed or earn less money than their graduated peers, their children also experience negative consequences because they live in lower socioeconomic conditions. Further, low wages require parents who are drop-outs to work such long hours that it is difficult for them to monitor their children's activities. As school drop-outs have lower occupational aspirations than their graduated peers, they also have lower educational expectations for their own children.

**b) To examine long term or on-going effects that female students might experience**

School dropout is the major problem that the female students face, as they have to look after their children at home and leave the learning institution for good, some do return to school after the child birth. The very same people will also be infected by HIV and AIDS and other related diseases, but at least some are quite aware that they can be infected/affected with the pandemic disease only a few are denying the fact that they can be infected during the process of sexual intercourse.

Dubois (1996:412) earlier states that, youth at risk of becoming parents are also at risk of dropping out of school and are more likely to be unemployed or underemployed throughout much of their lives, especially if they are minority youngsters. Adolescent mothers were three times more likely to drop out of school than mothers who delayed childbearing until they were in their 20's.

**c) To investigate the level of knowledge related to contraceptives and other means of preventing unplanned pregnancy**

The researcher found that female students do not have enough knowledge about the use contraceptives; there are only a few who are presently using contraceptives and there are those not using any contraceptives at all, and that puts a bigger challenge on health workers and even on South Africa as whole.

Williams-Wheeler (2005:72) agrees that numerous factors could contribute to the many female adolescent pregnancies in the University level. However, female students require knowledge to be able to make informed decisions and to evaluate their attitudes towards and beliefs about contraceptives.

McBurney (2001:320) also states that social values, beliefs and practices influence decision-making about the use of contraception. Some beliefs are beneficial and others are not. Female students are influenced by socio-psychological variables in deciding

about initiating sexual relations and contraceptives use, possibly allowing their individual perceptions to be greatly influenced by their peers influence and expectations.

## **5.4 Findings and Conclusions of the study**

### **5.4.1 Summary of the Findings of the study**

*The findings of the study were drawn from the data analyzed in chapter 4.*

The findings show that it is the young adults (15-19) years of age that are mostly affected by unplanned pregnancies. Racial group are the blacks, those who are not married, are mostly experiencing unplanned pregnancy. There are a few people who are using contraceptives; this also indicates that there is lot that needs to be done in educating people about the use of contraceptive. The majority of respondents agreed that unplanned pregnancy make them differ from their peers.

The findings further. indicate that students are not eager to do termination of pregnancy after unplanned pregnancy they want to keep their children inspite of the problems that they are going to encounter through the process of motherhood; as the findings show, that those who have not considered doing termination of pregnancy is 77%. Figure 4.2 shows that despite the fact that many students at higher learning institutions use alcohol and drugs; the 93% of pregnancies are not the result of using alcohol and drugs; gives this gives a clear picture that not all students are using drugs and alcohol then after fall pregnant.

Most of the respondents were supported by their friends during unplanned pregnancy only a few of them who did not receive any support from their friends. It is also noted that unplanned pregnancy causes financial constraints in many families; this is supported by the findings in Figure 4.9 that shows that many households experience financial constraints during unplanned pregnancy. These were the major findings according to the study that was conducted on female students of the University of Zululand.

#### **5.4.2 Conclusion**

The researcher has discovered that many students are not well educated about the issues of preventing unplanned pregnancy, and that the victims of unplanned pregnancy are not courageous to disclose information about the experience of unplanned pregnancy and that is going to be a problem for future researchers.

#### **5.5 Recommendations**

1) Local services should ensure that:

- Support for young mothers and their partners to prevent repeat pregnancies is included as an integral part of the coordinated package of support, starting in the ante-natal period with clear arrangements concerning who is responsible for ensuring young parents receive the support they need.
- Information about contraceptives should be accessible and young people friendly format should be given to young mothers, so that they are aware of the range of methods available and can choose the most suitable method. Information should also be provided to young fathers so they also have

accurate and up to date information about contraception and can support their partners in using their chosen method effectively

- Clear messages about the risk of pregnancy after birth are prominently displayed in General practice and Children's Centre.
- 2) There should be a chosen day for contraceptives and HIV and AIDS awareness within the campus, may be twice a month and each and every term.
  - 3) Condoms should be available anywhere around the campus, for an example, in the library, dinning halls, ladies and gents' room, residences, computer laboratories, taverns, in the departments and in the lecture halls where they can be easily accessible, as some students can be afraid to go to the clinic.
  - 4) There should be a support group on campus for the victims, to be able to share the problems they encounter on their daily lives.
  - 5) The importance of abstinence should be emphasized and encouraged to all students.
  - 6) Both female and male students should be included in study, because they are both part and parcel of the process of unplanned pregnancy.
  - 7) Male partners should be also taught about importance of contraceptives.
  - 8) Future researchers should include primary caregivers and lecturers as respondents, as they have got lot to say about problems caused by these unplanned pregnancies among them and the victims.

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[http://www.epigee.org/birth control education html.](http://www.epigee.org/birth%20control%20education.html)

## APPENDIX A

### Section A

#### Interview schedule used to collect data from the respondents

**Instructions:** Please supply information requested below. You are further requested to respond to all questions by marking cross next to your appropriate response.

#### Demographic characteristics

##### 1. Age

15-18

19-25

26+

##### 2. Race

Black

White

Coloured

Indian

**3. Marital status**

Single

Married

Widowed

Separated

**4. Faculty**

Arts

Education

Science

Commerce and Admin.

**5. Religion**

Christian

Islam/Muslim

Other

**6. Educational level**

First year

Second year

Third year

Fourth year

Postgraduate

**Section B**

1. Have you considered doing termination of pregnancy? Yes [ ] No [ ]

2. Does the use of Alcohol and Drugs have an impact in your unplanned pregnancy?

Yes [ ] No [ ] if Yes how?

.....

3. Are you still in an intimate relationship with your partner? Yes [ ] No [ ]

4. Have you used any contraceptives before? Yes [ ] No [ ]

5. Does unplanned pregnancy makes you differ from your peers? Yes [ ] No [ ]

6. Does unplanned pregnancy strengthen your relationship with your partner? Yes [ ] No

[ ]

7. Were your friends supportive to you during your unplanned pregnancy? Yes [ ] No [ ]

Explain

.....

.....

8. Does it affect you socially or emotionally? Yes [ ] No [ ] if Yes, how?

.....

.....

9. What is your opinion about termination of pregnancy? Explain

.....

.....

10. Does there a stigma in being pregnant before marriage? Yes [ ] No [ ]

11. As you experience unplanned pregnancy, have you considered the fact that you can be infected or affected with HIV and AIDS? Yes [ ] No [ ]

12. Have you ever felt that, you have been neglected by your family? Yes [ ] No [ ]

13. Does unplanned pregnancy causes any financial constraints in your family? Yes [ ] No [ ]

14. How many children do you have, been they planned?

.....  
.....

15. Are you presently using any contraceptives? Yes [ ] No [ ]

16. Is your unplanned pregnancy caused by rape? Yes [ ] No [ ] if yes. have you reported the rape case?

17. Have your studies been affected by your unplanned pregnancy? Yes [ ] No [ ] if yes how?

.....  
.....

18. Does unplanned pregnancy makes you feel good about yourself? Yes [ ] No [ ]

19. What is your perception about the utilization of contraceptives? Explain

.....  
.....

20. Which age group is at risk of experiencing unplanned pregnancy?

15-19

20-25

26-30

32-40

21. Have you heard of the DNA test? Yes [ ] No [ ]

22. If you do not know who impregnated but suspect someone would you go for the test to be sure of your child's paternity? Yes [ ] No [ ]