THE SOCIAL CONTEXT OF ADOLESCENT PREGNANCY: THE CASE OF MAMRE

by

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ABSTRACT

The present study examines the social context and experiences of pregnant adolescents with the aim of forwarding suggestions for intervention. The study was conducted in Mamre, a semi-rural, predominantly Moravian village near Cape Town. The study consisted of two parts. For the first part, names were obtained from the Mamre birth and registration list and the birth records of Wesfleur Hospital, Atlantis. The sample consisted of 25 women who at the time of conception were between 14-19 years. Names were divided into two randomly selected groups: 9 women who had babies under 18 months and 16 whose babies were between 2-4 years. A semi-structured questionnaire was administered to respondents in their homes. Interviews were tape-recorded, transcribed and qualitatively content analysed. For the second part of the study, 15 Mamre church records between the period 1837-1909 were drawn and examined for exclusionary practices in relation to premarital pregnancy in the Moravian church. Analysis indicates that tensions exist between attitudes to premarital sexuality and those to premarital sexual behaviour. Tensions furthermore exist between parents' acceptance of their daughters' babies and the condemnation of their daughters' teenage pregnancies. The study offers explanations for the apparent tensions. Taking these issues into consideration, ideas on intervention are suggested.

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CHAPTER 1

Introduction

Rationale and Aims in researching adolescent pregnancy

The latest (1987) teenage pregnancy rate for South Africa for so-called Coloured, Asian, Black and White population groups, respectively, is 13.9%, 8.4%, 11.4% and 6.6% (Department of Health, Pretoria, personal communication, 1993). Harrison (1991) suggests that the most recently available rate for teenage pregnancy in the Cape Peninsula is between 15-20%. De Villiers (1991) views the high local incidence of teenage pregnancy as a disaster in terms of personal, social and community development. Many approaches have been adopted in an attempt to curb teenage pregnancy. De Villiers (1991) advocates a "widespread implementation of community based education programmes which extend beyond the confines of the classroom" but is not specific about methods. Nash (1990) and Ortiz and Bassoff (1987) also suggest greater state support for young mothers and, more radically, the relaxation of current abortion legislation to allow girls under sixteen to have abortions on demand. Ortiz (1987) adopts a feminist position which essentially advocates a lifeskills-type training by and for women teenagers. This, it is argued, will engender feminist values with an increase in self-esteem which will improve women's access to available life options and make the option of early pregnancy less attractive. This stance is promising in terms of community based interventions. It is nevertheless problematic as it entails a western middle class conception of conversion of values. It may ignore powerful social and economic forces within specific communities. Yet, ironically, in the present context of economic recession and conservative legislature, education programmes which have been shown to be relatively unsuccessful in reducing teenage pregnancy, seemingly remain the only option. It is this phenomenon which suggests that unless the social context of and reasons for teenage

pregnancy are explored, education programmes which assume contraception as the single answer, may continue to fail.

The aim of the study therefore is to identify qualitatively the nature and context of teenage pregnancy and motherhood in Mamre (a description of the village follows below) which could allow one to explore the personal and social content of experiences.

It is envisaged that this study will furthermore explore and incorporate solutions possibly already existing for teenage mothers in the community with the ultimate aim of developing guidelines for intervention with them.

BACKGROUND TO STUDY

Focus on Mamre:

Mamre, a village with approximately 5000 inhabitants, is situated along the west coast about 48 km from Cape Town and was originally established as a Moravian mission station in 1808.

Much research has been carried out in Mamre since the establishment of the Mamre Community Health Project (MCHP) in 1986. The project is a collaborative effort between research and academic bodies in consultation with the community. Its purpose is to determine the health status and needs of people so that health in the community may be improved by introducing appropriate interventions. In addition, it is hoped that the development of appropriate health interventions may be applicable in similar communities.

The decision to incorporate Mamre as the area for establishing a community health project was based on the following:

a) it is a well-established community with strong traditions and many descendants of original families living there.

b) it is easily accessible to Cape Town and therefore to researchers from the University of Cape Town and the Medical Research Council.

c) the community is experiencing a process of rapid urbanisation.

d) it is a small, well-defined and circumscribed area which lends itself to research. (Hoffman, Yach, Katzenellenbogen, Pick and Klopper 1988; Katzenellenbogen, Joubert, Hoffman and Thomas 1988).

Service development within the MCHP since 1986

Since 1986, the MCHP has formulated interventions based on research results. Lay persons in the community have been incorporated and trained to run various programmes in assocation with professionals. The largest ongoing service contributions include a station to monitor residents' levels of hypertension and diabetes, and an associated weight-reducing club and smoking cessation group. In addition, a well-established psychological service deals not only with individual casework but also spearheads training and transfer of skills to both professionals and paraprofessionals working in the community. Further services offered include those of final year student placements from the Social work, Occupational therapy and Physiotherapy departments at UCT.

Since February 1992 the MCHP has also established a subsidiary Mamre Community Health Worker Project which employs four women from the community. The incorporation of Community Health Workers into health systems is widely advocated in the context of primary health care (Pick 1992). More importantly perhaps, they also facilitate transfer of skills to individuals and in so doing teach individuals to utilise their own resources.

Two MCHP health workers are "health activists", working in the area of youth, and deal largely with running preventative programmes. The other two health workers are "support workers" who do largely home nursing for people discharged from hospital in need of ongoing care. They assist with practical nursing, but more importantly teach the family members of patients how to care for them. They underwent a period of initial training and are also involved in ongoing training.

The results and recommendations from the present project could be useful to the "health activists" as they are involved with preventative programmes concerning youth.

The relationship between the MCHP and the present study

In the initial epidimiological study of Mamre in 1986 where baseline data were established, Katzenellenbogen, Joubert, Hoffman and Thomas (1988) found that 10% of females between the ages 14 and 19 had had children. Approximately 95% of these adolescent mothers were single. An analysis of the Mamre Birth Registration Lists reflect an average teenage pregnancy rate of 21% over the last 7 years. The teenage pregnancy rate in Mamre ranges between 12% in 1992 to 34% in 1989. (See appendix G). This rate of teenage pregnancy is similar to the Western Cape figures of 15-20% (Harrison, 1991). Concern has frequently been expressed over the rate of adolescent pregnancies by members of the community over a period of time.

Gaining access to the community

Gaining access to the community was not difficult as is recorded in other communities (Carolissen, Hansson, Naicker, Petersen and Sterling 1989). This was due largely to the

established links, trust and mutual accountability which had been built up between the University of Cape Town, The Medical Research Council and the Mamre community.

CLARIFYING THE RESEARCH QUESTION

Consultation with previous researchers

An informal needs assessment of relevant and intervention- directed research in the Mamre community was undertaken after August 1991. This consisted of establishing a needed area of research by interviewing the coordinator of the MCHP (Mercia Arendse), other researchers from the Medical Research Council (Judy Katzenellenbogen) and the University of Cape Town (Margaret Hoffman and Tracey Miller). Arendse, Katzenellenbogen and Hoffman, particularly, were targeted as resources as they had had experience with the MCHP since its inception and were involved in the initial epidemiological study of Mamre in 1986 where baseline data were obtained (Katzenellenbogen, Joubert, Hoffman and Thomas 1988).

Their experiences and research indicated that the youth experience difficulties in the community of which adolescent pregnancy raises the most concern among health workers and youth alike (Mercia Arendse, personal communication, 1991).

Consultation with community representatives

Mercia Arendse, who has always been a resident of Mamre, encouraged me also to consult with other members of the community who had expressed concern over teenage pregnancy. They included the nursing sister at the local Regional Services Council Clinic (Sister Witbooi), the Moravian priests (Reverends Engel and Cunningham) and a community nurse (Desiree Links), who had in the past offered practical advice to pregnant adolescents. When I was an

intern clinical psychologist based in Mamre (February to May 1992), Sister Witbooi approached the MCHP requesting assistance with support for adolescent pregnant mothers. While an exploration of adolescent pregnancy, which is the aim of this study, had not yet been done, the need to address associated problems seemed urgent. In this context, Desiree Links and I ran weekly information groups for pregnant adolescents and adolescent mothers during which they could be prepared for the process of birth and the period shortly thereafter. Mercia Arendse had also been approached by the Moravian church youth group who expressed their concern about adolescent pregnancy and requested assistance with attempts to intervene. All these requests furthermore seemed to suggest that concerns about adolescent pregnancy are widespread and ongoing.

Outline of the dissertation

Chapter 1 has provided an introduction and background to the study. Relevant literature in relation to teenage pregnancy is reviewed in Chapter 2. Chapter 3 discusses the social context of teenage pregnancy in Mamre and also briefly examines this historically. Chapter 4 describes methodology, and the results are discussed in Chapter 5. Recommendations and conclusions are presented in Chapter 6.

CHAPTER 2

REVIEW OF LITERATURE ON TEENAGE PREGNANCY

A conceptual framework for adolescent pregnancy

Gelles, Hamburg and Super (1986), in Garn, Pesick and Petzold (1986) suggest that the tradition of viewing adolescent pregnancy and parenthood as a social problem has encouraged researchers to identify negative outcomes and accept information that confirms poor biological and social outcomes. Thus, an apparent bias towards pathology appears to have impeded scientific progress.

To move beyond this mindset it is important to examine the social and developmental contexts of adolescence and the experience of teenage pregnancy within these. In Hamburg's (1986) model, three concepts of age, ie. chronological, biological and social age are identified. Chronological age refers to the individual's numerical age, biological age to physical maturity and social age to the cultural milestones, such as marriage, birth of first child or achievement of adult work roles. Generally, societal norms are violated for being off-time i.e. being too early or too late for a particular social age. During a teenage pregnancy, particularly, asynchrony between the various ages arises. This usually places additional stress on the individual at a time when she is already experiencing the stressors of transition to a new developmental stage (Spicer, 1977).

Hamburg outlines three central views of the context of adolescent pregnancy. These are a) problem-proneness, b) depression and c) alternate life course with competent coping.

a) Problem-proneness

It has been argued that there is a high correlation between adolescent pregnancy and other adolescent problem behaviours such as alcohol and drug use and drop in motivation and school achievement. There is extensive support for this perception (Allen, Philliber and Hoggson 1990; Choquet and Manfredi 1992; Spicer 1977; Winnett, King and Altman 1989).

Jessor and Jessor (1975), in Hamburg (1986) argue that in this age group, engaging in "problem behaviours" is functional.

Teenagers can:

a) achieve otherwise unavailable goals.

b) learn a way of coping with personal frustrations and anticipated failure.

c) express rejection of conventional society.

d) negotiate for developmental transition.

e) provide a badge of membership in peer subcultures.

b) Depression

It has been argued that adolescence, especially in women, often marks the onset of depression which includes feelings of loneliness and insecurity. This prompts a search for affection which often culminates in teenage pregnancy. The responsibility of pregnancy and parenthood often enforces the cycle of depression and holds negative emotional consequences for both the mother and the child (cf. Semens and Lamers, 1968, in Farley, Hebert and Eckhardt, 1979).

Both the above views lack a rounded developmental perspective and view teenage pregnancy as necessarily and inevitably negative. The following view, however, entertains the possibility of positive consequences of teenage pregnancy and takes a developmental view.

c) Alternate life course and competent coping

This view takes into account the importance of social age. In dominant culture, pregnancy is expected to occur in a mature adult who has completed schooling and adapted to the demands of marriage. Mainstream middle class adult women have tended toward early career establishment, later marriage and childbearing. Therefore adolescent pregnancy is seen as markedly deviant behaviour. While ill-timed according to current, middle class social norms, early fertility and pregnancy may be psychosocially appropriately timed for some adolescents. Hamburg (1986) argues that in some black, urban, poor subcultures, alternative life courses are available. Time events for women entering the work force and childbearing are reversed. There is not a natural progression from schooling to work to marriage and pregnancy. In some of these subcultures, it may be the best option to commence childbearing during the teen years. Since youth unemployment amongst blacks is high, this can be a woman's productive time off from the labour force. Children born of adolescent pregnancies are already old enough to manage substantial household responsibilities when their mothers do enter the work force. In this context, children may relieve the stressors on their working mothers. It is furthermore argued that working mothers can also expand kin networks on which urban black individuals depend for social and economic support. When entering the workforce, the kin network can also provide childcare. Black, single mothers usually live with parents approximately 5 years before establishing their own household. Though reasons for this are probably primarily economic, mothers also gain the opportunity to consolidate their own growth and concretise their networks in preparation for the role of head of the household once they work.

Teenage pregnancy, then, can also be an adaptive survival strategy which encourages personal and social development. These teenagers are not necessarily immature, problem-prone or emotionally symptomatic. While this model provides a refreshing view for understanding the social contexts of adolescence which encourages teenage pregnancy, it may create a contradiction for individuals. Althusser's (1971) concept of ideological state apparatus (ISA) may be usefully employed in this context. He defines ideological state apparatuses as institutions in society which attempt to maintain the status quo of the dominant classes through their enforcement of dominant ideology by way of the practices which they promote. Hamburg's model ignores the above concept which implies that individuals would internalise dominant social norms which suggest that teenage pregnancy is undesirable. Therefore it is possible that the internalisation of social norms at a subjective level leads to conflicts about objective practices, even in this positive context.

I now review some key research findings.

Prevalence of teenage pregnancy

Teenage pregnancy is always based on estimated figures, as factors such as abortion and miscarriage account for a discrepancy between the number of teenage conceptions and the actual number of births to teenage mothers. Current teenage pregnancy rates for South Africa are difficult to establish. The latest available figures (1987) suggest that the teenage pregnancy rate for so-called Coloureds, Asians, Blacks and Whites, respectively is 13.9%, 8.4%, 11.4% and 6.6%. (Department of Health, Pretoria, personal communication, 1993). It is therefore appropriate that local Western Cape teenage pregnancy rates be used for comparison with other countries as South African rates appear to be outdated. As mentioned earlier, it is estimated that 15-20% of all births in the Western Cape are to teenage mothers (Harrison,

1991). This is high compared to industrialised countries. Rates for the U.S.A., Sweden and Finland are 10%, 3.8%, and 4.3% respectively (Vydanoff and Donelly, 1990; Winnett, King and Altman, 1989; Wallace and Vienonen, 1989). As far as other developing countries in Africa are concerned, Kulin (1988) reports an adolescent birth rate to single mothers in Kenya of between 6-11% which is approximately representative of other African countries. On the other hand, the Namibian figure of 16.4% is as high as those in South Africa (Mostert and van Tonder, 1989). Reasons for such variable teenage pregnancy rates are given as access to abortion, socio-cultural practices and beliefs, education programmes and support structures (Dryfoos, 1990; Kulin, 1988; Ladjali, 1991; Russell, 1982; Voydanoff and Donelly, 1990).

Concern about adolescent pregnancy is growing as numbers of pregnant adolescents are increasing worldwide (Creatsas, Goumalatsos, Deligeoroglou, Karagitsou, Calpaktsoglou and Arefetz, 1991; Dryfoos, 1990; Jakobovits and Zubek, 1991; Lamb and Elster, 1990; Lancaster and Hamburg, 1986; Russell, 1982; Voydanoff and Donelly, 1990). One of the major physiological reasons contributing to teenage pregnancy rates is the fact that there has been a steady lowering in the age of menarche which is associated with a steady increase in height and weight in girls (Russell, 1982). Furthermore, the gap between age at biological maturity and marriage has widened. In addition, the media often present sexual activity as romantic and alluring without focus on responsibilty for the consequences of sexual activity (Dryfoos, 1990; Shaugnessy and Shakesby, 1992). Greater sexual freedom and acceptance of premarital sexuality have probably also increased since the 1960's (Voydanoff and Donelly, 1990) though this may be changing in the age of AIDS.

Factors which have a direct bearing on teenage pregnancy

The literature suggests that factors which have a direct bearing on adolescent pregnancy are: adolescent sexuality and risk of teenage pregnancy, access to contraception, and options following discovery of pregnancy and intervention. These factors will be discussed in turn.

Adolescent sexuality and risk-taking behaviour

Flisher, Roberts and Blignaut (1992), in their survey of 225 youth (15-24 years) attending Cape Peninsula Day Hospitals, express concern over the high risk sexual behaviour in which these adolescents engage. They report that:

> more than a quarter of the sample had had 2 or more sexual partners in the preceding year; about one tenth of the sample had not known their last sex partner for more than 7 days; and only 3,1% had used a condom on the last occasion that they had intercourse. (p. 106).

They furthermore report that 47.2% of the sample did not use any contraception at the time of intercourse. Apart from the other implications of high risk sexual behaviour, this suggests an increased risk of unplanned pregnancy.

Voydanoff and Donelly (1990) point out that adolescents who are likely to engage in early and high risk sexual activity are often poor, less educated, black and from unstable families. They are often socially isolated from peers, achieve poorly at school, have an adult role model who experienced pregnancy as a teenager and are often involved in other forms of risk taking behaviours (Winnett, King and Altman, 1989). There is often a lack of parental discipline within the family structure of these adolescents (White and De Blassie, 1992) or rigid parental discipline (Romig and Bakken, 1990). It therefore appears that typically, adolescents with the fewest resources are most likely to be sexually active.

Access to contraception

Teenagers less likely to use contraceptives are those who are younger, ambivalent about sexual activity and believe that birth control is unpleasant. Older adolescents and those who

show commitment and open communication in their relationships are more likely to use contraception (Voydanoff and Donelly, 1990). Various authors suggest that at least one third of all sexually active adolescents have unprotected intercourse and that those who do use contraception, tend to do this inconsistently (Dryfoos, 1990; Russell, 1982; Voydanoff and Donelly, 1990; Winnett, King and Altman, 1989). In industrialised societies this happens as a result of: infrequent intercourse; the fact that intercourse is unplanned; fear that parents would find out if they used contraception regularly; a conscience problem with contraceptives as there was no support from parents; ignorance about contraception; apathy to consider contraception; fears about contraceptive side-effects and problems in seeking help without confidentiality (Bury, 1986; Dryfoos, 1990; Russell, 1982; Voydanoff and Donelly, 1990). These attitudes to teenage contraception tend to be echoed in local South African communities (Norton and Da Fonseca, 1989; Preston-Whyte and Allen, 1992; Preston-Whyte and Zondi, 1992).

Additional sociocultural and political factors regarding the avoidance of contraceptive use is evident in African countries. High cultural and social value is placed on fertility, which makes pregnancy a valued state (Abdool Karim, Abdool Karim, Preston-Whyte and Sankar, 1992; Kulin, 1988; Preston-Whyte and Allen, 1992; Preston-Whyte and Zondi, 1992). In oppressive African regimes political reasons for non-use of contraceptives exist. These revolve around a claim for autonomy from state interference in family affairs, as in Algeria, and state imposition of contraceptive use, as in Namibia (Ladjali, 1991; Lindsay, 1991). Further political concerns arise around the widespread use of injectable progesterone such as Depo-Provera, which has attracted enough controversy for it to be temporarily banned in the United States of America, Britain and Zimbabwe (Kulin, 1988; Turshen, 1991). The banning was orchestrated by the World Health Organisation as there was evidence to support a link between longterm use of injectable progesterone and cervical cancer. Further side-effects commonly include

amenorrhea and delayed fertility (The Boston Women's Health Book Collective, 1984; Lindsay, 1991; Wilson, 1985).

Widespread enforcement of Depo-Provera use poses a particular political problem in Namibia, especially amongst teenagers. It is exclusively the black population which is targeted with Depo-Provera. It is also often administered to teenagers without their consent, postnatally. Teenagers are also not informed about any side-effects (Lindsay, 1991).

It therefore appears that contraception cannot be viewed as the only answer to fertility control, especially among adolescents, as there are widespread reasons for avoidance of contraceptive use. These reasons range from myths based on lack of knowledge to sociocultural and political factors.

Options following discovery of pregnancy

Various options exist for the teenager who discovers that she is pregnant. She can have an abortion, release the baby for adoption or choose parenthood. While adoption is a rare choice among adolescents, figures for abortion of adolescent pregnancies in the United States of America are approximately 40%, whereas approximately half of teenage conceptions result in parenthood (Vydanoff and Donelly, 1990). It is more difficult to establish rates of abortion in countries where it is illegal. However, parenthood as an option needs to be examined in more detail as it is becoming more common (Lamb and Elster, 1990).

The implications of adolescent parenthood

Medical implications

Toxaemia, anaemia, low birthweight and premature birth have been thought to be related to all teenage pregnancy. Greater risks are attached to mothers under 16 years of age and risk can be monitored by early clinic attendance. It is not inevitable that teenage pregnancy will result in negative medical outcomes (Gale, Seidman, Dollberg, Armon and Stevenson, 1989; Ncayiyana and Ter Haar, 1989; Russell, 1982; Slap and Schwartz, 1989; Voydanoff and Donnelly, 1990; Winnett, King and Altman, 1990).

Social implications of parenthood for adolescent parents and their children

Historically, child brides and adolescent pregnancy formed an integral part of many cultures (Russell, 1982). Kulin (1988) points out that in many developing countries, arranged marriages at young ages also gave rise to teenage parenthood. In these contexts, teenage parents were economically and psychologically supported by their extended families. They did therefore not experience the difficulties associated with teenage parenthood in industrialised societies. However, Kulin suggests that many developing countries are undergoing a process of urbanisation, with associated social changes such as the breakdown of traditional extended family structures. In this context, it appears that adolescent parents in developing countries are starting to experience similar problems to adolescent parents in industrialised societies.

Many teenage mothers do not choose marriage as an option following discovery of their pregnancy and therefore remain single parents. Adolescent parenthood is often associated with non-completion of schooling, working at low-paying jobs and receiving welfare benefits (Russell, 1982; Voydanoff and Donnelly, 1990).

It is well recorded that adolescent parents generally have little knowledge about parenting and that their offspring may not receive adequate parenting (De Cubas and Field, 1986; Lamb and Elster, 1990; Olds, 1986; Parks and Arndt, 1990 ; Report of the Committee of Inquiry into Child Mental Health Care Services for Children, 1988). The children of adolescent parents therefore tend to experience physical, educational and social problems and are more likely to become parents as adolescents. Voydanoff and Donelly (1990) suggest that this is related to the fact that adolescent parents are often of low socio-economic status, are single parents and live in large families. These are all recognised as risk factors for early sexual activity. However, outcomes for children are better when grandmothers, other family members or health professionals support adolescent parents (Lamb and Elster, 1990).

In summary, therefore, it appears that the focus of concern has shifted from adolescent pregnancy per se to adolescent parenthood as a result of far reaching individual and social implications for both the adolescent mother and her child.

Intervention

Intervention consists of two approaches: preventative and treatment oriented. These approaches should ideally be integrated to form a multi-disciplinary approach (Dryfoos, 1990; Voydanoff and Donnelly, 1990). Preventative interventions typically involve education programmes which teach non-pregnant adolescents about issues related to sexuality. Treatment interventions are concerned with providing support to those adolescents who are pregnant or who are mothers. Intervention programmes rarely have success in reducing teenage pregnancy. What they do achieve are improved contraception use among sexually active adolescents and delayed initiation of sexual intercourse (Dryfoos, 1990).

Preventative Approaches

School- based interventions

Dryfoos (1990) suggests that the inclusion of sexuality education in the curriculum improves knowledge, but that there is ultimately little change in behaviour. She suggests that sexuality education needs to be supported by school based clinics which run during school hours and include holistic health services such as emergency care, immunisation, contraceptive and psychological counselling. Only by contextualising sexuality education within a broader framework of healthcare, she argues, can teenage pregnancy be significantly reduced. Wallace and Vienonen (1989) also illustrate from their Swedish and Finnish experience that sex education in schools assists in preventing teenage pregnancy if community services and governmental policy work in conjunction with school programmes. In this context community services include free access to abortion and family planning clinics which offer free contraception and counselling.

Factors influencing the effectiveness of sexuality education

Oosthuizen (1990) suggests that methods of teaching sex education should be non-didactic and experiential and should take place at both home and school. It is also regarded as important in sexuality education that peer teaching be employed. In this context innovative methods such as drama, roleplay, songs, literature, videos and film shows have proved to be successful, once again within the context of state supported services (Dryfoos, 1990; Senanayake, 1992). Allen, Philliber and Hoggson (1990) regard it as even more important to have a volunteer component to preventative programmes as is illustrated in their evaluation of Teen Outreach, one of the only school-based, non-contraceptive-focused programmes to consistently demonstrate reductions in pregnancy. Lifeskills and goal planning in sexuality

education is furthermore thought to be important (Dryfoos, 1990; Ortiz, 1987; Voydanoff and Donnelly, 1990).

Treatment programmes

Programmes to assist teenage mothers aim largely to prevent a second pregnancy, to assist the mother with pre and postnatal care, infant care and, at times, job preparation and placement. They also aim to provide adolescents with means other than parenthood to achieve adulthood (Dryfoos, 1990; Voydanoff and Donnelly, 1990). A programme which attempts to do this is the Polly Mc Cabe Programme (Seitz, Apfel and Rosenbaum, 1991). In this American programme, women, on discovery of their adolescent pregnancy, are referred from their public schools to the above centre, continue their schooling, leave for the confinement and return to a public school after the birth of their babies. Girls have been encouraged to complete their education, secure jobs and avoid repeating pregnancies. Russell (1982) is sceptical of these kinds of programme as he argues that they are attractive and may present teenage pregnancy as an advantage.

It is thus evident that in all reasonably successful intervention programmes, the school forms the centre of intervention but needs to be supported by other community and governmental services and policy. It is important that intervention starts early within the school context (De Villiers, 1991; Van Coeverden de Groot and Greathead, 1987).

The present review of literature has highlighted the situations which lead to adolescents' early sexual activity. It has examined factors which encourage avoidance of contraception and considered various options following the discovery of pregnancy. Adolescent parenthood as an important consequence of pregnancy was examined in particular. Intervention was discussed in the context of preventative and treatment programmes.

CHAPTER 3

Practices in the Moravian church in relation to premarital pregnancy

Ninety percent of people in Mamre belong to the Moravian church, (Katzenellenbogen, Hoffman, Joubert, Pick, Yach and Klopper, 1988) and much of the social activity of the town centres around the church. (Mercia Arendse, personal communication, 1992). In the context of Mamre, the church, apart from the family, is ostensibly the most important ideological state apparatus and it would be useful to detail historically some church practices in relation to premarital pregnancy as they form part of the social context of teenage pregnancy in South Africa. Premarital pregnancy, historically, has been condemned from most religious perspectives and exclusion from the church has been common (Chidester, 1992). Chidester argues that despite strong social sanctions in the early twentieth century the church was never seen as an effective tool of sanction against pregnancy in South Africa. Instead, exclusion of mothers with consequent six month purification classes was seen as a ritual preceding baptism of children rather than a period of atonement for sins.

Community rituals known as "mocking songs" in traditional African societies at this time were more powerful sanctions against premarital pregnancy than the church. "Mocking songs" limited pregnancies and those that occurred were accommodated within the mother's household. Particular exclusionary practices were also adopted within the Moravian community.

Historically, reasons for exclusion in South Africa derived from European origin post colonisation. Cannibalism, heresy, witchcraft and illegitimacy exacted exclusion from the church. Chidester argues that the problem of illegitimacy in South Africa was in fact created

by the early Christian missionaries as no institution of marriage, western Christian religion and therefore no illegitimacy existed prior to the arrival of missionaries.

In Mamre, illegitimacy could therefore theoretically only have existed since 1808 when the first Moravian missionaries preached among the indigenous Khoikhoi (Balie, 1988; Kruger, 1966). Practices of exclusion in Mamre appear to have been enforced during the period after 1839 when there was an influx of liberated slaves into Mamre (De Boer and Temmers, 1987). The missionaries, who had strong European moral values, appeared perturbed by the seemingly informal cohabitation arrangements amongst Khoikhoi men and women. This may explain the occurence of group marriages, evident in Katzenellenbogen's data (1990), which occurred from 1840 onwards. Prior to this period no formal religious institution of marriage had existed for the slaves.

Exclusion as it exists within the Moravian church is a disciplinary action for transgression of church rules whereby the individual is temporarily excluded from participating in church activities as an ordinary member of the congregation, and is allowed only partial membership. The practice of exclusion is intended to help the transgressor and the rest of the congregation reflect on the sin committed as the transgressor is often publicly known within the church. After a period of atonement of sins, the transgressor is again allowed to assume full membership of the congregation. (Reverends Engel and Cunningham, personal communication, 1992).

It is not clear what the extent and nature of exclusion in relation to premarital pregnancy entailed historically within the Moravian church. However, it is known that Moravian people in Germany as early as the fifteenth century were subjected to strict disciplinary practices for transgression of church rules. Balie (1988) reports that people were subjected to "tug" or reprimanded according to certain procedures. They were firstly privately admonished by the

"leraar" (priest). If transgressions continued, they had to appear before the "ouderlinge" (churchwardens). The final procedure for continued transgression was appearance before the congregation with simultaneous publication of the transgression. Data from Katzenellenbogen's (1990) examination of church records dating from 1837-1909 in Mamre show that couples' exclusion from the church often occurred when marriage and birth of usually the first child took place within months of each other. This suggests that conception occurred outside of marriage and that this was followed by suspension from the church. (see appendix A).

Although the present study did not initially include an examination of exclusionary practices, it became quite apparent that these practices were part of the fabric of the premaritally pregnant woman's social context if she wished to continue in the church. It is also clear that exclusionary practices have changed over the decades, becoming seemingly less harsh in latter years. Informal communication with older members of the community suggest that approximately 20-30 years ago people were excluded in harsher ways. While they had to repent by attending church during their period of exclusion, they were separated from the rest of the congregation and had to occupy a prominent place in church commonly known as "die skandebank" (pew of shame). These women would be readmitted into church after a period of penitence and an almost obligatory marriage. On marriage, however, they had to conform to certain practices. They were not allowed to wear a white dress and veil, the red carpet would be rolled up in church so that they were denied the honour of walking on it and they had to get married in the conservatory and not in front of the altar. Furthermore, the church bell which heralds important events such as marriages and deaths in small Moravian communities, was not rung. The church would also allow the baby to be baptised only after all exclusionary practices and readmission had taken place. Most of the exclusionary practices by the church were directed to the woman.

Objectively, exclusionary practices seem less harsh than previously, although still alienating. Emphasis at present is largely placed on women with few sanctions applied to men. Women are expected to attend church every Sunday for a period of approximately three months, known as "bykom" (literally meaning being reaccepted into the church). For half an hour before each church service they have to meet with the clergy in prayer and when the church service begins, they enter the church with the clergy.

While these practices were once an integral part of Moravian life, it is not clear how much support exists for these practices at present as contradictory opinions exist between clergy steeped in tradition and those who are less traditional. Theologically some clergy question the validity of punishment for the one particular "sin" of illegitimacy while other reasons for exclusion have disintegrated over time. (Reverends Engel and Cunningham, personal communication, 1992).

CHAPTER 4

THE STUDY

The context of the study, the process of identifying teenage pregnancy as a feasible area of research and the relationship of the study to the MCHP, has been described in Chapter 1. Interviews for the current study took place between March 1992 and May 1992.

This section will examine methods employed in the study.

Respondents:

Respondents were drawn from three groups, totalling 33, and were constituted as follows:

1) All women between the ages of 14-19 who were pregnant. (2 women).
2) Half of women who had teenage pregnancies from September 1990 onwards; i.e. who now had babies under 18 months. (9 women).
3) Half of the women who had teenage pregnancies between January 1988 and December 1989; i.e. had toddlers who were 2-4 years old at the time of the study. (22 women).

Names of respondents were obtained from the local clinic, the MCHP's (Mamre Community Health Project) birth registration list and birth records from Wesfleur Hospital in Atlantis, the closest Day Hospital to Mamre. A random selection was made within groups 2 and 3 and a letter was sent to all respondents inviting them to participate in the study. (see appendix B). Both respondents in group 1 refused to be interviewed as did 6 respondents from group 3, leaving the final sample consisting of 9 group 2 and 16 group 3 respondents.

A summary of demographic data about the respective groups is presented below.

Table 1: Demographic Data

	GROUP 2		GROUP 3	
	n = 9		n = 16	
	MEAN	RANGE	MEAN	RANGE
AGE OF MOTHER (IN YEARS)	19.5	17-21	20.6	19-24
AGE OF MOTHER (AT BIRTH)	18.4	17-19	17.9	17-19
AGE OF BABY (IN MONTHS)	8.2	1-18	30	24-48
NO. OF PEOPLE IN HOME	6.4	2-14	8	4-12
OTHER FAMILIAL REMARITAL PREGNANCIES (PER RESPONDENT)	1.5	1-6	1	1-3
MARRIED / SINGLE	S:9		M:1, S:15	
EMPLOYMENT AT TIME OF PREGNANCY	unemployed: 5 scholars: 4 employed: 0		unemployed: 5 scholars: 5 employed: 6	
PRESENT EMPLOYMENT	unemployed: 9 employed: 0		unemployed: 11 employed : 5	

Methods:

The study included both formal and informal methods of research.

The study consisted of four parts:

a) A semi-structured interview schedule was designed, piloted on 3 respondents and adapted accordingly. (see appendix C). One of the respondents was employed to arrange times with other respondents as per agreement with the interviewer. Interviews were conducted in respondents' homes between March and June 1992. Each interview lasted approximately 45 minutes. Interviews were tape-recorded with accompanying notes and were afterwards transcribed. A content analysis of qualitative data which took the form of grouping of general themes was employed (Helman, 1991; Marshall and Rossman, 1989; Tesch, 1990). Each respondent was sent a letter highlighting the main findings of the study. (see appendix D).

b) It became apparent during the course of the interviews with mothers that they were affected by exclusionary practices within the Moravian church. As a question about exclusionary practices was not directly posed to mothers, data which is not uniform to all interviews is presented. In addition to data collected from some respondents, one of the community health workers in the MCHP who herself had been subjected to exclusionary practices also volunteered to share her experiences. These results are important to include as they reveal some present experience in relation to exclusionary practices within the church.

c) An analysis was done of 15 church records, which was raw data obtained from a previous study in Mamre (Katzenellenbogen 1990). Records which indicated expulsion from the church due to premarital pregnancy were drawn and analysed into

categories. (see appendix A). Results have been presented in Chapter 3. Records were not selected at random as not all people were expelled from the church for premarital pregnancy. Furthermore the present study also used the above data only to show that exclusion from the church existed historically.

d) During the course of the study, some mothers expressed the intent to marry the fathers of their babies at a later stage. It was decided to empirically determine to what extent this practice existed. This was done by analysing a sample of the Mamre Birth and Registration Lists in conjunction with Mercia Arendse (the MCHP coordinator) who knew all the women on the list. A specific year (1987) was chosen. All the mothers' names on the list were scanned and Mercia Arendse identified their marital status at the time of the births. She then identified all the women who had married and whether they had married the babies' fathers or not (see appendix F for summary of data from 1987 Mamre Birth and Registration List). At the same time, the Mamre Birth and Registration Lists were used to calculate a representative teenage pregnancy rate. This was done by dividing the total number of teenage pregnancies by the total number of pregnancies for each year. The sum of all teenage pregnancies from 1986-1992 was added and divided by the sum of all pregnancies during those same years. (see appendix G).

CHAPTER 5

ANALYSIS AND RESULTS

(see appendix E for summary)

ANALYSIS

Categorisation of responses

The questionnaire was divided into specific categories. (see appendix C). Therefore, on collection, the data was already subdivided into broad categories. Data therefore had to be categorised within each broad category of the questionnaire. This was done by identifying all possible responses to a specific question. Following this, the frequency of respondents giving a specific response, was added for each category and converted into percentages. For example, under "reactions to pregnancy", 3 categories were identified. They were: 1) embarrassment, shock and disappointment, 2) scared to tell parents and 3) happiness. Each response from each respondent could be categorised within one of the three categories. In other words, the categories were mutually exclusive and collectively exhaustive. The frequency for the number of respondents giving a specific answer, was added and converted to percentages.

RESULTS

Reactions to pregnancy

Half of the teenagers initially reacted to the pregnancy with embarrassment, shock and disappointment (52%). Roughly half were scared to tell parents (44%), with one woman expressing happiness at the pregnancy. They were scared chiefly because they feared parents'

ostracising them from the home or family activities. However, their expected responses from parents were not entirely reality based. Parents tended to scold but accept the pregnancy (48%), accept the pregnancy without expressing disappointment (20%) or were not happy, but accepted the situation without scolding (24%):

> Ek was bang dat my ma my sou uitskel, maar my suster het vir my ma gesê. Sy het my dokter toe geneem en uitgevind ek was pregnant. My ma was baie afgehaal gewees.

> Ek was baie senuweeagtig. Ek wou nie vir my ma sê nie. Ek het vir my suster gesê en sy het vir my ouers gesê. My ma het geskel en gesê dis my eie skuld, want sy het gesê ek moet op die inspuiting gaan.

Only one woman reported rejection from her mother, without communication during the pregnancy. The broader community did not generally ostracise the pregnant teenager (52%), while some gossipped (16%) and offered support (4%). At times women did not know what the community's reaction was (28%). In those instances where mothers were initially ostracised by either the community or parents, they reacted by feeling either very hurt (36%) or slightly hurt even though a negative reaction was anticipated (40%). Some mothers reported their reactions as being reasonably happy (40%).

OPTIONS FOLLOWING DISCOVERY OF PREGNANCY

Adoption or Abortion

All mothers in the sample did not consider abortion or adoption as an option. Most mothers reported wanting a child (40%), while others were indignant at the suggestion of abortion as they thought of it as sinful and punishable by God (32%). Some mothers said that it had not

occurred to them at all (20%) or that they loved their boyfriend and could not give away their child (8%):

> Nee, want my familie sal dit nooit aanvaar het nie, want hulle sê dat die Here weet van beter, hoekom ek moet swanger gewees het en dat Hy vir my sal straf as ek die kind moet wegmaak.

> Nee , ek was baie bly vir die kind, want ek het self verlang na 'n baba partykeer.

Marriage

Only one woman got married following the discovery of her pregnancy as they did not want an illegitimate baby. Most of the other women felt that they were too young to get married (72%). Other reasons given for not considering marriage were that they did not want to force marriage, that they did not want a relationship, that the boyfriend was unemployed or smoked dagga and that they did not think of getting married:

> Hy wou trou as hy kollege klaarmaak, maar ek wou nie. Ek het gesê ek is nog te jonk en te lief vir my uitgaan. Ek sal op 'n latere stadium met hom trou aangesien hy die baba se pa is.

The intent to marry the baby's father at a later stage, as expressed in the above quotation, appears to be a commonly expressed attitude. On a follow-up examination of mothers who had given birth during 1987, 35% of mothers married the father of their child within six years after the pregnancy. (see appendix F). Five percent of mothers married men who were not the fathers of their children.

REACTIONS TO BIRTH AND EARLY PERIOD

Most mothers reacted happily to the birth (64%), while others were just happy that the birth

process was over (20%). Others were upset because the baby was of the unpreferred gender (8%), while others could not remember their reactions (8%):

> Oe! ek was baie bly gewees dat ek 'n babatjie gehad het en dat hy gesond is, maar ek was net 'n bietjie upset ek het hom sommer nie gekry nie, want hy was te koud.

All mothers found it very difficult to cope during the first few weeks as they needed help with practical tasks such as bathing and feeding the baby and breastfeeding. They received help in these areas mostly from family members and reported adapting to their babies within the first and second months.

SUPPORT FOR MOTHER AND CHILD

All mothers reported having friends and family to assist. Most commonly, though, the women's parents and her boyfriend and his family would assist. To a lesser degree mothers reported friends, aunts, sisters and grandmothers supporting them. Support took the form of helping the mother to get to the doctor, helping to buy clothes for the baby, helping with tasks surrounding the baby and visiting regularly.

Boyfriends and their family members were deemed to be the primary source of support (64%), with others reporting parents to be their primary support (20%). Some mothers supported their children (12%) while sisters, brothers and aunts were the primary support for the rest of the sample. Most of the boyfriends paid maintenance (80%) and were still involved with the mother and baby:

> My outjie betaal die meeste support van die geboorte af tot nou toe.

For those women whose boyfriends did not pay maintenance, the following reasons were given for non-support: that he did not want to work and that she already tried reporting him, that he was a student and had no income, that he hit the mother and was forbidden to visit by her mother, that he did not arrive at the court for a claim and that she did not bother further, and that he was retrenched.

CARE FOR CHILDREN

All mothers reported care which consisted of supervision, feeding and dressing to be satisfactory. Most mothers themselves took care of their children during the day (80%), while the rest were taken care of by a family member (16%) or a creche (4%).

LENGTH OF RELATIONSHIP

Most mothers had had established relationships with boyfriends at the time of falling pregnant. The mean length of relationship was 3.04 years, ranging from 1 - 8 years. Intercourse was usually unplanned (92%) and irregular (84%).

CONSEQUENCES

At the time of their pregnancy, most mothers were employed (40%). The unemployed totalled 24% and 36% were scholars. Most scholars were doing their 3 final years of schooling, while the employed were doing semi-skilled factory work. Many women felt that the pregnancy did not affect at all what they were doing (44%). Even those in this group who were scholars, felt that they were going to leave school anyway. The rest of the sample felt that the pregnancy affected what they were doing as they had to leave school (36%), had to be absent from work often (8%), and did not have the freedom they formerly had (24%).

Many women (84%) found it difficult to cope with the changes and do not really know how they managed except that they tried to make a success of it with the help of their families. The rest were either embarrassed or upset but felt that they had to accept the situation.

> Ek was in st. 9. Ek wou graag verpleging gaan doen en was baie spyt toe ek maar by die huis moet bly om te help kyk na die baba. Ek weet nie hoe ek dit gehanteer het nie, maar my familie en my kêrel se familie het my baie gehelp.

The five mothers who started working after their pregnancy, did so when their babies had reached a mean age of 9.2 months, and ranging from 3-7 months. Most mothers (72%) felt that teenage pregnancy was a disadvantage as they: still wanted to have their freedom and go to dances (28%), had to leave school even though they wanted to complete matric (28%), thought that it was not good to have babies early (8%), had wanted to reach the age of 21 "unblemished" (4%), and regretted that they became fat (4%). Of those mothers who thought that teenage pregnancy was advantageous, 12% thought that it proved fertility, one woman thought that she had benefitted by getting married, another looked forward to having the baby and the other did not know:

> Dis definitief 'n nadeel, want ek het my skooljare verloor.

> Vir my voel dit soos 'n voordeel want ek is nou getroud. Ek weet wat dit is om ma en huisvrou te wees. Ek het my huis, my kind en my man en dan weet ek hy kry nou sy kos gereeld.

Exclusionary practices within the church

Exclusionary practices within the church are an important consequence of premarital pregancy for Moravian women in Mamre. Results gathered informally suggest that while most women at present still experience exclusionary practices as alienating and humiliating, they seem to

accept them as part of the social consequences of premarital pregnancy in a Moravian community. One mother who got married on discovery of her pregnancy chose to leave the Moravian church to avoid experiencing exclusionary practices. She became a member of and was married in the Dutch Reformed Church. All other mothers in the study who mentioned exclusionary practices, chose to abide by the church rules and remain in the Moravian church.

KNOWLEDGE ABOUT SEXUALITY

The majority of women interviewed reported having received sexual information (80%). They heard mostly from guidance teachers (92%) or nurses visiting schools and also books. They were generally told about how the male and female body works, how babies are conceived, sometimes about birth control, how to say no, AIDS and relationships:

> Ja, hulle het gepraat oor seks, hoe ontstaan 'n kind. Hulle het vir ons films gewys. Ek was in st. 5.

> Ons het seksvoorligting gekry by die skool. Hulle het gepraat oor seks, hoe jou liggaam verander en oor voorbehoedmiddels.

Most mothers reported that they would not have prevented the pregnancy if they could have (80%) as they did not want to become infertile (44%), they wanted the baby (32%) and one was getting married as a result (4 %):

> Nee, ek wou nooit die goed (birth control) gebruik het sommer nie, want die mense het altyd gesê dat as jy op die goed gaan voor jy 'n baby het, gaan jy swaar 'n baby kry of dan kan jy nie babies kry nie.

Even the mothers who reported that they would have liked to prevent it, suggested that they would not like to use birth control for fear of infertility (16%):

> Ja, want ek wou nie nou al 'n kind gehad het nie, maar ek sal nie voorbehoedmiddels wou gehad het nie, want dan kan jy nie jou eerste kind kry nie.

Only one mother reported not using birth control as she was concerned that people would think that she was a "bad girl".

ACCESS TO CONTRACEPTION

Seventy two percent of mothers reported having no difficulties in gaining access to contraception. Even though they did not use it, they knew of its availability at the local clinic. The remaining women reported that they did not know of its availability or were not interested (20%). Others thought that they had to have parents' permission and some felt uncomfortable about fetching it from the clinic. Nevertheless 92% of women were using contraceptives at the time of the study with 80% using Depo Provera and 12% Triphasil. Of the other two women who were not using contraceptives, one still feared infertility and the other had stopped, after suffering side effects from Depo Provera. Most women (96%) reported discussing contraception either with nurses (76%) or with family and friends (20%). One woman reported not discussing it as she was not using it.

GENERAL

No women reported having any other support outside the family as they felt that it was not necessary. Most mothers (84%) felt that the physical pain during childbirth was the most

difficult to cope with, whereas others could not identify difficulties and one woman cited her mother's rejecting attitude as the most difficult:

> Alles kan gegaan het, maar die pyne wat jy moet verduur. Ek het gehuil by die kraam-saal.
>
> Die pyne was baie seer. Ek moes die hele tyd net my maag vryf en so 'n bietjie rondloop.

It appeared most difficult for women to identify what was the easiest during the pregnancy. Women generally felt that nothing could be done to assist with their difficulties (52%), whereas some women felt that preparation for childbirth might have helped (20%). Others did not know what could have helped and one woman suggested that birth control might have helped.

CHAPTER 6

DISCUSSION AND CONCLUSION

Refusal rate

Before discussing the present findings, it is important to discuss the considerable refusal rate among subjects who participated in the study. The first group consisting of two pregnant adolescents, as well as 6 out of 22 respondents in group 3, refused to participate. All respondents in group 2 participated in the study.

It was possible to ascertain reasons for non-participation in some cases, but this information could not be collected systematically because not all the refusers were willing to discuss their reasons. Some of the reasons for refusal revolved around the fact that they felt that they had made mistakes, and that their problems did not concern anyone. Further sentiments included the fact that they felt judged and isolated, as individuals, in a community where there were many other teenage pregnancies. These attitudes were especially evident amongst the teenagers who had recently discovered their pregnancies. Possible explanations for this phenomenon are suggested. In a community where premarital sexual activity is overtly condemned, adolescent mothers may feel judged and attempt to deny the pregnancy by an avoidance of any discussion which revolves around their pregnancy. They may also be experiencing initial shock and embarrassment at their discovery of the pregnancy while, at the same time, having to integrate their new status as potential mothers. These factors may encourage them to avoid discussion of the pregnancy.

It is suggested that most, but not all, adolescent mothers become more comfortable with their status at a later stage as more mothers from groups 2 and 3 were willing to discuss their

experiences of adolescent pregnancy. Those mothers in group 3 who refused to participate, did so for reasons similar to the first group, but also as a result of lack of interest in the study.

In this context, where a reasonable refusal rate exists, results may be skewed. Women who agreed to participate may already have integrated their status as adolescent mothers. In addition, they may hold attitudes and have had experiences more favourable with respect to teenage pregnancy than those subjects to whom the study had no access. It can therefore be argued that the study is not representative of those adolescent mothers who had not yet integrated their status as adolescent mothers or mothers who had very bad experiences surrounding their pregnancies.

Contextualising present findings

The present study supports previous findings in the field.

Preston-Whyte and Allen (1992) and Preston-Whyte and Zondi (1992) had similar findings to the extent that teenage mothers reacted to the pregnancy with shock. They always feared parents' reactions even though many mothers or family members themselves had had teenage pregnancies. Teenage mothers furthermore commonly appeared to express indignation at abortion and adoption. This was especially considered a grave sin in Mamre. One instance of adoption which the researcher identified, was hidden from the community. This is not an easy task to accomplish in such a small community.

Most respondents reported no difficulties in gaining access to contraception. Yet contraception use was poor prior to the first pregnancy. A small number of mothers reported misinformation about contraception and felt uncomfortable about fetching it from the clinic. These findings in relation to avoidance of contraception are consistent with the literature

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(Bury, 1986; Dryfoos, 1990; Russell, 1982; Voydanoff and Donnelly, 1990). However, in contrast to studies emanating from industrialised countries where reasons for avoidance of contraceptives are infrequency of intercourse and fear of parents, a basic strong cultural value underlying fertility underpins avoidance of contraceptives in many South African contexts. In the present study women avoided the use of contraceptives before a first birth as they generally believed that this could cause infertility. This finding is consistent with other studies in South Africa and other studies in developing countries, especially Africa (Kulin, 1988; Norton and Da Fonseca, 1989; Preston-Whyte and Allen, 1992; Preston-Whyte and Zondi, 1992). While this could probably be due to the fact that myths around contraception do realistically exist, it can be argued that these myths have been built up around partial truths. As most women in the study used Depo Provera, people could have generalised their experiences, and their attitudes, with this contraceptive to contraception in general. Depo Provera eradicates menstruation, a possible sign of fertility. It is also furthermore true that women who have used Depo Provera do take a longer time to fall pregnant than women on other contraceptives, giving the impression that women are infertile (The Boston Women's Health Book Collective, 1984; Lindsay, 1991; Wilson, 1985).

Furthermore, political reasons may also exist for the refusal of contraception. Enforced Depo Provera without premaritally pregnant mothers' consent, appears to be administered postnatally, at the Wesfleur Hospital in Atlantis. (Personal communication with nursing sister at Wesfleur Hospital and with some respondents in the study, 1992). It is not clear what the extent of this practice is, but it is consistent with practices at some hospitals in Namibia (Lindsay, 1991).

In an attempt to understand the various attitudes towards premarital pregnancy in this study, it is important to view it in context.

The social context of teenage pregnancy in Mamre

As mentioned earlier, the church and the family are probably the most important ideological state apparatuses in Mamre and which essentially define the social context for premarital pregnancy. Yet it appears that premarital pregnancy continues despite sanctions from the church as detailed in chapter 3. It can be argued that the church is in the process of surrendering its policing role in relation to premarital pregnancy as the harshness of exclusionary practices have become slightly diluted over a number of decades. The proposition that this role is being surrendered is furthermore based on the fact that splits exist within the church between more traditional and less traditional priests as to the importance of exclusionary practices. (Reverends Engel and Cunningham, personal communication, 1992).

The question arises as to what determines women's social attitudes in relation to premarital or particularly teenage pregnancy. It is argued, based on this study, that the answer to the above question is twofold. Firstly, it can be seen as the family and the shaping of a particular consciousness within the immediate and extended family system that creates subjectively, an unconscious but determining covert attitude to teenage pregnancy, per se. The attitude which is unconsciously created in this context is one of acceptance towards premarital pregnancy. Objectively, however, the attitude espoused by the family is condemnatory of premarital pregnancy, but overwhelmingly accepting of the baby. Thus tension exists between the objective acceptance of the baby and the overt condemnation of premarital pregnancy. The impression is that these tensions may be conflated for both teenagers and parents. This could result in the covert assumption for people in the community that premarital pregnancy is acceptable.

In addition, tension exists on another level; that of behaviour and covert attitude in relation to sexual attitudes and practice. While the behaviour and covert attitude is one of acceptance

towards teenage pregnancy and the baby, as explained above, the overt attitude condemns it on a moral basis, leaving a discrepancy between sexual attitudes and practice. Many women indirectly expressed that sexuality should be reserved for marriage. This discrepancy appears to be consistent with other local studies (Preston-Whyte & Allen, 1992; Preston-Whyte and Zondi, 1992).

In summary, it is therefore proposed that two levels of tension or discrepancy appear to exist in relation to premarital sexuality and its consequences:

1) tension between the acceptance of the baby and the condemnation of premarital pregnancy and
2) tension between expressed sexual attitudes and actual behaviour.

While this discrepancy exists, clearly reasons should simultaneously exist for the unwitting acceptance of teenage pregnancy and the more overt acceptance of the baby. It is suggested that families live with these contradictions and incorporate them into their lives. This is evident when examining the experiences which mothers have during and after childbirth and the practices which exist during this period.

Firstly, all the mothers in the study, could on average, identify at least one other member of their immediate or extended family who had conceived during their teenage years or premaritally. Voydanoff and Donnelly (1990) suggest that this often provides a positive role model of premarital pregnancy for young girls, especially when their life options are reduced. Secondly, apart from initial discontent in some parents, all of them provided extensive support, either financially or emotionally, to their pregnant children. It is well recorded in the literature that family support is of crucial importance to how well mothers adjust after the birth of the baby (Furstenberg and Crawford 1978, in Seitz, Apfel and Rosenbaum, 1991). Thirdly, most of the fathers of the children continued to have some relationship with the mothers and a large percentage of them saw the children on a daily basis. Most of them also

paid regular maintenance as from the child's birth, if they were working. Often where the fathers of the children were not working, their families would contribute to the child's maintenance as best they could. It appears in this context that in most cases a remarkable coherence exists between families of the teenage parents involved. It is suggested that this is due to fairly long relationships between couples, (3.04 years on average), where there is enough time for them to be socially constituted and accepted as a couple. In addition, the stability of families in Mamre could also contribute to the coherence of families and the support given. These factors, it can be argued constitute the cornerstones of continued acceptance and perpetuation, albeit at an unconscious attitudinal level, of premarital pregnancy.

Furthermore, in the context of Hamburg's (1986) model, there is the impression that some teenage mothers appear to opt for alternate life courses. In Mamre they bear children, find employment and in some cases marry the fathers of their children. This appears evident from the fact that 35% of mothers who had premarital pregnancies in 1987, married the fathers afterwards and 5% married men who were not the fathers of their children. However, while it may be seen that mothers are coping reasonably competently and that this is their productive time off work in the context of unemployment, it is true that many of them experience teenage pregnancy as a disadvantage. Based on this study, it is suggested that competent coping exists in the context of extensive family support. It is therefore proposed that the mothers of teenage mothers may bear the brunt of the consequences of teenage pregnancy while their daughters are not married and still in the home.

Implications for intervention

Most mothers reported little need for intervention as they had support from their families. This however conflicted with other reports, for example where sexuality education was deemed to

be inadequate. It appears that respondents could have felt that they have enough support with practical tasks around the baby and therefore felt that they needed no further intervention. It is possible that some of these women did not consider preventative approaches and other forms of support. Other respondents in the study did, however, consider this. Some felt that preparation for childbirth and knowledge about contraception might have helped. Others did not know what may have helped.

Any programme attempting intervention with teenage pregnancy in Mamre, should take into consideration, that:

1) while knowledge of sexuality is available, it may be inappropriately taught. Many respondents reported having had some sexuality education at school. They pointed out that teaching consisted of films or talks with little or no follow-up discussion. Oosthuizen (1990) and Senanayake (1990) suggest that these didactic, non-participatory methods do not encourage retention of information.
2) there are many individual and socio-cultural myths about contraception
3) mothers of teenagers mothers are centrally involved in care

A useful community based approach involving the "community health activists" could possibly be developed in preventative education. This could involve community health workers training peer groups in general sexuality education and life skills (Dryfoos, 1990; Ortiz, 1987; Senanayake, 1990). The trained peers could then form zonal groups and establish "teenage clubs" which focus not only on sexuality education but also have other activities which are of interest to teenagers. The important difference between this approach and established ones is the fact that teaching methods will be less didactic, encouraging participation. They will also be receiving information from their peers with whom they share experiences. Various authors emphasise the importance of peer groups and experiential learning for effective sexuality education (Oosthuizen, 1990; Senanayake, 1990).

However, intervention needs to be taken further and include support for teenage mothers. Mothers themselves felt that nothing could have been done to help difficult experiences which they described as being largely physical pain during childbirth. As suggested in the results, mothers may have found the birth process easier and less fear-inducing if they were well prepared for birth and had education around the birth process. This could also be a task to be taken up by community health workers. They could be trained to run groups with teenage mothers which could include educational input but also sharing of mothers' feelings in relation to birth and general difficulties.

Another axis of support for mothers is an indirect one. Based on the support which teenage mothers are already receiving during the period shortly after the babies' birth it seems that no external intervention is needed in this regard. It is suggested that the mothers of teenage mothers could possibly benefit from some emotional support.

Teenage mothers' formal education is often terminated when they discover the pregnancy. For those who wish to continue their education, inbuilt state support systems based on programmes such as the Polly Mcabe programme, should ideally be considered (Seitz, Apfel and Rosenbaum, 1991). If this kind of programme were applied in the Mamre area, it would probably consist of a school for adolescent mothers which would serve the region. A school of this nature would most likely be placed in Atlantis, a more industrialised town on the West-Coast, approximately 7 kilometres from Mamre. Mothers from Mamre would commute to Atlantis to attend the programme when their pregnancy is discovered. The most important benefits from a programme of this nature, do not only relate to the the fact that mothers can continue their education. The nature of their education would also be different. The curriculum would include both ordinary subjects and discussion of health issues during pregnancy, preparation for pregnancy, ante-natal care and support systems. In this system, a

school based clinic staffed by a doctor, nurse, social worker and counsellors could attend to adolescent mothers' medical, psychological and social needs. After the confinement, the mother would then return to her previous school. Taking into account that mothers have a good support system in Mamre, this could be a useful intervention for mothers to continue education. This is clearly an approach which could materialise only, provided enough advocacy is constituted to influence government policy for more lenient attitudes towards continued education for adolescent mothers. Limited financial resources could also be a major deterrent to the implementation of such a project.

A cheaper, extramural community, rather than school based option which would draw on the above ideas, could more realistically be implemented in Mamre. In this context, the multi-disciplinary team working in the MCHP includes a psychologist, social worker and occupational therapist. These professionals could liaise with other health workers (for example, nurses, doctors and community health workers) in the community in setting up support structures for adolescent mothers who want to continue their education. The intervention would be similar to that employed in the Polly Mc Cabe programme but it would be based extramurally, rather than at a school. This could take place while young mothers are allowed to continue their education. Here, the most important component is the support of a multi-disciplinary team which Wallace and Vienonen (1989) and Voydanoff and Donnelly (1990) argue, are essential components of a successful programme.

This discussion has examined some of the reasons for the discrepancy between attitude and practice in relation to premarital pregnancy within the social context of Mamre. Some forms of intervention were also suggested based on teenage mothers' and their families' experiences.

Possible shortcomings of and suggestions for further research

The refusal rate was identified as possibly the most important shortcoming of the study. The

representativeness of the study furthermore possibly only extends to mothers who live in a similar social and economic environment as Mamre. It may therefore not be replicable in other contexts.

The study further neglected to explore the fathers' experience of the consequences of teenage pregnancy. As fathers remain involved, in general, their views are important. It would therefore be important to examine fathers' perceptions of early pregnancy and examine their roles in childrearing where the relationships do continue.

The mothers of teenage mothers became an area for concern during the course of this study as they, it is suggested, are probably the most unsupported group within the social context of adolescent pregnancy. Research could usefully explore the nature of their experiences which could assist intervention, if appropriate.

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APPENDIX A

RAW DATA FROM MAMRE CHURCH RECORDS PROJECT INDICATING SUSPENSIONS AFTER PREMARITAL PREGNANCY AND READMISSIONS AFTER CONSEQUENT MARRIAGES

COUPLE	SUSPENDED	MARRIED	BIRTH
David & Betje	28/04/1862	04/05/1862	1862
Petrus & Justina	03/10/1884	15/10/1884	1885
Friedrich & Betje	30/06/1854	16/07/1854	1854
Joel & Juliana	10/04/1876	03/07/1876	1877
Rudolphine & Apollo	1866	26/02/1866	1866
Magrietha & Carl	16/02/1864	26/06/1864	1864
Leonhard & Henrietta	13/06/1852	13/06/1852	1852
Deborah & Carl	19/03/1856	13/04/1856	1857
Amalia & Friedrich	20/12/1872	24/01/1873	1869
Helena & Ephraim	08/05/1858	06/06/1858	1859
Benjamin & Agnes	07/11/1852	22/02/1852	1852
Jakob & Rebecca	08/02/1855	18/02/1855	1856
Cornelia & David	15/10/1862	16/06/1862	1862
Judith & Hendrik	01/10/1868	26/10/1868	1869
Helena & Christian	31/01/1855	18/02/1855	1854

APPENDIX B

LETTER INVITING WOMEN TO PARTICIPATE IN THE STUDY

Liewe .....

Ek wil graag 'n opname maak van tienerswangerskappe in Mamre oor die laaste 6 jaar. Met u toestemming sal ek graag 'n onderhoud met u wil voer om vas te stel watter moeilikhede en voordele u uit u ervaring van tienerswangerskap met my kan deel. Dit sal ook baie help as u kan verduidelik watter soort ondersteuning u moeilikhede sou kon gehelp het.

Ek wil graag die uitslae van die opname aan u bekend maak en dit ook gebruik om ander jong tienermeisies wat miskien swanger word, te help om hul situasie en vrese beter te hanteer.

Ek sien uit daarna dat u my sal kontak aangesien u bydrae belangrik is vir die sukses van die opname. Ek kan gekontak word by:

24 Johannesstraat
Mamre
Tel: 61020

Ek is Maandae, Woensdae en Donderdae tussen 9 en 4 uur daar beskikbaar. U kan op ander dae ook vir Mercia Arendse by dieselfde nommer kontak of vir Desiree Links by 61703. U kan dan u naam en nommer met hul los sodat ek u weer kan kontak vir 'n afspraak.

Groete
Ronelle Carolissen

APPENDIX C INTERVIEW SCHEDULE

IDENTIFYING DATA

NAME:

AGE:

AGE(S) OF CHILD(REN):

MARITAL STATUS:

OCCUPATION AT PRESENT:

OCCUPATION AT TIME OF PREGNANCY:

NUMBER OF PEOPLE LIVING IN THE HOME:

OTHER PREMARITAL PREGNANCIES IN THE FAMILY:

QUESTIONS

REACTIONS TO PREGNANCY

What were the reactions to your pregnancy by:
a) yourself
b) parents
c) community

How did the reactions of your parents and the community make you feel?

Did you consider other options like adoption as opposed to keeping the baby? Why/Why not?

Why did you decide to/not to get married on discovering your pregnancy?

REACTIONS TO BIRTH AND EARLY PERIOD

What were your reactions to the birth of your baby?

Did you find it easy to cope with the baby during the first few weeks? What do you think helped / didn't help?

SUPPORT FOR MOTHER AND CHILD

Did you have family / friends to assist you at the time of your pregnancy?

Who is the child's primary support?

For how long did you have a relationship with your child's father when you fell pregnant?

Does the child's father contribute to maintenance ? If not, why?

Who takes care of your children while you are you are at work?

What does care involve? Is it satisfactory? If not, what would be better?

CONSEQUENCES

What did you do for a living before your pregnancy?

How did your pregnancy affect what you were doing at the time? How did you feel about that?

How did you cope with the changes?

If employed, how long after your first pregnancy did you start working?

Do you think you have gained/lost by having your first baby during your teenage years? Explain.

KNOWLEDGE ABOUT SEXUALITY

Were you given any information about sexuality before your pregnancy? If yes:

a) from whom did you get the information?

b) What kind of information did you get? / What were you told?

Would you have wanted to prevent the pregnancy if you could have?

ACCESS TO CONTRACEPTION

Did you at the time of your pregnancy / birth:

a) have difficulties in gaining access to contraception in Mamre?

b) What were the difficulties?

Have they changed for you? If not, how do you think the difficulties can be overcome?

Do you currently use contraception? If so, what kinds do you use?

Do you ever discuss contraception with anyone? If not why?

GENERAL

At the time of your pregnancy:

a) Did you have any other supports?

b) What was the most difficult for you during this time?

c) What was the easiest to cope with?

d) What do you think would have helped you with things that were difficult for you?

APPENDIX D

LETTER SENT TO RESEARCH PARTICIPANTS AFTER STUDY

Liewe .....

Baie dankie vir jou deelname aan die opname oor tienerswangerskappe van verlede jaar. Dit was inderdaad gewaardeer. Hieronder volg die belangrikste uitslae van die opname.

Die meeste moeders het gesê dat hulle geskok en teleurgesteld was oor die swangerskap en dat hulle bang was om vir hul ouers te sê. Die meeste ouers het geskel toe hulle hoor, maar het die swangerskap aanvaar.

Moeders het almal die babatjies gehou en het nie hul kinders afgegee vir aanneming nie, want hulle het gevoel dis sonde of hulle wou die babatjie gehou het. Net een mammie in die opname het getrou, terwyl al die ander mammies gedink het dat hul te jonk is om te trou.

Die meeste moeders was baie bly oor die geboorte van hul baba. Alhoewel hulle dit nie in die eerste weke maklik gevind het om met hul babatjies oor die weg te kom nie, is hul baie gehelp deur hul familie. Die meeste mammies het gesê dat hul outjies, ouers of vriende vir hul bygestaan het en ook met geld gehelp het vir die baba.

Baie moeders het gevoel dat die swangerskap nie geaffekteer het wat hul gedoen het voor die swangerskap nie, terwyl ander gevoel het dat dit hul lewe verander het omdat hulle die skool moes verlaat. Baie mammies het eintlik gevoel dat hulle nie weet hoe hulle die veranderinge gehanteer het nie. Hulle het dit aanvaar en was gehelp deur hul familie.

APPENDIX E

SUMMARY OF RAW DATA

Summary of demographic data

NOTE: Group 3 data bracketed in italics.

	GROUP 2 *(GROUP 3)*	MEAN	RANGE
Age of mother (in years)	17,20,20,20,21,20,19,20,19, *(20,20,22,24,20,20,20,21,21,23,19,21,19,20,19,21)*	19.5 *(20.6)*	17-21 *(19-24)*
Age of mother (at birth)	17,19,19,19,19,18,18,19,18 *(18,18,18,19,18,18,17,17,19,19,17,19,17,17,17,19)*	18.4 *17.9*	(17-19) *(17-19)*
Age of baby (in months)	1,4,15,1,18,17,10,4,4 *(24,24,48,48,24,24,36,48,24,36,24,24,24,36,24,36)*	8.2 *(30)*	1-18 *(24-48)*
no. of people in home	2,7,5,14,6,6,3,10,5 *(9,10,7,8,12,7,9,4,9,5,12,4,8,9,8,8)*	6.4 *(8)*	2-14 *(4-12)*
other premarital pregnancies in family	1,6,1,0,2,1,1,1,1 *(0,2,2,0,0,0,0,1,3,0,0,1,2,1,2,2)*	1.5 *(1)*	1-6 *(0-3)*
married / single	s,s,s,s,s,s,s,s,s *(s,s,s,s,s,s,s,s,s,m,s,s,s,s,s,s)*	s: 9 ; *(s: 15; m: 1)*	

present employment	u,u,u,u,u,u,u,u,u *(e,u,u,u,u,u,u,u,e,e,e,u,u,e,u,u)*	unemployed: 9 *(unemployed: 11* *employed: 5)*
employment at time of pregnancy	s,s,u,s,u,u,u,s,u *(s,s,u,e,e,e,u,s,u,e,s,e,s,u,u,e)*	unemployed: 5 scholars: 4 employed: 0 *(unemployed: 5)* *(scholars: 5)* *(employed: 6)*

SUMMARY OF RESPONSES TO QUESTIONS

REACTIONS TO PREGNANCY

Yourself		
Embarassed / Shocked / Disappointed at pregnancy	13	(52%)
Scared to tell parents	11	(44%)
Happy	1	(4%)
Parents		
Scolded but accepted	12	(48%)
Accepted without expressing disappointment	5	(20%)
Not happy, but accepted without scolding	6	(24%)
Rejection, with no communication during	2	(8%)
pregnancy		
Community		
Nothing	13	(52%)
Gossip	4	(16%)
Support	1	(4%)
Don't know	7	(28%)
Feelings to reactions		
Very hurt	9	(36%)
Reasonably happy	6	(24%)
Although expected, slightly hurt	10	(40%)

OPTIONS

No, sinful, God will punish	8	(32%)
No, wanted child	10	(40%)
Didn't occur at all	5	(20%)
Loved boyfriend	2	(8%)

MARRIAGE

YES

Did not want an illegitimate child	1	(4%)

NO

Didn't want to force marriage	1	(4%)
Too young	18	(72%)
Didn't want relationship	2	(8%)
Boyfriend unemployed	1	(4%)
Boyfriend smoking dagga	1	(4%)
Didn't think of getting married	1	(4%)

REACTIONS TO BIRTH AND EARLY PERIOD

Reactions to birth

Very happy	16	(64%)
Upset because baby unpreferred gender, but accepted afterwards	2	(8%)
Happy process was over	5	(20%)
Can't remember	2	(8%)

Easy to cope during first few weeks

NO	25	(100%)

Helped to have family member assist with practical educational tasks, eg. showing how to bathe, feed baby, giving advice on breastfeeding.

SUPPORT FOR MOTHER AND CHILD

Family, friends to assist

YES	25	(100%)

(Ratings, in sequence, of family members who assisted most)

Parents	(12)
Boyfriend and his family	(11)
Friends	(7)
Aunts	(5)

Sisters	(4)
Grandmother	(2)

Ways in which they assisted:
Helped to get her to doctor
Helped to buy clothes for baby
Helped with task surrounding baby and visited regularly

Primary Support

Boyfriend and another family member	16	(64%)
Parents	5	(20%)
Sisters	2	(8%)
Brothers	1	(4%)
Aunt	1	(4%)
Self	3	(12%)

Other assistance
None

MAINTENANCE

YES	20	(80%)
NO	5	(20%)

Boyfriend:
Does not want to work- reported him
Is a student, no income
Hit girlfriend, mother forbade him the home
Didn't arrive at court for claim, she didn't bother further
Was retrenched

CARE FOR CHILDREN

Takes care of children

Self	(20)	(80%)
Family member	(4)	(16%)
Creche	(1)	(4%)

100% feel that care which involves supervision, eating, dressing, is sufficient.

LENGTH OF RELATIONSHIP (IN YEARS)

3, 5, 2, 1.5, 5, 3, 2, 2, 4, 5, 5, 8, 1.5, 2, 2, 4, 2, 3, 2, 3, 1, 4, 1, 3, 2
Mean: 3.04 years
Range-: 1-8 years

Intercourse:
Planned: 2
Unplanned: 23
Regular: 4
Irregular: 21

CONSEQUENCES

What did you do before pregnancy?

Unemployed	6	(24%)
Employed	10	(40%)
Scholars	9	(36%)

How did pregnancy affect what you were doing?

Not at all	11	(44%)
Very upset, had to leave school	6	(36%)
Had to be absent from work often	2	(8%)
Didn't have the freedom (going out) as often as before	6	(24%)

How coped with changes?

Don't really know, was difficult, but tried to make success of it with help of family	21	(84%)
Very embarassed, but had to accept	1	(4%)
Upset, hope to go back to school with family help	3	(12)

How long after pregnancy started working?
3, 12, 12, 12, 7
Mean: 9.2 months
Range: 3-7 months

Teenage pregnancy: advantage/disdvantage?

Advantage	7	(28%)
Proves fertility	3	(12%)
Married, husband and child	1	(4%)
Looking forward to baby	1	(4%)
Don't know	1	(4%)
Disadvantage	18	(72%)
Still want to have freedom, go to dances, now can't	7	(28%)
Had to leave school, wanted to do matric	7	(28%)
Not good to have babies early	2	(8%)
Wanted to reach age of 21"unblemished"	1	(4%)
Became fat	1	(4%)

KNOWLEDGE ABOUT SEXUALITY

Given information?

Yes	20	(80%)
No	5	(20%)

If yes, what kind of info and by whom?

Teacher (often guidance teacher)	23	(92%)
Books	1	(4%)
Nurses visiting school	1	(4%)

Were told about:
how male and female body works
Sex, how baby is conceived
birth control (sometimes)
how to say no, AIDS, relationships

Would you have wanted to prevent pregnancy?

No	20	(80%)
Didn't want to become infertile	11	(44%)
Wanted baby	8	(32%)
Was getting married	1	(4%)

Yes	5	(20%)
But didn't want birth control, fear of infertility	4	(16%)
But didn't want birth control, people would think she was a bad girl	1	(4%)

ACCESS TO CONTRACEPTION

Difficulties in gaining access?		
Yes	7	(28%)
Didn't know of availabilty / wasn't interested	5	(20%)
Had to have parents' permission	1	(4%)
Wouldn't have felt comfortable fetching it	1	(4%)
No	18	(72%)

Do you currently use contraception? What kinds?

Yes	23	(92%)
Depo Provera	20	(80%)
Triphasil	3	(12%)
No	2	(8%)
Fear of infertility	1	(4%)
Used Depo for two years, suffered from blackouts, stopped	1	(4%)

Discuss contraception with anyone?

Yes	24	(96%)
Nurses	19	(76%)
Family and friends	5	(20%)
No	1	(4%)
Don't want to because I'm not using it	1	(4%)

GENERAL

Any other supports?

No	25	(100%)
Not necessary		

Most difficult during this time?

Pains during childbirth	21	(84%)
Mother's rejecting attitude	1	(4%)
Don't know	3	(12%)

What could have helped with difficult things?

Nothing	13	(52%)
If someone prepared her for process of childbirth	5	(20%)
Don't know	6	(24%)
Maybe birth control	1	(4%)

APPENDIX F

SUMMARY OF DATA FROM 1987 MAMRE BIRTH AND REGISTRATION LIST

Total number of births:	85
Total number of teenage mothers:	17
Percentage of teenage births in 1987:	20%

TEENAGE MOTHERS ON FOLLOW-UP IN 1993

Number of teenage mothers who married since 1987:	7	(41%)
Number of mothers marrying original fathers:	6	(35%)
Number of mothers not marrying original fathers:	1	(5%)
Number of mothers still unmarried:	10	(59%)

APPENDIX G

AVERAGE RATE OF TEENAGE PREGNANCY (MOTHERS AGED 14-19) OVER A PERIOD OF SEVEN YEARS

YEAR	BIRTHS	TEENAGE MOTHERS	TEENAGE BIRTHS
	(Number)	(Number)	(Percentage)
1986	127	33	26%
1987	85	17	20%
1988	101	13	13%
1989	68	23	34%
1990	74	15	20%
1991	55	12	22%
1992	83	10	12%
TOTAL	**593**	**123**	

AVERAGE TEENAGE PREGNANCY RATE FROM 1986-1992: 21%