J Soc Sci, 49(1,2): 134-144 (2016)
PRINT: ISSN 0971-8923 ONLINE: ISSN 2456-6756 DOI: 10.31901/24566756.2016/49.1,2.17

Willingness to Dropout among Pregnant Teenage Learners in South African High Schools

T.P. Majozi[1], K.D. Ige[2] and N.G. Tshabalala[3]

Department of Sociology, University of Zululand P.B. X1001, Kwadlangezwa, 3886 South Africa
Telephone: [1]<+27788251162>, [2]<+27832020197>, [3]<+27835674140>
E-mail: [1]<thandop.majozi@gmail.com> [2]<igedavies@gmail.com>, [3]<jeffrey058@gmail.com>

KEYWORDS Teenage. Pregnancy. Education. School. Learners

ABSTRACT The study investigated the impact of the discrimination against pregnant teenage learners and their willingness to drop out of school. It uncovered pregnant learners' non - attendance of school activities and absenteeism, their knowledge on Sexual Transmitted Infections and HIV, and the extent of their knowledge and use of preventative contraceptives. Using the survey strategy, data was collected from a sample 70 students (n = 70), using a questionnaire. Scales were computed by means of the Principal Components Analysis (PCA). Correlational analyses on the relationships between variables were carried out through bivariate correlations. The results showed that a preponderance of teenagers between the ages of 16 to 19 became pregnant. It was further revealed that pregnancies were due to learners' limited knowledge about, and use of contraceptives. The results further showed that pregnant learners experienced varying levels of discrimination among other learners, which made them consider quitting education. It was recommended on the basis of research findings that learners must be taught about the importance of using contraceptives to prevent early pregnancy and, consequently, the propensity of girls to drop out of school.

INTRODUCTION

Teenage pregnancy rates in South Africa have reached shocking levels. Social research on incidences of teenage pregnancy has preponderantly conceptualised teen pregnancy as a social problem with its untoward negative repercussions (Macleod 2011). It is common knowledge that teenage pregnancy often leads to the disruption of the teenagers' education. Consequently, as has been shown in past studies, (Mkhize 1995), pregnant teenagers often do not wish to return to school. As a result, future career prospects for these young ones are restricted, thus, potentially limiting their chances of upward social mobility. This problem has attracted attention from both governmental and non-governmental organisations to fight against teenage pregnancy. It is projected that one in three girls will be pregnant before their 20th birthday (Russels 2002).

The moral panic about teenage pregnancy in South Africa is strengthened by speculations in the media about possible links between teenage pregnancy and the government's child support grant, increasing school dropout and the visibility of pregnant girls in South African schools. The rate of teenage pregnancy is especially high in rural areas and this leads to high rates of dropout for girls, portending an increased rate of un- educated youth and, thereby, sustaining the high rate of poverty. The reasons for this state of affair have ranged from early exposure to sex, insufficient contraceptive knowledge, non-use or misuse of contraceptives, inadequate knowledge about fertility and conception (Bearinger et al. 2007; Jewkes et al. 2009; Pettifor et al. 2009).

Teenage Pregnancy and Teenager Education

Teenage schoolgirl pregnancies have been on the increase in the past years, in spite of decades of government expenditure on sex education/ AIDS awareness programmes. In recent studies, approximately 30 percent of teenagers in South Africa reported *'ever having been pregnant'*, the mostly, unplanned (Jewkes et al. 2009; Lince 2011; Flanagan et al. 2013; Pettifor et al. 2009; Ardington et al. 2012). Although this number has arguably declined over the past few decades, it remains excessively high. Studies showed that of teenagers who fell pregnant, a mere third eventually stayed in school during their terms of pregnancy and subsequently returned after childbirth. The highest rate of return has been among Grade 12 learners. Falling pregnant has a devastating effect on girls' sec-

ondary schooling. This has attendant long-term negative consequences for their lives.

The driving forces for teenage pregnancy in South Africa often included gender inequalities; differential cultural gender expectations for teenage boys vis-a-vis girls; this includes for example, sexual taboos for girls as against sexual permissiveness for boys. Other drivers include; poverty and reduced access to contraceptives or dissolution of pregnancies; incorrect and erratic contraceptive use; poor attitudes of many health care workers; high incidences of gender-based violence; and lack of proper sex education (Bearinger et al. 2007; Jewkes et al. 2009; Pettifor et al. 2009).

Quite often teenagers possess rudimentary knowledge about contraceptives and protection from STIs and HIV. Nevertheless, research showed that many have inadequate contraceptive knowledge and inconsistent or incorrect use. Similarly, there is evidence of inadequate knowledge about fertility and conception. Makhaza and Ige (2014) reported that whilst most girls began by using hormonal injections after falling pregnant, many had insufficient contraceptive knowledge prior to getting pregnant. While post birth pregnancy use is useful in preventing further unintended pregnancies, this is not the case when it comes to preventing STIs or HIV. Access to contraception is a major problem. This is further exacerbated by the poor attitudes of health workers and facilities who often prevented teenagers from gaining access to contraceptives.

Young people's use of contraceptives is affected by the availability, accessibility, and acceptability of health care services. For young women this impacts their utilization of preventative methods which, impacts their exposure to pregnancy and HIV/AIDS. As Bearinger et al. (2007: 1220) argued young people access to adequate and friendly facilities delivered by professionals who have been trained to work with young people. Sex education initiatives must, therefore, provide correct and inclusive information that enhances the building of the requisite skills for discussing sexual behaviour. Such initiatives must also offer young people both girls and boys equal access to programmes that connect them with supportive institutions and provide them with educational and economic opportunities.

Furthermore, previous academic performance has been noted to influence contraceptive utilization and exposure to pregnancy and diseases. Girls with good academic records prior to falling pregnant often continued to obtain good academic grades when they became mothers. Additionally, teacher support is desirable and teachers enhance the school experience. However, returnee teenage mothers have sometimes reported unsupportive teachers and principals. The evidence thus shows that teacher support is not a crucial factor to returning mothers.

Young girls' willingness to return to school after childbirth is also predicated upon the availability of childcare, of consequence here is the availability of financial wherewithal to pay for childcare or the availability of a family member to look after the baby during school periods. In instances where childcare support from their family (in particular, their mothers), is lacking, the girls are forced to stay back at home and cater for the babies. Other factors that influence the mother's choice to return to school often include; stigma (from peers and teachers); teacher support; pre-pregnancy academic performance level, as well as the precarious balancing of being a learner and a mother.

The literature has also emphasized the role of the school in assisting teenage mother, to cope as learners and mothers. Although South Africa is committed to gender parity in schools, and assisting young women to realise the right to education, childcare responsibilities remain gendered and remain the responsibilities of the teenage girls. In order to ameliorate this situation, the schools must support mothers as a learner if they choose for example to breastfeed. Schools must be encouraged to provide facilities to enhance this. For example, schools may procure childcare facilities to support the returning teenage mothers. No doubt, this will assist teenage mothers who lack childcare support and consequently reduce their burden.

The right of teenagers to sexual and reproductive health (SRH) care are guaranteed in the South African Constitution (1996). Other laws allow young people to access contraceptives, terminate pregnancies as well as to access sundry SRH services. The youths are equally legally protected from sexual violation. While these laws are all encompassing however, their implementations have been less impressive. Often youths report obstacles in accessing SRH services. In many instances health workers and teachers have been impediments. High incidenc-

es of reported sexual and physical violence against females and the lack of proper implementation of policies weaken legislations on sexual offences.

It therefore appears that there is disjoint between these policies and the mileu within which implementation ensues. The South African Schools Act (1996) allows pregnant youths and mothers to remain in school while pregnant and to return after childbirth. Jewkes et al. (2009) noted that although policy focuses on preventing pregnancies, it fails to produce the environment in which the girls can continue in school. Policy implementation therefore remains a challenge. Implementation often depends on attitudes of school heads, teachers and governing bodies. Thus the best interests of the teenagers are rarely prioritised. As Bhana et al. (2010: 880) reported, the manner in which teachers interpret the policy of permitting pregnant pupils to attend school varies across schools.

Teenage Pregnancy and School Performance

Being pregnant while still at school creates difficulties for which teenagers have to find solutions (Bezuidenhout 2004: 40). The teenagers often have to decide if they will carry the pregnancy to term or have an abortion. In the event that they decide to carry the pregnancy to full term, their studies would inevitably be interrupted and they are placed in positions of disadvantage (Bezuidenhout 2004). It is a well-known fact that poor academic performance leads to poor future financial prospects. This potentially has detrimental effects on all aspects of the lives the mother, the babies and the family as a whole (Enderbe 2000: 16). Studies in the USA however showed that many former adolescent mothers did not become welfare-dependent. Many completed school, secured employment and had large families.

Teenage pregnancy, has led to, among others, grade repetition and periods of withdrawal from school. In sub-Saharan Africa, many women often remained enrolled at the primary or junior secondary levels past puberty and into their late teenage years. This increases the risk of pregnancy-related school interruptions (Grant and Hallman 2006). Many schools in South Saharan Africa often excluded pregnant girls and mothers from attending. According to the Forum for African Women Educationalists (FAWE), in Zambia, 2,230 girls were made to drop out of school last years because they became pregnant. In many parts of Africa therefore, teenage pregnancy often results in school dropout. Teenage pregnancy thus predisposes youths to drop out from school.

Teenage Pregnancy and Emotional Behaviour

For adolescents, engaging in sexual behaviour is not usually for the purpose of getting pregnant. Unplanned teenage pregnancies may thus lead to rash decision making that are the result of pressures from parents, peers, society or schools. Young people's inability to foresee the imminent consequences of their actions and their psychological immaturity puts them at risk (Mokwena 2003: 49). Youths who have experienced the death of a loved one, parental separation or divorce, or some major changes, often go into depression and are often at increased risk of teen pregnancy (Varga 2003). Risky sexual behaviour and early pregnancy are also linked to the pain from failed relationships. Other factors include; the feeling of betrayal and abandonment, lowered self-esteem, and the diminished ability to form healthy relationships.

According to Seabela (1990: 25), teenage pregnancy is associated with a psycho-socio and economic repercussions for the child, the mother as well as the society. Poverty and distress predict teenage pregnancy. The stigma of pregnancy often leads to low self-esteem and poor academic performance. Depression in pregnant teenagers has been linked to problems at school and at home. The negative effects of pregnancy on teenage mothers are shown when they face psychological, economic, and social problems which often interrupt their self-identity formation (Thompson 2004: 6). Teenage mothers face social isolation, poor life habits and depression. In addition to medical consequences like pregnancy-induced hypertension (PIH), teenage mothers face severe social consequences like weak or unhealthy children, as well as the emotional stress of being a single mother.

The Present Study

The study investigated the discrimination against pregnant learners and their willingness to drop out of school. It was hypothesized as follows:

H1. There is a correlation between the perception of discrimination toward pregnant learners and teenagers' willingness to drop-out of school.

H2. There is a correlation between the experience of pregnancy and teenager's willingness to drop-out of school

H3. There is a correlation between knowledge of contraceptives and teenagers' willingness to drop-out of school.

H4. There is a correlation between the use of contraceptives and teenagers' willingness to drop-out of school.

H5. There is a correlation between the rate of attending school activities and teenagers' willingness to drop-out of school.

H6. There is a correlation between the effect of knowledge of Sexual Transmitted Infections and HIV and learner pregnancy.

RESEARCH METHODOLOGY

The population of *Mphathesitha* High School at the time of the study was 865. However, a target sampling procedure was adopted to enumerate the number of female students who were pregnant at the time of the study. A total of 70 learners had either experienced pregnancy previously or were pregnant at the time of the study. All pregnant learners were, therefore, included in the sample. The total sample for the study was, therefore, 70 respondents (n=70).

The quantitative approach was used to explore all possible data for the study. The approach used in the study included the systematic collection of quantifiable information. Data were collected using a questionnaire. Copies of the questionnaire were distributed to the learners by the researcher. Data were coded and analysed using the *SPSS 22*. Scales were computed with the aid of Principal Components Analysis. Relationships between variables were tested using bivariate correlations.

RESULTS

Scales and Measures

Perception of Discrimination against Pregnant Pupils (PERDIPPUL)

Five questionnaire items were used to obtain information on the respondents' perception of discrimination against pregnant learners. In order to determine the mean rating of these items and the extent of the individual item's contribution to extracted factor, factor reduction was computed through Principal Component Analysis on the five items. The result in Table 1 showed that PCA was suitable for the items given KMO X= .741, BTS, χ^2= 139.667 (df = 10), p < .000 One factor (PERDIPPUL), accounting for 57.743 percent of one variable in the was extracted (see Table 1).

Table 1: KMO and Bartlett's Tests

	Kaiser-Meyer-Olkin measure of sampling adequacy	*Bartlett's test of sphericity*	*Df*	*Sig.*
PERDIPPUL	.741	139.667	10	.000
REDPREG	.806	214.077	21	.000
FAMCONTRA	.667	176.565	10	.000
US CONTRA	.476	17.882	10	.057
SCHACT	.884	225.961	15	.000
KNOWSTI	.696	115.666	15	

Level of Readiness for Education during Pregnancy (REDPREG)

Seven questions were used to elicit the information on the respondents' self-rating on their level of readiness for Education during pregnancy. In order to determine the mean rating of these items and the extent of the individual item's contribution to extracted factor, factor reduction was conducted through Principal Component Analysis on the seven items. The results in table 1 showed that PCA was suitable for the items given KMO = .806, BTS, χ^2 = 214.077 (df = 21), p < .000 One factor (REDPREG), accounting for 52.805 percent of one variable in the outcome was extracted (see Table 1).

Familiarity with Different Types of Contraceptives (FAMCONTR)

Five questions were used to elicit information from the respondents on familiarity with different types of contraceptives (FAMCONTR,). To obtain the mean rating of the items and the extent of the individual item's contribution to the extracted factor, factor reduction was conducted with the aid of Principal Component Analysis on the five items. The results in Table 1

showed that PCA was appropriate for the items given KMO = .667, BTS, χ^2=176.565 (df = 10), p < .000 One factor (FAMCONTR), accounting for 53.808 percent of one variable in the outcome was extracted (see Table 1).

Level of Use of the Contraceptives (USECONTR)

Five questions were used to elicit information from the respondents on the level of use of contraceptives (USECONTR). To decide the mean rating of these items and the extent of the individual item's contribution to extracted factor, factor reduction was conducted through Principal Component Analysis on the five items. The result (See Table 1 showed) that PCA was appropriate for the items given KMO = .476, BTS, χ^2 =17.882 (df = 10), p < .057 One factor (USECONTR), accounting for 29.569 percent of one variable in the outcome was extracted (see table 1).

Level of Attendance of School Activities During the Pregnancy (SCHACT)

Six questions were used to elicit information on respondents' level of attendance of school activities during pregnancy (SCHACT). To produce the mean rating of these items and the extent of the individual item's contribution to extracted factor, factor reduction was conducted with the aid of Principal Component Analysis on the six items. The result (See Table 1 showed) that PCA was appropriate for the items given KMO = .844, BTS, χ^2 =225.961 (df = 15), p < .005 One factor (SCHACT), accounting for 63.806 percent of one variable in the outcome was extracted (see Table 1).

Knowledge of STIs (KNOWSTI)

Six questions were used to elicit respondents's rating of their own knowledge of STIs and HIV (KNOWSTI). To obtain the mean rating of these items and the extent of the individual item's contribution to extracted factor, factor reduction was conducted through Principal Component Analysis on the six items. The results in Table 1 showed that PCA was appropriate for the items given KMO = .696, BTS, χ^2 =115.666 (df = 15), p < .000 One factor (KNOWSTI), accounting for 45.499 percent of one variable in the outcome was extracted (see Table 1).

Table 2 shows that the most important factor in the descriptive values of the perception of the discrimination of pregnant pupils was the item '*Parents treat pregnant learners differently*', mean =2.69, SD=1.450.

Table 2: Descriptive statistics for PERDIPPUL

	Mean	*Std. deviation*[a]	*Extraction*
Learners are unfriendly toward pregnant people	2.36	1.373	.576
Teachers isolate pregnant students	2.64	1.384	.801
Parents treat pregnant learners differently	2.69	1.450	.708
Learners use insulting words towards pregnant learners	2.47	1.370	.702
Partners often abandoned pregnant learners	2.89	1.490	.101

Socio-demographic Correlates with Perception of the Discrimination of Pregnant Pupils (PERDIPPUL)

Table 3 indicates the correlation between the perception of discrimination against pregnant pupils (PERDIPPUL) and social demographic, where the total number of participants is 70 (n=70), Pearson Correlation Sig is (2-tailed). The results showed that social demographic factors are not correlated with the perception of discrimination against pregnant learners. Results show that the gender of participants cannot be computed because participants are all females. The results showed that the variable PERDIPPUL does not correlate with the level of study of participants, r= -116, age of participant, r = .091 (1-tailed). The results, however, further showed that PERDIPPUL correlated with the province of participant, r. = .032, p<0.05 (1 tailed).

Table 3: Zero-order correlations for PERDIPPUL and demographics

	1	*2*	*3*	*4*	*5*
(1) Study level					
(2) Age					
(3) Province					
(4) Race					
(5) Age at pregnancy					
(6) PERDIPPUL	-.116	-.091	.032*	.035	-.060

The relationships between PERDIPPUL and all other social demographic variables fell below the standard levels of statistical significance. Studies have shown that one of the best predictors of teenage mothers' readiness to go back to school was whether they had family support to assist with finance or child-care responsibilities (Jewkes et al. 2009; Bearinger et al. 2007; Pettifor et al. 2009). Support for a teenage mother with finance and childcare are therefore the critical factors in their decision to return to school or not.

Rating Level on Readiness for Education during Pregnancy (REDPREG)

Table 4 shows that the most import factor in the descriptive values of the rating level of education during the pregnancy is the item '*I am thinking of dropping out and continuing next year'*, mean =3.39, SD = 1. 427.

Table 4: Descriptive statistics for REDPREG

	Mean	*Std. deviation*[a]	*Extraction*
I am tired of school	3.13	1.483	.517
I don't like it here any more	3.37	1.364	.696
School is a waste of time	3.84	1.175	.739
I am not gaining anything here	3.70	1.196	.597
I can no longer combine school with raising my child	3.03	1.414	.313
I am tired of everything	3.44	1.326	.509
I am thinking of dropping out and continuing next year	3.39	1.427	.325

Source: Data collected for the study.

Socio-demographic Correlates of Level of Education during the Pregnancy (REDPREG)

Table 5 depicts the Social Demographic correlates of the level of education during the pregnancy. Results show that gender of the participants cannot be computed because participants are all females. Result shows that REDPREG correlate with the level of study r =.054, p< 0.05, ages r =.021, p< .005 and also ages of the pregnant correlate at r =.135, p<0.05. The results also indicate that the province of participants r =-.214, p < 0.05 and race r= -320, p<0.05 do not correlate with REDPREG. This indicates that there is correlation between the rating level of education during the pregnancy (REDPREG), and social demographic.

Table 5: Zero-order correlations for REDPREG and demographics

	1	*2*	*3*	*4*	*5*
(1) Study level					
(2) Age					
(3) Province					
(4) Race					
(5) Age at pregnancy					
(6) PERDIPPUL	054*	.021*	-.214*	-.320	.135*

*. p< 0.05 (2-tailed)

Familiarity with Contraceptives (FAMCONTR)

Table 6 shows that the most import factor in the descriptive values of the variable, familiarity with contraceptives is the item; *'How familiar are you with Condoms'*, mean = 1.36, SD =. 615.

Table 6: Descriptive statistics for FAMCONTR

	Mean	*Std. deviation*[a]	*Extraction*
How familiar are you with Condoms	1.36	.615	.715
How familiar are you with Pills	1.47	.717	.871
How familiar are you with injection	1.42	.730	.757
How familiar are you with Rhythm method	2.66	1.443	.242
How familiar are you with Loop	3.39	1.506	.106

Source: Data collected for the study

Table 7 indicates the correlation between the familiarities of different types of contraceptives

Table 7: Zero-order correlations for FAMCONTR and demographics

	1	*2*	*3*	*4*	*5*
(1) Study level					
(2) Age					
(3) Province					
(4) Race					
(5) Age at pregnancy					
(6) PERDIPPUL	245*	.213*	-.149	.059*	-.249

*. p< 0.05 (2-tailed)

(FAMCONTR) and social demographic, where the total number of participants is 70 (n=70), Pearson Correlation Sig is (2-tailed). Results show that the gender of the participants cannot be computed because they are all females. Results indicate that FAMCONTR correlate with the race of participants r = .059, p<0.05, age r= 213, p< 0.05 and level of study r = 245, p< 0.05.

Level of Use of the Contraceptives (USECONTR)

Table 8 shows respondents' levels of use of the contraceptives. The results showed that the most important factor in the descriptive values of the Level of use of contraceptives is the item, *'How often have you used condoms'*, mean =1.99, SD =1. 257.

Table 8: Descriptive statistics for USECONTR

	Mean	*Std. deviation*[a]	*Extraction*
How often have you used condoms?	1.99	1.257	.595
How often have you used pills?	3.47	1.411	.486
How often have you used injection?	3.56	1.379	.350
How often have you used the rhythm method?	3.34	1.658	.043
How often have you used the loop?	4.54	.988	.005

Source: Data collected for the study.

Socio-demographic Correlates of Level Use of Contraceptives (USECONTR)

Table 9 shows the correlation between the level of use of contraceptives (USECONTR), and social demographic. The result indicates USECONTR is correlated where age r= .072, p< 0.05, province r = .158, p<0.05, and ages of pregnant r = .128, p<0.05. The results, however, also indicate that the level of study r = -.053, and race r = -.002 had no significant relationship with USECONTR.

Table 9: Zero-order correlations for USECONTR and demographics

	1	*2*	*3*	*4*	*5*
(1) Study level					
(2) Age					
(3) Province					
(4) Race					
(5) Age at pregnancy					
(6) USECONTRA	-.053	.072*	.158*	-.002	.128*

**. p< 0.01 (2-tailed), *. p< 0.05 (2-tailed)

Level of Attending the School Activities during the Pregnancy (SCHACT)

Table 10 shows the level of attendance of school activities during the pregnancy. The most weighty factor in the descriptive values of the level of attendance of school activities during the pregnancy, is the item *'How often did you attend day classes'* mean =1.91, SD =1. 100.

Table 10: Descriptive statistics for SCHACT

	Mean	*Std. deviation*[a]	*Extraction*
How often did you attend day classes?	1.91	1.100	.524
How often did you attend night classes?	3.06	1.226	.746
How often did you attend sport activities?	3.44	1.211	.739
How often did you attend social events?	3.66	1.190	.715
How often did you attend political activities?	3.96	1.221	.491
How often did you study/read in the library?	3.01	1.313	.615

Extraction Method: Principal Component Analysis

Socio-demographic Correlates of Level of Attending School Activities (SCHACT)

Table 11 shows the correlation between the level of attending school activities during the pregnancy (SCHACT), and social demographic.

Table 11: Zero-order correlations for SCHACT and demographics

	1	*2*	*3*	*4*	*5*
(1) Study level					
(2) Age					
(3) Province					
(4) Race					
(5) Age at pregnancy					
(6) SCHACT	-.022	.088*	-.020*	.242	.081*

*p< 0.05 (2-tailed)

Results indicate that SCHACT is correlated with ages at pregnancy r = .081, p< 0.05, race r = .20, p<0.05, and age r = .088, p<0.05. The results, however, indicate that the level of study r= -.022 and province r = -.202 do not correlate with SCHAT.

Knowledge of STIs and HIV (KNOWSTI)

Table 12 shows respondents' levels of the knowledge of STIs and HIV. As depicted, the most weighty factor in the descriptive values of the rates on the knowledge of STIs and HIV, is the item *'STIs and HIV are not the threat to pregnancy'* mean =3.63, SD =1. 206.

Table 12: Descriptive statistics for KNOWSTI

	Mean	*Std. deviation*[a]	*Extraction*
STIs and HIV are not the threat to pregnancy	3.63	1.206	.007
STIs and HIV are dangerous during sex	2.16	.973	.359
STIs and HIV can be prevented towards the baby	2.11	.894	.635
STI can be treated	1.93	.786	.521
HIV women are given the pill to protect the baby	2.01	.789	.630

Socio-demographic Correlates of Rating the Knowledge of STIs and HIV (KNOWSTI)

Table 13 indicates the correlation between the rating of STIs and HIV (KNOWSTI**)** and social demographic. The results indicate that KNOWSTI does not significantly correlate with ages at pregnancy r = -.160, , race r = -.077, province r = -.028, and age r = .070. The results, however, showed that the level of study correlated with KNOWSTI, r = .036, p<0.05 (2-tailed).

Table 13: Zero-order correlations for KNOWSTI and demographics

	1	*2*	*3*	*4*	*5*
(1) Study level					
(2) Age					
(3) Province					
(4) Race					
(5) Age at pregnancy					
(6) KNOWSTI.	036 *.	-.070	-.028	-.077	-.160

*. p< 0.05 (2-tailed)

Teenage Pregnancy and School Dropout

Table 14 indicates the correlation of independent variable and other variables (dependent). Results show that the gender of participants cannot be computed because they are all females. The results indicate PERDIPPUL and USECONTR are correlated r = .287, p< 0.05 (2-tailed). It was also shown that REDPREG and SCHAT correlate, r = -.299, p< 0.05 (2-tailed) while SCHAT correlates with USECOTR, r = .337, p< 0.01 (1-tailed). All other relationships, however, were below all levels of statistical significance.

DISCUSSION

Teenage pregnancy is often accompanied by difficulties. Teenagers often feel ostracised and

Table 14: Correlation for all variables

		PERDIPPUL	*REDPREG*	*FAMCONTR*	*USECOTR.*	*SCHACT*	*KNOWSTI*
PERDIPPUL	Pearson Correlation	1	.185	.177	.287*	-.006	-.084
	Sig. (2-tailed)		.125	.142	.016	.962	.489
REDPREG	Pearson Correlation	.185	1	.033	.084	-.299*	-.027
	Sig. (2-tailed)	.125		.787	.490	.012	.825
FAMCONTR	Pearson Correlation	.177	.033	1	.067	.156	-.010
	Sig. (2-tailed)	.142	.787		.580	.198	.934
USECOTR	Pearson Correlation	.287*	.084	.067	1	.337**	.055
	Sig. (2-tailed)	.016	.490	.580		.004	.650
SCHACT	Pearson Correlation	-.006	-.299*	.156	.337**	1	.093
	Sig. (2-tailed)	.962	.012	.198	.004		.444
KNOWSTI	Pearson Correlation	-.084	-.027	-.010	.055	.093	1
	Sig. (2-tailed)	.489	.825	.934	.650	.444	

*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).

rejected (Ntombela 1992; Zama 1991). The results from the present study showed that whilst pregnant teenagers are isolated by their partners, parents and friends, they avoid abortions and come back to school after delivery and continue with their studies. According to Makhaza and Ige (2014), the level of use of contraceptives among young people remains low, thus, exposing them to sundry STIs and unwanted pregnancies.

South Africa has had a high prevalence of teenage pregnancy. The *Sowetan* live (2011) estimated that one in three girls would have had a baby by age of 20. However, other studies have used the Health Belief Model to control the changing behaviour of people and to control the transmission of STI's among young people. It is well known that the condom is an effective birth control method that equally offers protection against sexually transmitted infections (STIs). However, people's failure to use the birth control method has led to high rates of death. Past studies showed that lack of knowledge of contraception, peer pressure to engage in sex, family/cultural disorganization and poor self-identity/ image are significant factors in teenage pregnancy. Many teenagers have been found to be lacking an understanding of menstruation, sex and fertility (Boult and Cunningham1992; Preston-Whyte and Zondi 1989; Richter 1996; Boult and Cunningham 1992; Bodibe 1994; Mkhize 1995).

The results of the present study, consistent with past findings, showed that teenagers in South Africa continue to have children at younger ages (Craig and Richter-Suydom 1983; Mpanza 2006). One of the major objectives of the present study was to uncover ways by which pregnant teenage mothers can be sustained to continue in school or return after childbirth. It seems, however, that most school going teenagers wish to complete their studies and thus construe pregnancy as disruptive of their goal attainment attempts and possibilities. Contrary to the assumption that African culture places a premium on fertility and that this catalyses fertility intentions (Preston-Whyte and Zondi 1989: 226), a preponderance of the respondents in this study opined that pregnancy at teenage was culturally inappropriate.

Story (1999) reported that many university students engage in sexual intercourse, usually with multiple partners with many not using contraception. Thus, limited knowledge and use of contraceptives persists among young people. The results of this study showed that the learners of Mphathesitha High School are now developing or growing in their academic life because they have knowledge about their life, they are being positive even though they are facing lots of problems because after having babies they continue with their education. The study aimed to decipher the relationship between the variables that were used in this research, which are PERDIPPUL, REDPREG, FAMCONTR, USECONTR, SCHACT and KNOWSTI. It was evident from the results that the variables are correlated, meaning that the rating level of education during the pregnancy determines their level of using the contraceptives, and it also determines their level of attending school activities during their pregnancy.

The study showed clearly that teenage pregnancy affects the education of learners. It also showed that the willingness to drop out of school affects the society if the teenagers end up dropping out of school. This would result in a high level of uneducated people, high rates of joblessness and poverty in the community. It can, therefore, be argued that there is a significant relationship between discrimination against pregnant teenage learners and their willingness to drop out of school, and support from other people. Although others do not get any support during their pregnancy, they still survive.

Recent research showed that traditional pregnancy reduction approaches like sex education and better sexual health services are becoming less effective. This has brought about interest in the adoption of interventions that target the indices of social disadvantage that are related to early pregnancy. Social disadvantage connotes social and economic difficulties confronted by individuals, like unemployment, poverty and discrimination that are linked to ethnicity, socio-economic position, educational attainments and residential location.

CONCLUSION

Education disruption has been regarded as one of the major repercussions of teenage pregnancy. Studies showed that teenagers who fall pregnant often do not have the option of returning to school. On the other hand, while young boys as fathers are not saddled with childcare

responsibilities like adolescent mothers they are often known to exhibit lower academic performances, higher school drop-out possibilities and diminished future potentials than their peers**.** Teenage mothers end up poorer than adult mothers and have higher exposure to hypertension, premature labour and sundry medical conditions. Teenage pregnancies further result in relationship difficulties, ostracism, and rejection by her family. One of the significant findings of the present study was that in spite of these precarious conditions, pregnant teenagers often avoided abortion, deliver their babies and returned to school. Similarly, after giving birth, many of these teenagers in spite of coming from poor families often continued in school. This presents them with better opportunities to earn a better future for themselves.

RECOMMENDATIONS

The results of this study show that teenagers are aware of the challenges facing them during the pregnancy, thus the study recommends that there should be programmes that will seek to develop teenagers in order for them not to become pregnant during the adolescence stage. For example, these could be programmes that teach them about the contraceptives, especially condoms, which would help them to avoid sexually transmitted diseases, like HIV/AIDS that can be contacted through the lack of using contraceptives.

Other programmes could teach teenagers about the importance of schooling, so that they should not dropout from schools during pregnancy. One may say that there are many different ways to prevent unplanned pregnancy and STDs and there is still a need to build strategies to educate and develop life skills for the young people who are potential victims of unplanned pregnancy and HIV and AIDS. Health care clinics must teach all learners, even at primary level, even those that are not in the teenage stage, so that they should be careful, during this stage, about the advantages and disadvantages of becoming pregnant at a young age, so that they can use contraceptives or abstain from sexual activities. Parents must also be taught about the importance of education, so that they should allow teenagers to go back to school after delivering their babies. Parents should be educated about the importance of giving their children another chance, by taking them back to school.

Teachers must always encourage teenagers to return to school, they should make learners to believe in themselves, even though they have made mistakes. For example, there are teachers who, like learners, had their babies during their teenage years, but they were given a second chance in life.

This study recommends that social workers should try by all means to support teenagers who become pregnant during their schooling, especially those who are poor or who depend on the pension grant of their grandparents, by taking care of their children after birth, so that the teenagers may get a chance to go back to school. In this way, their progress in school would not be hampered, because they would know that their children are well taken care of.

Government should provide rural communities with day care services for the little young ones, for an example, there must be people during the day who focus on poor families, who take care of babies and feed them so that their mothers may be able to go back to school. This study recommends that in rural societies there must be Home Based people, like in townships, who would make sure that children are growing well and, if the baby is ill, they would decide to take him/her to the clinic where the baby could be provided nutritious baby food that can boost the immune system of the baby – something they do for HIV people**.**

The study also shows that the people or teenagers in rural communities are educated because they all wish to finish their studies even though they are pregnant. The teenagers are interested mostly in planning for a better future for to their babies. Finally, the study recommends that the teenagers must not opt for abortion even when their partners have abandoned them because it is dangerous to their own lives. This is true, especially, because most people who do abortions are not educated and they use medication which is not tested or recommended by doctors or scientists. Most of the teenagers who go to unqualified local women who are known to perform abortions die or rot inside their wombs.

REFERENCES

Ardington C, Branson N, Lam D, Leibbrandt M, Marteleto L, Menendez A, Mutevedzi T, Ranchold V 2012. *Revisiting the 'Crisis' in Teen Births: What is the Impact of Teen Births on Young Mothers and Their Children?* A Southern African Labour and Development Research Unit Policy Brief. UCT.

Bearinger LH, Sieving RE, Ferguson J, Sharma V 2007. Global perspectives on the reproductive health of adolescents: Patterns, prevention, and potential. *The Lancet*, 369: 1220-1231.

Bezuidenhout FJ 2004. *A Reader on Selected Social Issues.* 3rd Edition. Pretoria: Van Schaiks.

Bhana D, Morrell R, Shefer T, Ngabanza S 2010. South African Teachers' response to teenage pregnancy and teenage mothers in schools. *Culture, Health & Sexuality*, 18(8): 871-883.

Boult BE, Cunningham PW 1992. Black teenage pregnancy: An African perspective. *International Journal of Adolescence and Youth*, 3: 303-309.

Burns N, Grove SK 1993. *The Practise of Nursing Research, Conduct, Critique and Utilization*, Philadelphia: WB Saunders.

Bodibe CR 1994. *Investigating the Sexual Knowledge, Attitudes and Behaviours of Black Adolescents*. Master's Thesis, Unpublished. University of South Africa.

Campbell R, Pound P, Pope C, Britten N, Pill R, Morgan M, Donovan J 2003. Evaluating metaethnography: A synthesis of qualitative research on lay experiences of diabetes and diabetes care. *Social Science & Medicine*, 56(4): 671-684.

Craig C, Richter-Suydom, D 1989. *Perception of Teenage Pregnancy among South African Adolescent*: Unpublished Report. Pretoria: Medical Research Council.

Campbell R, Pound P, Pope C, Britten N, Pill R, Morgan M, Donovan J 2003. Evaluating meta ethnography: A synthesis of qualitative research on lay experiences of diabetes and diabetes care. *Social Science & Medicine*, 56(4): 671-684.

Constitution of the Republic of South Africa No. 108 of 1996. From <http://www.gov.za/sites/www.gov.za/files/images/a108-96.pdf> (Retrieved on 12 June 2014).

Dev Raj A, Rabi B, Amudha P, Van Teijlingen E, Glyn C 2010. Factors associated with teenage pregnancy in South Asia: A systematic review. www.HSJ.GR – *Health Science Journal*, 4(1): 612-645.

Downey G, Coyne JC 1990. Children of depressed parents: An integrative review, *Psychological Bulletin*, 108: 1-27.

Elliott L, Brantley C 1997. *Sex on Campus: The Naked Truth about the Real Sex Lives of College Students.* New York: Random House.

Elliot AJ, Church MA 1997.A hierarchical model of approach and avoidance achievement motivation. *Journal of Personality and Social Psychology*, 72: 218–232.

Enderbe E 2000. *Cambridge Handbook of Psychology, Health and Medicine*. New York: Cambridge University Press.

Goldberg GL, Craig CJT 1983. Obstetric complications in adolescent pregnancies. *South African Medical Journal*, 64: 863-864.

Holt K, Lince N, Hargey A, Struthers H, Nkala B, McIntyre J, Gray G, Mnyani C, Blanchard K 2012. Assessment of service availability and health care workers' opinions about young's sexual and reproductive health in Soweto, South Africa. *African Journal of Reproductive Health*, 16(2): 283-294.

Jewkes R, Morrell R, Christofides N 2009. Empowering teenagers to prevent pregnancy: Lessons from South Africa. *Culture, Health & Sexuality*, 11(7): 675-688.

Lemos G 2009. *Freedom's Consequences. Reducing Teenage Pregnancy and their Negative Effects in the UK.* London: Lemos & Crane.

Lince N 2011. Early Marriage and Teenage Pregnancy in South Africa. PowerPoint Presentation. *Ibis Reproductive Health Conference*, Johannesburg.

Ntombela BB 1995. The perception of pregnancy by the black primigravida teenagers in the Mlazi area of Kwa-Zulu Natal. *Chasa*, 6(3): 152-154.

MacLeod C 2011. The "causes" of teenage pregnancy: Review of South African research-part-2. S*outh African Journal of Psychology*, 29(1): 8-16.

Makhaza M, Ige KD 2014. Knowledge and use of contraceptives among tertiary education students in South Africa. *Mediterranean Journal of Social Sciences*, 5(10): 500-510.

Mkhize ZM 1995. *Social Needs of Teenage Mothers in the Rural Communities of Ongoye and Enseleni Districts.* Master's Thesis, Unpublished. South Africa: University of Zululand.

Mokwena JP 2003. *The General Health and Coping Strategies of Teen Mothers*. South Africa: University of the North.

Mpanza ND 2006. *The Study of Educators' Attitudes towards Teenage Pregnancy.* Masters Dissertation, Unpublished. South Africa: University of Zululand.

Pettifor A, O'Brien K, MacPhail C, Miller W, Rees H 2009. Early Coital Debut and Associated HIV risk factors among young women and men in South Africa. *International Perspectives on Sexual and Reproductive Health*, 35(2): 82-90.

Preston-White E, Zondi M 1989. To control their own reproduction: The agenda of Black teenage mothers in Durban. *Agenda*, 4: 47-68.

Pond TS 1987. *A Psychodynamic Approach to the Adolescent Unmarried Mother.* Master's Thesis, Unpublished. South Africa: University of Pretoria.

Richter LM 1996. *A Survey of Reproductive Health issues among Urban Black Youth in South Africa.* Report, Unpublished. Pretoria: Medical Research Council.

Russell ST 2002. Childhood developmental risk for teen childbearing in Britain. *Journal of Research on Adolescence*, 12: 305–324.

Seabela SR 1990. *Teenage Unwed Motherhood amongst Blacks: A Sociological Study*. South Africa: University of South Africa.

Story WA 1999. *The Effect of Unplanned Pregnancy among College Women*. Virginia: University Press.

South African Schools Act No. 84 of 1996. From <http://www.education.gov.za/LinkClick.aspx? fileticket=aIolZ6UsZ5U%3D&tabid=185&mid=1828> (Retrieved on 12 June 2014).

Sowetan Live 2011. Teenage Pregnancy in Soweto. From <http://scholar.lib.vt.edu/theses/available/etd> (Retrieved on 23 September 2013).

Thompson LE 2004. *Teenage Pregnancy: The Missing Male Factor*. Barry University, United States. ProQuest Information and Learning Company.

Varga CA 2003. How gender roles influence sexual and reproductive health among South African adolescents. *Studies in Family Planning*, 34: 160-172.

Zama N 1991. *Attitudes of Parents towards Teenage Pregnancy*. BA Honours Dissertation, Unpublished. South Africa: University of Zululand.

Paper received for publication on January 2016
Paper accepted for publicaiton on September 2016