

AN EXPLORATORY FIELD STUDY INTO
SCHOOLGIRL PREGNANCIES, WITH
EMPHASIS ON THE ROLE THE SCHOOL
CAN PLAY IN THEIR PREVENTION

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THESIS

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ABSTRACT

This piece of research explores the problem of schoolgirl pregnancies and suggests a role which the school might play in their prevention.

Concern over the growing number of unplanned pregnancies under the age of eighteen years at the author's school, culminated in the present study. Experts on the subject often perceive the problem to be self-defeating to the young girls, medically contra-indicated and socially disruptive.

The purpose of this investigation was to determine attitudes towards the description of the problem, to identify causative factors predisposing to pregnancy, and to obtain views on how the school can reconcile efforts to address the problem. The relevant research data was obtained through a comprehensive 64 item attitudinal and knowledge-base questionnaire which was administered to a sample of 187 subjects. The sample comprised seven different occupational groups namely, senior schoolgirls, parents of senior schoolgirls, ex-schoolgirl primigravidae, parents of ex-schoolgirl primigravidae, school teachers, members of the clergy and various health care professionals.

The appendices contain full statistical tables as well as full responses to the open-ended essay based on the research questionnaire so that the reader is free to check the reasonableness of the conclusions drawn. In the final chapter the author provides a brief summary of findings, offers justification why the teaching of sex education should be a priority in public schools, and makes recommendations, in the main, for the inclusion of school-based sex education as a component of Guidance in terms of rationale and implementation.

In addition, suggestions are made with regard to school policy formulation and networking with parents and other community resources. Finally, a choice of four current model programmes for sex education are proposed in an effort to improve and build upon existing programmes in the present South African curriculum.

It is the author's belief that this investigation may contribute to course design and perhaps provide hypotheses for more specific studies in the future.

ACKNOWLEDGEMENTS

This thesis is the culmination of four years' of thinking, planning, field-research, data collection and writing. Every facet of this investigation has been arduous. If there has to be any recompense for this work, it will be in the knowledge that it can make a small contribution towards assisting education departments and schools in designing family guidance and sex education programmes geared towards preventing early, unplanned schoolgirl pregnancies.

The author wishes to express his sincere appreciation to the following persons who have contributed towards the realisation of this research study: Professors R. Tunmer, A. Penny and T. Marsh of Rhodes University, responsible for the M.Ed coursework, and particularly his thesis adviser, Mr George Euvrard for his patience, consistent encouragement, and guidance.

Deepest gratitude is expressed also to the pupils, ex-schoolgirl primigravidae, parents, teachers, members of the clergy, and health care personnel who so willingly participated in completing the research questionnaire.

The author is especially indebted to Ms Janet Slater, Community Liaison Officer of the Department of National Health and Population Development for assisting in acquiring vital statistical information on teenage pregnancy cases in the East London region. The author also wishes to acknowledge Ms Lynn Garizio for her sterling effort in typing this manuscript.

Needless to say, the findings in this work are neither those of, nor are they endorsed by, the instances or persons mentioned above.

ADDENDUM

This manuscript was submitted for preparation in thesis format in the final quarter of 1991. The four-year research study that it describes began in mid-1987 and terminated in mid-1991.

Because of the relative obsolescence of current statistical data, the author carefully monitored and compiled the needed information from records at the Frere Hospital, the main catchment area for all teenage pregnancy cases in East London, for the five-year period 1986-1990.

DEDICATION

This work is dedicated to all persons with vision, compassion and courage, and to the young schoolgirls whose health and future we have an obligation to ensure.

BRIEF NOTES FOR THE READER

1. Appendix A contains explanations of certain concepts/terms which are necessary for an understanding of the different concerns of the problem.
2. As most researchers on the subject commonly use the all-embracing term "teenage pregnancies" to refer to pregnancies in school-age or adolescent girls, the terms schoolgirl/teenage/adolescent pregnancies will be used inter-changeably for the purposes of this study.
3. The following glossary of abbreviations relating to the research questionnaire is deemed necessary:
 - 3.1 SKQ = Sexual Knowledge Questionnaire
 - 3.2 RPQ = Reproductive Physiology Questionnaire
 - 3.3 CKQ = Contraceptive Knowledge Questionnaire
4. A brief explanation is also needed as to how the target population (embracing seven groups of subjects) was classified and coded. The group codes used are as follows:

G1(S)	=	Schoolgirls
G2(ES)	=	Ex-Schoolgirls
G3(P)	=	Parents of schoolgirls
G4(PES)	=	Parents of Ex-Schoolgirls
G5(T)	=	Teachers
G6(C)	=	Clergy
G7(HCP)	=	Health Care Professionals
5. Since the non-tabular raw data (respondents' comments/ideas in the Open-Ended Essay) run into several pages, these have been incorporated as a whole into the section on Appendices.

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CHAPTER ONE

INTRODUCTION

- 1.1 Introduction
- 1.2 Incidence of Schoolgirl Pregnancies
- 1.3 Problems of Schoolgirl Pregnancies
- 1.4 Attempts to Ameliorate the Problem
- 1.5 Formulating the Problem
- 1.6 Aims of this Study
- 1.7 The Potential Significance of the Study
- 1.8 Presentation of the Contents

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

There is an increasing concern about the growing number of schoolgirls that become pregnant each year. This situation causes problems at various levels (Pittman, 1985).

Norton and Bernstein (1985) note that, firstly, schoolgirl pregnancies often lead to both the interruption and termination of the young girl's school career. Secondly, such pregnancies and related problems are perceived to be damaging to the individual and to society as a whole. Parents and the family feel anger and distress, the Churches react with shock, and medical personnel, social workers, parents and teachers try to formulate a response to what has been called "the epidemic of teenage pregnancy" (Dickman and Gordon, 1988, p.3). Concern about the phenomenon and its negative repercussions has spread beyond the community to national and international levels.

The question often asked is "What can we do?". While there appears to be no single solution, a broad consensus of opinion among researchers in the field states that education authorities and schools must become more involved in reconciling efforts to address the problem (Van Regenmortel, 1977; Craig and Richter-Strydom, 1982 ; Botha, 1986; Nash, 1990).

1.2 INCIDENCE OF SCHOOLGIRL PREGNANCIES

The incidence and problems associated with schoolgirl pregnancies in the world and in the Republic of South Africa is not fully known as there is little published research on this phenomenon (O'Mahony, 1987, p.771). However, a plethora of information is currently available on the concept of the phenomenon of adolescent or teenage pregnancies. Most researchers (Ross, 1979; Prinsloo, 1984; Parker, 1987) on the subject do not make a distinction between schoolgirl pregnancies and teenage pregnancies. They prefer to use the more common term "teenage pregnancies" instead.

The incidence and trends relating to teenage pregnancies in the world, especially in the decade of the eighties, have been well-documented through numerous international surveys, population studies, comparative studies and journal reports. For example, the International Planned Parenthood Federation of America, the Alan Guttmacher Institute, and the Children's Defence Fund have consistently monitored teenage fertility trends in developed and third world countries (St. Paul Adolescent Health Services Project Manual, Minnesota, 1988). These organisations report that the United States of America is believed to have the highest teenage pregnancy rate in the world. Great Britain is second and Canada is placed third. In comparison to America and Great Britain, European countries such as the Netherlands, France and Sweden have much lower rates. The reason for the disparity in fertility rates is that the governments in European countries, unlike their western counterparts, promulgate sex education and contraceptive education extensively in the schools and in all the media (The Alan Guttmacher Institute Study, 1985).

According to Venter (1989), national surveys conducted by the Human Sciences Research Council (hereafter referred to as the HSRC), show that South Africa has high teenage pregnancy rates for the four major population groups which parallel rates for America and Great Britain (pp.1-6). In fact, some sources have claimed that South Africa had the highest teenage pregnancy rate in the world in 1985 (Population Development Programme Monitoring Reports - 1987-1988 - of the Department of National Health and Population Development; hereafter referred to as the Department of National Health). Statistical trends indicate that teenage births constitute approximately 11% of all births in South Africa, and about five percent of all mothers were 16 years old or younger (Nash, 1990). Statistics collected by the Department of National Health in 1990 indicate that on a nationwide basis, as many as 74% of teenage girls become pregnant before their 20th birthday. Many provincial hospitals and clinics, e.g. the Tygerberg Hospital, the Pregnancy Advisory Service of Groote Schuur Hospital and the Cape Town Teenage Clinic report high fertility rates, especially for the Black and Coloured communities. Research evidence from these hospital reports seems to indicate that the number of cases, especially in the 14-19 year age-group, are on the increase each year (Nash, 1990). In the East London and Border Region, the Frere Hospital (the main catchment hospital for all teenage births)

records this region to have the second highest teenage pregnancy rate in the whole of South Africa. The Western Cape Region is placed first. The latest figures for East London show that 17,1% of all births were to teenage girls (Correspondence B1, Appendix B). This figure is believed to be much higher but the processing of more recent data was incomplete at the time.

Relatively high figures are also reported each year for the 14-19 year age-group at the author's school, a co-educational Coloured secondary school, which has an average intake of approximately 950 pupils. The average annual rate for schoolgirl pregnancies is approximately 20 known cases (see Chapter Two). The Youth Education Advisory Services of the Department of National Health in East London suggest that as there are many unknown cases, the total number of cases at the author's school might be as high as 25 or more per annum.

1.3 PROBLEMS OF SCHOOLGIRL PREGNANCIES

Parker (1987) notes that pregnant schoolgirls encounter "multi-factorial problems during their pregnancies and afterwards" (p.121). Many social problems result as most pregnancies necessitate the girls' leaving school prematurely. Many do not return to school and consequently do not complete their education. The so-called "drop-out" syndrome is common and this often has devastating consequences on the life chances of both the young immature mothers and their babies. Lynda, writing on the subject in the British Medical Journal, alerts school authorities to the fact that "Pregnancy in their pupils is rightly a matter of concern to schools and teachers, for loss or disruption of education is surely one of the most serious consequences of pregnancy at this age" (1980, p.1061). The teenage mothers are sometimes ostracised by their families, schools and communities. In addition, Norton and Bernstein assert that "such pregnancies often perpetuate a cycle of poverty and social welfare dependency that impose added stress on the young mothers, their offspring, and their families (1985, p.14).

Parker's recent study on the psychological problems relating to teenage pregnancies, indicates that the girls "initially experience negative

feelings regarding their pregnancy, which subsequently develop into a resigned acceptance" [of their situation] (1987, p.121). The young girls are faced with personal guilt and failure, frustration, anxiety and depression because they are unable to cope with early motherhood and because they "lack adequate parenting skills and a sound knowledge of child development" (Parker, 1987, p.121).

In addition to the social, personal and psychological problems, there are also medical problems which can impose serious health risks on the pregnant teenagers and their offspring. Examples of these medical problems are low birth weight, pre-eclampsia, hyper-tension, carcinoma of the cervix, pre-term labour, and toxæmia due to inadequate physical and physiological development (Parker, 1987, p.121). These complications often lead to the death of the offspring.

Parents, the community and health care professionals have increasingly expressed the need for active intervention to curb and prevent the often unwanted and unintended pregnancies in schoolgirls. Education departments and school authorities also agree that something needs to be done (Botha, 1986).

1.4 ATTEMPTS TO AMELIORATE THE PROBLEM

A range of initiatives and programmes has evolved in recent years, particularly in overseas countries, to reduce pregnancy and childbearing and ameliorate its adverse effects.

In western countries, for example, schools and community services have developed the following popular programmes / models: the School-based Sex Education Programme, Postponing Sexual Involvement Programme, Healthstart, the Social Inoculation Model and the Basic High School Clinic Model. However, the success rate of these programmes / models is not known, as they are relatively new (St. Paul Adolescent Health Services Project Manual, 1988, pp.1-54).

Elsewhere in this study, the author discusses these programmes in some detail and also attempts to provide a brief evaluation of the efficacy of

various preventative and ameliorative strategies that are currently undertaken.

And what has been done in South Africa? Little is known about whether sex education curricula or programmes are followed in South African schools (Correspondence B2, Appendix B). Neither is it known under what heading they are taught, what the exact nature of their content is, and the extent to which these programmes are supported by parents and the communities in which they live. However, the current initiative for sex education in South African schools is taken by local authority health departments which employ outside youth advisers and family planning personnel for their function (Correspondence B3, Appendix B). Critics charge that many of these outside programmes fail because they are too academic in nature, too fragmented and unstructured or because the content is not geared to meet the present day needs of adolescents (Rogers, 1974; Botha, 1986; Pittman, 1986; Bam, 1989).

Sadly, in spite of many attempts to offer sex education in schools, the problem of premature sexual activity and pregnancies in school-age girls is on the increase. Evidence of this fact is the growing number of cases of teenage pregnancies reported each year and borne out by statistical evidence obtained through national surveys undertaken by the HSRC (Venter, 1989).

It has therefore become necessary for schools in recent years to review their strategies and roles in addressing the problem.

1.5 FORMULATING THE PROBLEM

From the foregoing sections it is clear that pregnancy in schoolgirls constitutes a complex and serious phenomenon as the known consequences of such pregnancies are very much to the disadvantage of the girls and their babies. In short, the girl who becomes pregnant whilst still a teenager, "has 90% of her life-script written for her and most of it is negative" (Greathead, 1988, p.20).

Although many innovative prevention programmes are available today, they are generally not successful (Furstenberg, Brooks-Gunn and Chase-Lansdale, 1989). One serious drawback appears to be the enormous diversity of course

material available for school practice. Another is that all the accumulated wisdom about the prevention programmes seem to have little if any practical application in school classrooms because of lack of knowledge, skills and training on the part of teachers in the field of pregnancy prevention.

It is the author's contention that the situation calls for a re-examination of the whole problem. Secondly, he is also quietly confident that in virtually every school today there exists opportunities for exploring and discovering targeted strategies to take on the challenge of advancing the cause of pregnancy prevention.

1.6 AIMS OF THIS STUDY

In the light of the above, there are three aims which are addressed in detail in this investigation. Of the three aims, the final topic is explored in outline and is deemed as crucial to the author's investigation.

The aims of this study are as follows:

- (a) To determine attitudes towards the description of the problem of schoolgirl pregnancies.
- (b) To identify causes of the problem.
- (c) To clarify the role the school can play in the possible prevention of the problem.

1.7 THE POTENTIAL SIGNIFICANCE OF THE STUDY

This study attempts to provide a new definition and understanding of the concept of the phenomenon of schoolgirl pregnancies and suggests a role the school might play in the prevention effort.

It is anticipated that this study's findings will serve to inform, enlighten and guide in an area where knowledge and understanding may be lacking, and possibly equip current and prospective educators, teachers and counsellors with relevant research information. It is hoped that this information will

serve as terms of reference for their future educational concern and endeavours with adolescent youth.

Considering the relative complexity of the subject, the author expresses the belief that the documentary and research evidence presented will help to enrich both educational theory and practice, as well as raise new questions and perhaps provide new hypotheses for future research.

1.8 PRESENTATION OF THE CONTENTS

In CHAPTER ONE, the rationale for, and the aims of the study have been discussed. The remainder of the thesis is divided into four sections.

CHAPTER TWO contains a review of the related literature on the subject.

CHAPTER THREE focuses attention on the investigation that was undertaken referring *inter alia* to the design of the study, the specific aims and the research methodology.

CHAPTER FOUR contains a presentation of the results and discussions based thereon.

CHAPTER FIVE attempts to place the conclusions, implications and recommendations of this research in a pedagogical perspective.

The Appendices contain a glossary of concepts/terms used in the study, a brief summary of findings of an in-school survey conducted in 1985, the research questionnaire, statistical tables and full responses to the open-ended essay, and all other relevant information.

CHAPTER TWO

LITERATURE REVIEW

- 2.1 Introduction
- 2.2 Historical Perspective
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- 2.7 Current Approaches towards the Teaching of Sex Education in South African Schools
- 2.8 Prevention Programmes and Evaluation
 - 2.8.1 Attempts to Resolve the Problem Abroad
 - 2.8.2 Attempts to Resolve the Problem in South Africa
- 2.9 Conclusion

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Before presenting the research, it is necessary to review the ideas and findings of researchers which have inspired and adumbrated the present study. The literature is organised by topic for the purpose of pointing out what is known about the various aspects of the study, and to attempt to offer as complete a picture as possible of the background to the study.

2.2 HISTORICAL PERSPECTIVE

The two major world wars had the effect of liberating women's attitudes towards sex (Wharton, 1989, pp. 20-33). Women started campaigning for the right to control their fertility, the first family planning clinic was opened in Britain in 1920, and in the 1930's abortion became legal in countries such as the Soviet Union, Scandinavia, Yugoslavia, Argentina, France and the United States. In the 1950's abortion was made safer and easier through a medical breakthrough by two Chinese doctors who developed the vacuum method of abortion. Then the sexual revolution of the 1960's dawned upon young women. With the development of reliable contraception and greater access to abortion facilities, young people's attitude to sex changed even further, and pressure was put on them to engage in sexual intercourse for which they were not necessarily prepared. This increased sexual activity has resulted in a growing increase in teenage pregnancies (McGibbon, 1990; Nash, 1990; Preston-Whyte, Karim, Sankar, Karim and Zondi, 1991).

Swart in her recent study on Teenage Pregnancies, confirms that "the majority of these pregnancies are unplanned and take place out-of-wedlock" (1986, pp.1-5). Furstenberg *et al* argue that fundamentally two demographic changes, namely, "the increasing rates of sexual activity among younger girls and the falling rates of teen marriages", contributed to the birth of this phenomenon (1989, p.313).

According to Sapire "13 million out of 60 million women who gave birth to children during 1975 were not adult [and] one in seven women who gave birth to children in the maternity unit where she worked was aged 19 or under" (quoted in Koegh, 1988, p.30). In a recent Sex Education Update of The Planned Parenthood Association of Southern Africa, it is estimated that "1 in 5 babies are born to teenagers 16 years of age or younger in South Africa" (1990, pp.1-3). Since accurate and reliable statistics are not always readily available, few people realise the enormity of the problem.

In addition, today's children are physically maturing earlier than ever before. Experts (Rigg, 1978; Langeni, 1988) in the field believe that "the biological clock is ticking faster" for children of this era.

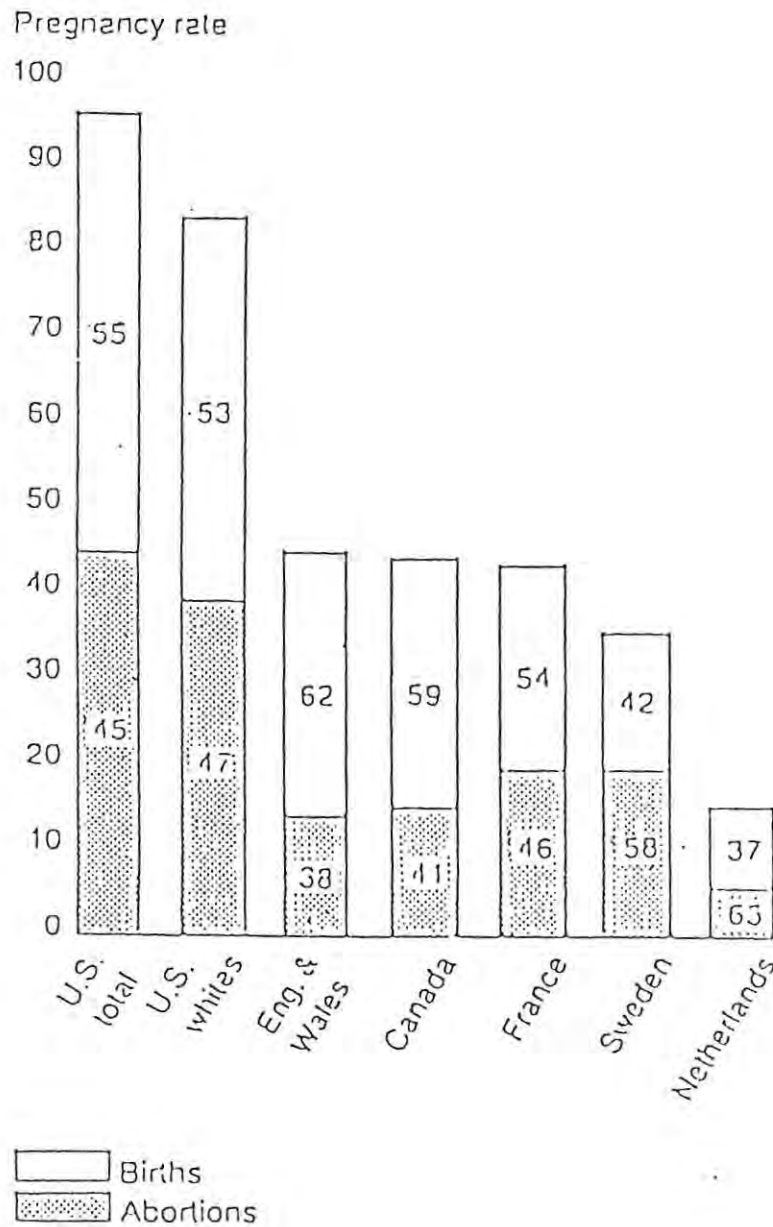
It has been pointed out by State Education Policymakers for Public Schools in the United States that, "their years of childhood have been shortened by the earlier onset of puberty" (A Guide for State Education Policymakers, 1987, p.3). Langeni, at a nurses' seminar on Teenage Pregnancy, in South Africa in 1987, noted that the age at which young girls reach menarche today is steadily getting lower (1988, p.17). Simpkins in his study confirms that "the average age of menarche for girls in the United States has declined from 14 years in 1900 to roughly 12,9 years today" (quoted in Swart, 1986, p.8). Further, Rigg, in the Journal of the Teacher Psychologist Association (CP) reports that "every 10 years puberty in girls occurs three months earlier, and there is no evidence to suggest that this trend will not continue" (1978, p.10). While young girls are reaching reproductive maturity much earlier, the present technological society demands longer years of schooling and deferred marriage of its adolescent girls (A Guide for State Education Policymakers, 1987, p.1).

2.3 INCIDENCE

International evidence suggests that the incidence of such pregnancies is unacceptably high (Dickman and Gordon, 1988). Amongst the developed countries in the world, the United States of America is quoted in a study by The Alan Guttmacher Institute as having the highest incidence of teenage pregnancies and childbearing. The study reports that the U.S. rate for 15-19 year olds stands at 96 per 1,000 compared to 14 per 1,000 in the

Netherlands, 35 per 1,000 in Sweden, 43 per 1,000 in France, 44 per 1,000 in Canada and 45 per 1,000 in Great Britain (1985, pp.1-5). These statistics also suggest that Great Britain has the second highest and Canada the third highest teenage pregnancy rate in the world (see Fig. 1 below).

FIGURE 1: Percentage distribution of pregnancies, and pregnancy rates, for women aged 15-19, 1980/1981.



Notes: The rates can be estimated by measuring the height of the bars against the vertical axis. The numbers inside the bars represent the percentage distributions.

Source: The Alan Guttmacher Institute Study, pp.1-5, March 1985.

It is also estimated that, in the western world, more than one million teenagers aged 15-19, become pregnant annually, of whom over 40% give birth (Nash, 1990, p.147). Other researchers (Lincoln, Jaffe and Ambrose, 1976), confirm this figure, but state that an additional 30,000 girls under the age of 15 years become pregnant each year, of which two thirds are conceived out-of-wedlock, and are unintended (cited in Kapp, Taylor and Edwards, 1980, p.80). The same authors ascribe the cause to the fact that the majority (80%) of sexually active teenage girls use no contraception, or use it ineffectively, with the subsequent high pregnancy rates.

It was almost twenty years ago that Miller (1973) wrote that school systems in the U.S.A. agree that "pregnancy is the greatest single cause of school drop-outs among teenage girls" (quoted in Berg, Taylor, Edwards and Hakanson, 1979, p.32).

Newman writes that similar trends are indicated for Great Britain where it is estimated that altogether 13,000 schoolgirls, aged between 11 and 15 years, become pregnant each year (1987, p.45). Current trends show that an increasing number of pregnant schoolgirls, the so-called "gym-slip mums" or "teenage mums" decide to keep their children. This situation often results in the girls leading the double life of child at school and mother at home.

Table 1 below serves to illustrate trends in teenage pregnancy for girls in the under 16 age-group in Great Britain.

TABLE 1: Trends in conceptions to teenage girls under 16 in England and Wales.

YEAR	CONCEPTIONS LEADING TO MATERNITY		CONCEPTIONS TERMINATED BY ABORTION		TOTAL CONCEPTIONS	
	<u>Number</u>	<u>Rate</u>	<u>Number</u>	<u>Rate</u>	<u>Number</u>	<u>Rate</u>
	1976	4.300	3.7	4.900	4.2	9.200
1977	4.200	3.6	4.800	4.0	9.000	7.6
1978	4.400	3.7	4.700	3.9	9.100	7.6
1979	4.100	3.4	5.000	4.2	9.100	7.5
1980	3.900	3.3	4.600	3.9	8.600	7.2
1981	3.700	3.1	4.900	4.1	8.600	7.3
1982	3.900	3.4	5.100	4.4	9.000	7.8
1983	4.000	3.6	5.300	4.7	9.400	8.3
1984	4.300	3.8	5.400	4.8	9.600	8.6

Note: The rate is per 1000 girls aged 13-15.

Source: OPCS Monitor FMI 85/8, 3 Dec 1985 and FMI 86/3 15 July 1986, in Frater A, 1986, Teen Pregnancy-Under Sixteens, Brook Advisory Centres, Education and Publications Unit (page unnumbered).

It is interesting to note the reasons for the disparities between the United States teenage pregnancy rates and those of the other developed countries. In the developed countries of Europe, unlike the U.S.A., there are national policies for achieving lower rates of teenage pregnancies, abortions and births through effective sex education programmes in schools and free but confidential contraceptive services which are easily accessible to teenagers (The Alan Guttmacher Institute Study, 1985, pp.1-5).

Teenage pregnancy rates appear to have reached near "epidemic" levels in many countries of the world and South Africa is no exception. Population studies by the HSRC have documented the fact that South Africa has one of the highest incidences of teenage pregnancy in the world as approximately 11% of all babies born in South Africa are born to teenagers (Venter, 1989, pp.1-5).

Schlrmer and Van Blema, with reference to the above surveys, confirm that "currently many of the statistical findings indicate surprising parallels in attitudes and behaviour between teenage girls here [in South Africa] and in the United States" (1987, p.14). They add that generally South African teenagers become sexually active at a slightly younger age than their American counterparts. Whilst the overall average age of first coitus was 16,9 years in the U.S.A., in South Africa it was 15,9 years (Schlrmer and Van Blema, 1987, p.15).

Research in South Africa shows that large numbers of high school pupils become sexually active at an early age.

In Preston-Whyte's Cape Town study of 337 high school pupils, the findings indicated that 75% of the pupils admitted to being sexually active and only 11.4% admitted to having used contraceptives (Sunday Tribune, 31 March 1991, p.19). Karim and Sankar (1991), however, in a similar study involving a group of 52 standard 9 and 10 pupils of all races with an average age of 16 years from 10 schools in the Natal Midlands, found that only 32% of the pupils were sexually active (p.19).

A recent survey, conducted by the Family Planning Association of South Africa, revealed that early sexual intercourse contributed to teenage pregnancies since girls aged 15 years and younger were "twice as prone to pregnancy during the first 6 months of unprotected sexual intercourse compared to those girls who postponed sexual intercourse until after the age of 19 years" (Venter, 1989, pp.1-2). The fact that early sexual intercourse did take place is borne out by the findings of the latest survey conducted by the HSRC which indicate that "38.2% of teenage girls in South Africa had experienced sexual coitus before the age of 15 years" (Williams, 1990, p.25).

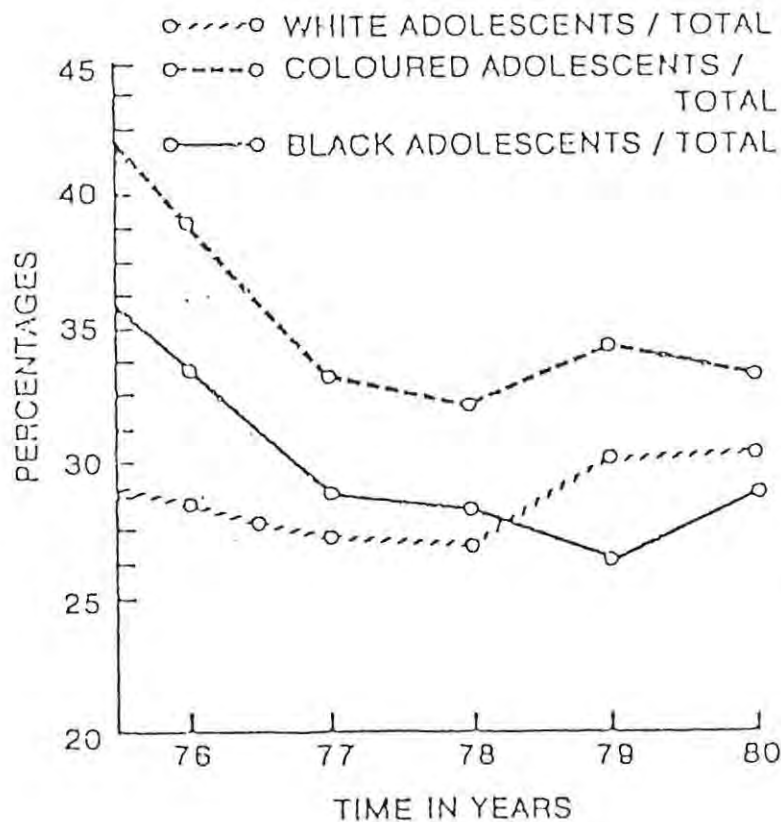
If the trend continues, the Department of National Health estimates that some 50% of Black teenage girls, 60% of Coloured teenage girls and 20% of White teenage girls can expect to have a first pregnancy before they are out of their teen years, and face the risk of a repeat pregnancy soon thereafter. A Sex Education Update reports that Dr. P. de Villiers's 1973-1983 study at the Paarl Hospital, recorded 6284 teenage births which

constituted 30,5% of the total number of births there (1990, pp.1-2). It is estimated that this was one of the highest recorded percentages in the world.

The same report states that in the Western Cape, the Regional Services Council recorded the following teenage births in recent years: 1987 = 2426 ; 1988 = 2772; 1989 = 3092 (1990, pp.1-2).

Prinsloo's interesting study on trends for teenage pregnancies at Tygerberg Hospital during the five-year period 1976 - 1980 showed a decline but remained at a high level of 29,4% of black patients, 33,3% of coloured and 30,5% of white (1984, pp.695-696; see Fig. 2 below).

FIGURE 2: Deliveries among White, Coloured and Black adolescents at Tygerberg Hospital, expressed as percentages of total deliveries, 1976 - 1980.



Source : Prinsloo FR, 1984, Trends in Adolescent Pregnancies at Tygerberg Hospital, South African Medical Journal, Vol. 65, p.695.

Also, Prinsloo's study shows that "the average illegitimacy rates for the five-year period (1976 - 1980) were 67,8% for Blacks, 81,6% for Coloureds and approximately 20% for Whites", respectively (cited in Nash, 1990, p.147).

Venter states that South Africa has a population of approximately 34,5 million of which 50% is below the age of 20 years and 40% below the age of 15 years (1989, pp.1-7). These figures indicate that South Africa has a high teenage population. The breakdown for the different race groups is shown in Table 2 below:

TABLE 2: Teenage population in South Africa expressed as a percentage of the total population.

White teenagers	:	28% of the population.
Coloured teenagers	:	39% of the population.
Black teenagers	:	41% of the population.
Asian teenagers	:	37% of the population

Source : Langeni NT, 1988, Teenage Pregnancy - A fact of life? Fiat Lux, Vol. 23, No.2, p.17.

According to surveys conducted between the years 1984 - 1988 by the HSRC on births to teenagers in South Africa, the following figures (see Table 3), indicate the high teenage pregnancy rates (Population Development Programme Monitoring Report, 1987, p.107).

TABLE 3: Births to teenagers in South Africa during the years 1984 - 1988.

	<u>1984</u>	<u>1985</u>	<u>1986</u>	<u>1987</u>	<u>1988</u>
Whites	7,0%	7,2%	7,2%	7,3%	7,0%
Coloureds	16,0%	15,0%	16,0%	15,1%	14,0%
Blacks	-	-	13,8%	12,4%	14,7%
Asians	10,0%	9,6%	10,9%	9,7%	9,2%

Note: The above birth rates are expressed as a percentage of the total births in South Africa for each group respectively.

Source: Population Development Programme Monitoring Report, 1987; Teenage Pregnancies, Department of National Health and Population Development (p.107).

However, the recent statistics of the Department of National Health provide a more complete picture on teenage births at regional level for South Africa as a whole (see Table 4 below).

TABLE 4: Births to teenagers at regional level, in South Africa during 1989-1990.

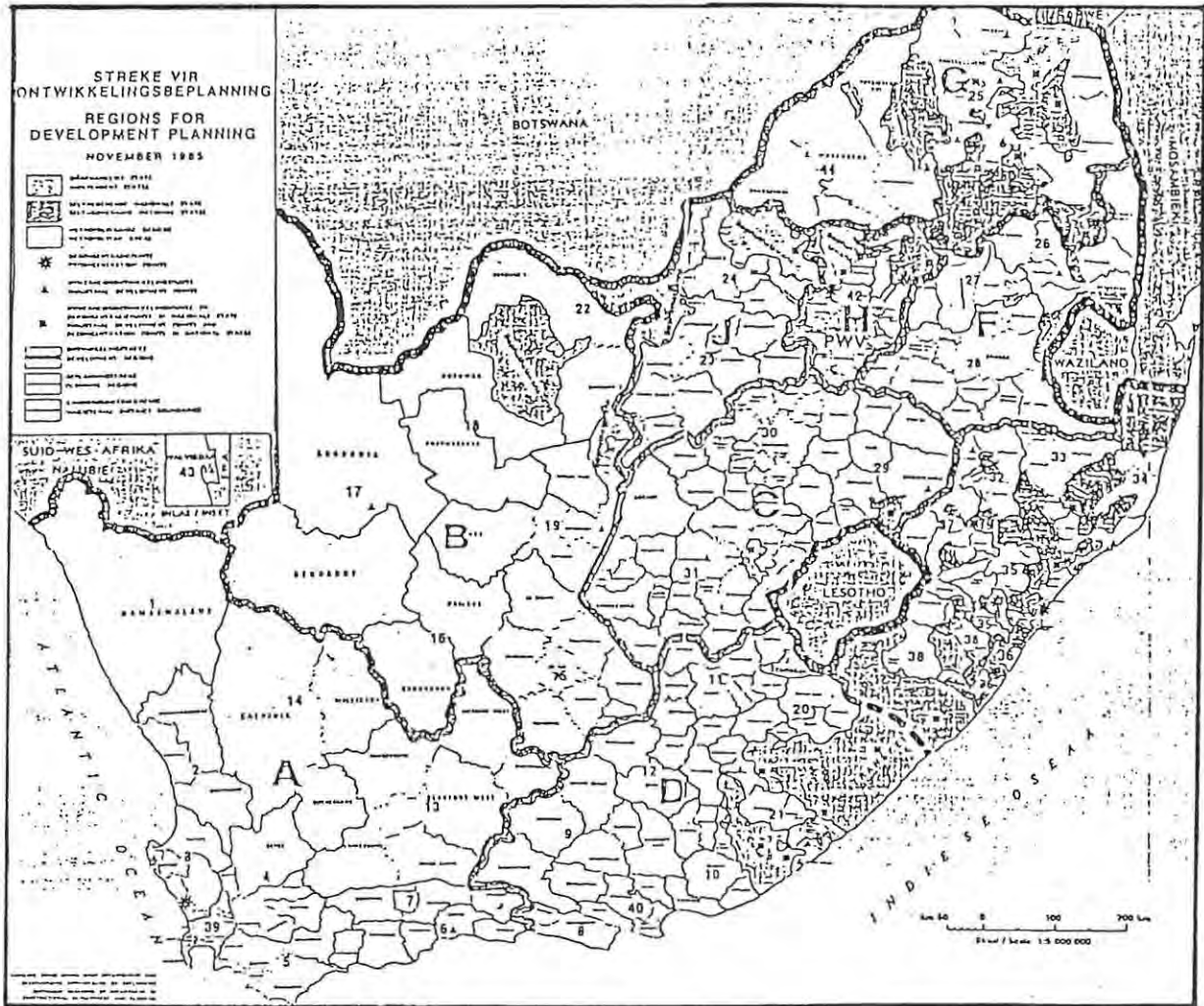
<u>Region</u>	<u>Whites</u>	<u>Coloureds</u>	<u>Blacks</u>	<u>Asians</u>
A	3.0	12.9	4.6	5.6
B	4.3	13.5	11.0	-
C	5.8	13.4	13.7	-
D	4.9	12.8	5.5	6.0
E	5.3	10.9	8.8	9.0
F	7.5	12.0	13.1	-
G	6.0	-	22.3	-
H	6.8	11.6	9.6	5.1
J	7.0	12.9	7.7	-

Notes :

1. The above birth rates are expressed as a percentage of the total births in South Africa for each group respectively.
2. The Regional Map of South Africa (Map 1.) below demarcating regions A-J is to be used in conjunction with the above statistics for clarity.

Source: Department of National Health and Population Development (Correspondence B4, in Appendix B).

Map 1: The Regional Map of South Africa showing Regions A -J.



Source: Monitoring Report (1988), Teenage Fertility Trends, Department of National Health and Population Development, pp.110-122.

The above state of demographic realities in relation to statistics on teenage pregnancies, gives one an idea of the extent of what one might term the social problem of teenage pregnancy, in so far as it affects the broader society.

After reviewing trends at the Peninsula Maternity and Neonatal Service of Cape Town, a survey by Van Coeverden de Groot found that "whereas the teenage pregnancies declined from 22% in 1974 to 15% in 1983, the number of pregnant teenagers, mainly Coloured and Black, had increased" (cited in Nash, 1990, p.147).

Ross's survey on unplanned teenage pregnancies conducted in the Durban area of Natal, indicated that 18% of all pregnancies occurred amongst teenagers. The incidence for the four major population groups varied between Whites 14%, Coloureds and Blacks 20% and Asians 17%. He further observed that these figures compared favourably with a world-wide teenage pregnancy rate of 10-15% (1979, p.22).

According to an illuminating study on schoolgirl pregnancies in the rural context of Transkei, adolescent girls constituted 26% of the 1255 patients who delivered at St. Barnabas Hospital in the year ending September 1985 (O'Mahony, 1987, p.771). The literature reports that Black homelands and townships, generally, are not immune to the problem (Craig *et al*, 1982; O'Mahony, 1987; Preston-Whyte, Zondi, Mavundla and Gumede, 1988; Gubuza, 1989). For example, an analysis of Black fertility patterns in Cape Town and the Republic of Ciskei showed that 49% of females had had their first pregnancy before the age of 20 years (Roberts and Rip, 1984, cited in Nash, 1990, pp.147-148).

Gubuza obtained the following interesting statistical data (see Table 5) on teenage pregnancies between February 1988 and February 1989 in the Ciskei from four health centres (1989, p.3). His findings also show that teenage pregnancy is a major problem facing that country.

TABLE 5: Numbers of Black teenage pregnancies at four health centres in the Republic of Ciskei between February 1988 to February 1989.

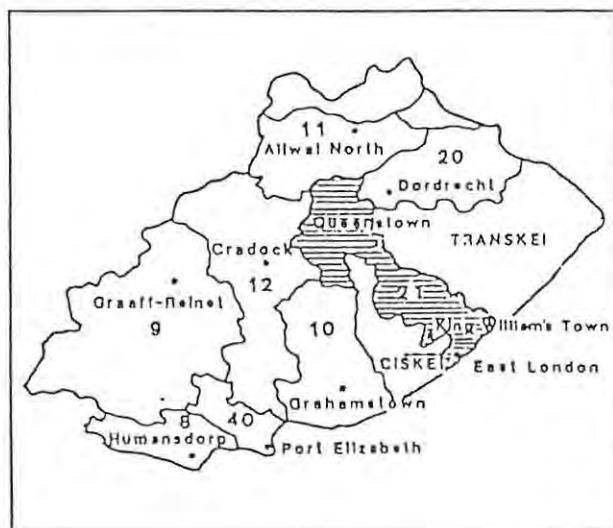
<u>CENTRE</u>	<u>14YRS</u>	<u>15YRS</u>	<u>16YRS</u>	<u>17YRS</u>	<u>18YRS</u>	<u>19YRS</u>	<u>20YRS</u>	
A	1	2	7	28	39	23		
B	3	4	8	15	28	14		
C	2	4	9	14	8	13	14	
D	2	4	9	22	29	20	5	
Total	8	14	31	79	104	70	19	= 325

Source: Gubuza GV, 1989, Teenage Pregnancies - "A Crisis Today", Seminar Paper presented by the Inter-Departmental Committee for Population Development, pp.1-8.

The Department of National Health reported that not all cases of teenage pregnancies in South Africa resulted in delivery. Many teenagers were granted termination of pregnancy in terms of the provision of the Abortion and Sterilisation Act No.2 of 1975 and its amendments (Nash, 1990, p.148).

East London and the Border Region fall under Region D(21) in the planning regions of the Department of National Health and Population Development. (See Map 2 below for demarcation).

Map 2 : Planning Region D(21) Border Area.



Source: Socio-Economic Regional Report (1989), Planning Region 21 Border Area : Teenage Fertility Rates, Department of National Health and Population Development, pp.29-32.

In this region, the Frere Hospital is the main catchment hospital for all deliveries. The following abridged table (Table 6) shows teenage pregnancy rates for the different population groups respectively in East London during the years 1986-1990.

TABLE 6: Teenage births at Frere Hospital, East London, 1986-1990.

<u>YEAR</u>	<u>POPULATION GROUP</u>	<u>TEENAGE BIRTH RATES</u> expressed as percentage of total live births.
1986	White	5.9
	Coloured	18.0
	Black	20.3
	Asian	7.0
1987	White	6.6
	Coloured	19.4
	Black	20.8
	Asian	8.5
1988	White	7.3
	Coloured	21.7
	Black	19.9
	Asian	9.7
1989	White	6.6
	Coloured	22.0
	Black	20.1
	Asian	10.6
1990	White	5.2
	Coloured	22.1
	Black	18.9
	Asian	23.5

Note: See Appendix C for corresponding full tables (Tables 6A-6E) on teenage deliveries at Frere Hospital for the five-year period 1986-1990.

Source: Department of Obstetrics and Gynaecology, Frere Hospital, (Correspondence B5-B6, Appendix B). Department of National Health and Population Development, Reports 1986-1990, East London.

A growing number of schoolgirls fall pregnant each year at the author's school, a co-educational Coloured secondary school (Std 6-10) in East London with a school population of approximately 900 pupils. The author monitored the number of pregnancy cases over a five-year period between 1986-1990, and the following figures were extrapolated:

TABLE 7: Schoolgirl pregnancies for Std 6-10 at author's school between 1986-1990.

<u>YEAR</u>	<u>NUMBER OF CASES</u>
1986	27
1987	21
1988	16
1989	19
1990	18

Source: School Admissions and Withdrawals Register, Author's School, East London, 1986-1990.

The age range was 13-19 years and the mean age was 16 years. The above figures in Table 7 show that the greatest number of pregnancies was reported in 1986. Research has shown that there is an increase in schoolgirl pregnancies during times of prolonged school boycotts (Craig and Richter-Strydom, 1982), and 1985 was marked by such events nationwide.

In the same year (1985) an in-school survey (see Appendix D) on the problem was undertaken at the author's school. The results generally indicate that there was support for sex education and a more open communication between parents and their children on sexual matters (Brief Summary of Findings of In-School Survey, 1985, pp.1-2; see Appendix E).

2.4 CAUSATIVE FACTORS

2.4.1 Increased sexual activity.

Today greater numbers of young adolescents engage in pre-marital sex, despite prohibitions, because the restrictive rigid codes of the past, in many instances, have largely disappeared. It is often remarked that the present generation of young adolescents have had to mature in the shadow of a sexual revolution. This situation has resulted in the "breakdown of [traditional] family authority structures [and] community norms" (Cuenod, 1987, pp.1-3). Consequently, many young adolescents have been left to fend for themselves from an early age. Often no clear guidelines for expected social behaviour seem to exist, and the youth are exposed to the so-called liberal western standards of living and a changing value system which aim at greater sexual permissiveness and materialistic living. In this era of permissiveness, the disappearance of the "sexual double standard" and the tendency towards a casual acceptance of sexual promiscuity of pre-marital sex, have also been highlighted in the literature as being causative factors for unplanned adolescent pregnancies (Ross, 1979; Craig *et al.* 1982; Preston-Whyte *et al.* 1991).

Craig and Richer-Strydom's study on unplanned pregnancies amongst urban Zulu school children, found that the present social changes was a factor that resulted in "institutional breakdown which indirectly caused unrestricted sexual experimentation" and the high level of unplanned pregnancies (1982, p.452).

In some developed countries, 75% of teenagers had had their first coitus before the age of 20 years (a chapter of a book entitled "Sexuality in Adolescence and the Elderly", p.418, source and date unknown). A Canadian study by Gemme (1979), projected that by 1994, 95% of the young people will have engaged in pre-marital sex (pp.37-40). Scanzoni reasons that the problem was directly linked to the fact that the age at which persons experienced pre-marital sex, was decreasing progressively (1981, pp.80-81).

The Johannesburg Child Welfare Society Report notes that in South Africa an increasing number of girls and boys were sexually active between the ages

of 13 and 19 years. Also, 80% of the girls who attended one of the family planning clinics of the Johannesburg Child Welfare Society for the first time, had already been sexually active for a year or more (1989, pp.1-3). The most plausible reasons for increased sexual activity among school-going children have been offered by A Guide for State Education Policymakers in America entitled "Creating Family Life Education Programmes in the Public Schools" (1987, pp.1-13). The guide noted that the present generation of "[school] children were physically maturing earlier than ever before, their years of childhood [had] been shortened by the earlier onset of puberty, and the [present] technological society demanded longer years of schooling and deferred marriage of its adolescents" (1987, p.1). Thus, instead of young people marrying two years after reaching physical maturity, they were now marrying 10 to 12 years after achieving the capacity for reproduction. One effect of this dilemma, the guide notes, is that more than 75% of young women began sexual activity before marriage and approximately 50% of them had had sexual coitus at least once by the age of 17 years (1987, p.1). It appears, therefore, that earlier reproductive maturation is a contributory factor to earlier sexual activity and unplanned pregnancy in young adolescents.

Another contributory factor to the increased sexual activity amongst adolescents is the decreasing age at which these young people are physically becoming sexually mature. Much of the contemporary literature reports that the age of menarche has decreased progressively over the last few decades, probably because of improved physical health (Koegh, 1988; Langeni, 1988; Nash, 1990). As mentioned earlier in this study, the average age of menarche reported is 12,8 to 13,8 years. Also, the onset of puberty is 18 months earlier for girls than among boys. Van Coeverden de Groot's study of teenagers attending the Cape Town Teenage Clinic, established that more than half the number of girls (roughly 56%) with a menarche at the average age of 12 years or less, had had their first sexual experience by the age of 15 years. Such girls were also found to be at high risk of becoming pregnant (1987, pp.434-438).

Peer-group pressure to engage in sexual coitus is another important factor. Young girls who are usually emotionally involved, tend to be pressurised into experimenting with sexual coitus to demonstrate their maturity.

Adolescents often project images of people who think they "know it all" or are worldly wise and mature. The first experience with coitus is very often unprotected and unpremeditated. Especially "young people, aged 12 to 15 tend to think in terms of the present and rarely consider the future" (a chapter of a book entitled "Sexuality in Adolescence and the Elderly", p.419, source and the date unknown). More importantly, they do not think about nor understand the health risks and grave consequences associated with an adolescent pregnancy and childbearing.

The mass media such as literature, films, television, videos, and rock music also tends to play an important role in propelling the trend towards increasing pre-marital sexual activity. The National Association of State Boards of Education (America), states that children and adolescents are exposed to the media messages which are often irresponsible, and which exploit sexuality (A Guide for State Education Policymakers, 1987, pp.3-4).

It appears, therefore, that the mass media as well as pressure from peer-groups tend to coax the adolescent girl into consenting to sex rather than abstaining from it. Hence the problem of early sexual activity and unplanned pregnancy.

The question arises again: is it the school which should shoulder the responsibility, more than ever before, "to mitigate the damage done to school children from such pervasive and persistent media messages"? (A Guide for State Education Policymakers, 1987, p.4).

2.4.2 Lack of sex education and contraceptive knowledge.

A belief commonly held by writers (Ross, 1979; Sapire, 1986; Mfono, 1989) is that a lack of knowledge and poor communication between parents and their children regarding sex and sexuality, have been identified as the major causes of the problem. Sex education in many schools today is taboo. Despite the fact that there is widespread public support for sex education programmes today, the number of schools actually offering them remains quite low. Evidence from two national surveys in America, for example, as reported by Orr (1982), indicated that only 36% of public schools in America offered some programmes (cited in Meikle, 1984, p.125). An explanation given for

this discrepancy was the fact that opponents of sex education in many communities were successful in mounting campaigns to block sex education programmes (Meikle, 1984, p.125).

In the vast number of South African schools sex education and advice about contraception for those teenagers who wish to contracept is inadequate. Teenagers therefore do not appear to know nor to understand the facts about the menstrual cycle and contraception. In some schools basic physiology and anatomy of reproduction are taught (Botha, 1986, pp.92-96). Teaching about human sexuality which involves "the whole person, his relationships and behaviour within the context of family, societal, cultural and religious values", or about birth control, is much less available (Sex Education Update, 1990, pp.1-3). Since many teenagers appear to be uninformed about the "facts of life" and about contraception, they often obtain most of their information (and misinformation) from their peers and the media (Rogers, 1974; Ross, 1979; Sapire, 1986). Parents, the school and health professionals appear to contribute sex information only minimally. In the absence of correct information from parents or the school, there is, therefore, an urgent need to introduce sex education in schools to provide adolescents with timely and accurate information as well as skills which will enable them to make informed and responsible decisions regarding their sexuality in a rapidly changing society.

Young adolescent girls, today, tend to hold many false beliefs regarding the consequences of their behaviour. According to The Johannesburg Child Welfare Society Report, the most common myths that abound are : "You can't catch a pregnancy because you are too young"; or "You can't get pregnant because it is the wrong time of the month"; or "...if you have it occasionally" or "...if you have sex standing up". Yet others have mistaken notions that "everyone's doing it so why can't I?" or "it is the answer to loneliness and the way to get love and attention" (1989, pp.3-4). Koegh notes that "adolescents find it difficult to understand the likelihood of pregnancy following intercourse, and may need time to link information received, and the results of behaviour" (1988, p.30). It appears that there are also many teenagers who know that they can fall pregnant, but nevertheless choose to take the risk.

2.4.3 Psychological factors.

The broad body of literature reports that certain psychological factors were also responsible for adolescent pregnancies (Schiller, 1977; Swart, 1986; Parker 1987). Because of emotional insecurity, boredom, lack of meaning and fulfilment, poor scholastic achievement, resentment of parental authority or authority in general, adolescent girls often "lacked the necessary responsibility for their own actions, and attempted to use pregnancy as a desperate plea for help" (Koegh, 1988, p.31). Young girls sometimes see pregnancy as solving a problem in their lives. They may, for example, see pregnancy as a way of hurting or spiting parents, of proving that they are feminine and womanly, or of exploring the "Sterility Fantasy" (did not fall pregnant the first time and want to test out whether they can; The Johannesburg Child Welfare Report, 1989, pp.6-7), or they may need to have babies as playthings to compensate for emotionally deprived childhoods.

2.5 CONSEQUENCES AND IMPLICATIONS

Schoolgirl pregnancies may have devastating effects on the life chances of the young mothers as well as their offspring. Much of the research evidence on the subject tends to document the adverse personal, medical, social psychological and economic consequences of such pregnancies. For example, Dr Jannice Rossouw, chief director of Family Planning in South Africa, notes that "Teen pregnancies impose lasting hardships on at least two generations - the teenage parents and their children" (quoted in Oxford, 1987, page unnumbered).

2.5.1 Educational and career consequences.

Card and Wise (1991) also agree that "pregnant schoolgirls are more likely to leave high school, even when compared with girls of similar socio-economic backgrounds and academic aptitude who postpone early childbearing" (cited in Furstenberg *et al*, 1989, p.315). A National Research Council report in America cites that a few of the most obvious and immediate personal costs of schoolgirl pregnancies such as "discontinued educations, reduced employment opportunities, unstable marriages (if they occur at all), low incomes and heightened health and developmental risks to the children...

sustained poverty, frustration and hopelessness are all too often the long-range outcomes" (quoted in Dickman and Gordon, 1988, p.4). According to an American study, only half the number of girls who give birth before the age of 18 complete high school as compared with 96% of those who postpone their first pregnancy (Wallis, 1985, p.2).

2.5.2 Physical consequences.

Irresponsible teenage sexuality may lead to emotional, health and sexual problems. And if it results in pregnancy, it may have serious health risks for the young mother and her child (Parker, 1987, p.121). These pregnancies often result in tragic choices. The girl has several alternatives to consider: abortion, getting married, living alone, living with parents and adoption. In South Africa abortion is not usually an option as it can only be obtained legally if the pregnancy is found to be a severe threat to the mother's life. In America, studies report that "just below 50% of pregnant teens choose birth, 30% terminate their pregnancies with abortions" and the remainder suffer miscarriages and other mishaps (A Guide for State Education Policymakers, 1987, p.4). Medical evidence, generally, seems to demonstrate several physical and health disadvantages for both the adolescent mother and child (Prinsloo, 1984; Wharton, 1989; Nash, 1990). Since abortions on demand are illegal in South Africa, many "backstreet" abortions do occur. Although there are no reliable statistics on this, the number of girls admitted to hospitals with complications from these abortions shows that it is a problem that often results in death, infertility and disease. Thus, Rockey (1986), points out that "pregnant teenagers [do] constitute a high-risk group in obstetric practice" (p.16).

A Service Report of the Planned Parenthood Federation of America states that "the younger the adolescent [girl], the more likely she will suffer medical complications of pregnancy, such as toxæmia and eclampsia [convulsion that may lead to death]" (The Planned Parenthood Federation of America (PPFA) Service Report, 1986, p.4). Childbirth, too, may present greater risks to younger mothers. A study by Ross (1979) on teenage pregnancies and perinatal care, shows that childbirth was most risky in adolescent girls below 15 years of age (cited in Prinsloo, 1984, p.699). For those girls who are "under the age of 15 years, the maternal death rate is

two and a half times that of mothers aged 20-24 years" (PPFA Service Report, 1986, p.4).

2.5.3 Psychological consequences.

Studies show that unintended pregnancies can have serious psychological effects on the young schoolgirls. Langeni (1988), for example, states that pregnant girls may experience shock at learning that they are pregnant, emotional problems in having to deal with unwanted pregnancies, and depression as they may be ostracised by their families, friends and boyfriends (p.3). This situation often causes life-long trauma for these girls. De Barros writes, "Not only does teenage pregnancy result in unwanted children, early unstable marriages and family stress, it also has a direct link to teenage suicide and abortions" (a South African article entitled "When Children Have Children", page unnumbered and source unknown). In a recent study on the teenage pregnancy crisis in the Republic of Ciskei, Gubuza observed that although most pregnant girls were compelled to leave school, many remained at school until the *height of fundus* was clearly visible even to other pupils (1989, p.3). This caused much embarrassment to classmates as well as to themselves as they laboured to adjust to the profound changes taking place in their bodies.

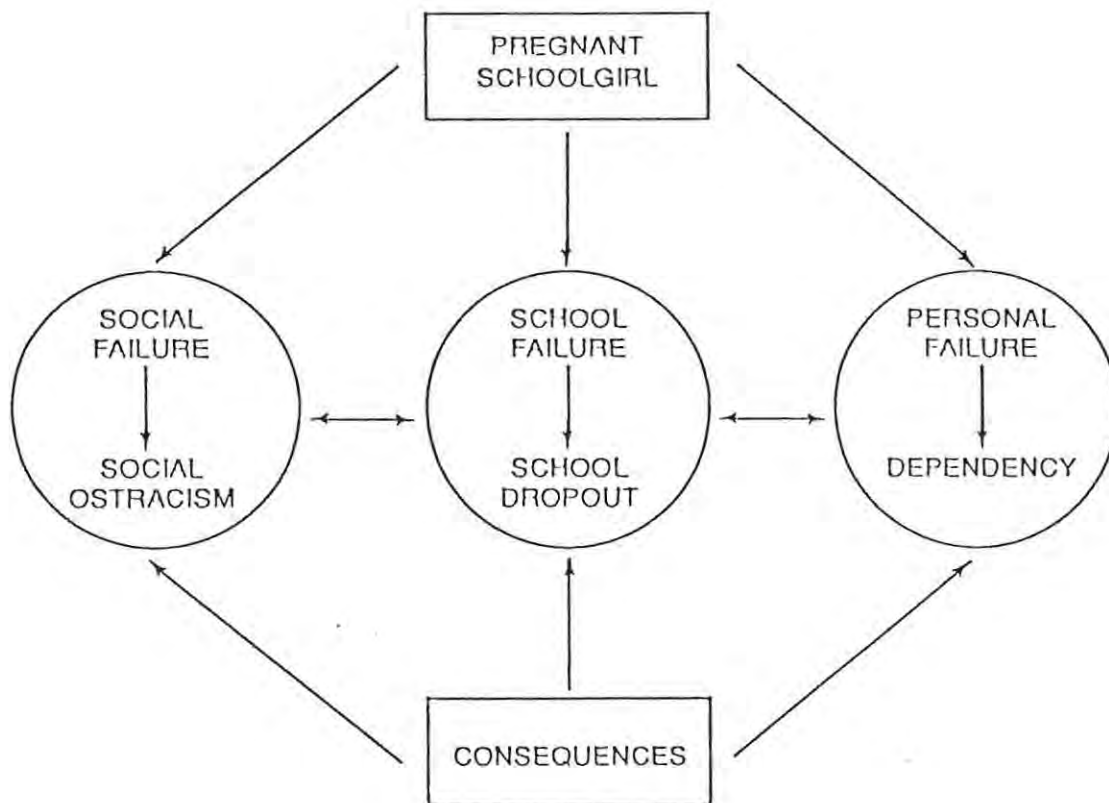
Bolton (1981) agrees that schoolgirl pregnancies may lead to despair, depression and suicidal attempts, and reports that "the suicide rate for pregnant teenagers [in America] is 10 times that of the general population" (pp.977-986). In addition, such girls who leave school tend to become resentful of their lost freedom and isolation from their friends who are at school.

2.5.4 Social consequences.

Many social problems arise for the pregnant schoolgirls and their children. Often their parents, the school, the church, and the community react with shock, anger and distress when learning about their pregnancies (Preston-Whyte *et al*, 1988, pp.1-6). The unfortunate teenagers, are faced with the "social stigma, guilt and public disapproval associated with illegitimacy" (Prinsloo, 1984, p.697). These schoolgirls are thus faced with

"social failure, school failure and personal failure" (Kalafatich, 1975, p.33). See Fig. 3 below which illustrates the three spheres of failures.

FIGURE 3: Three spheres of failure impact upon the pregnant schoolgirl.



Source : Kalafatich A J, 1975, Approaches to the Care of Adolescents, p.33.

Schiller, (1977), after collecting massive data in her study concerning the social consequences of adolescent pregnancies, noted that her findings generally supported the assumptions of other researchers. These were that adolescent mothers perceived their unwanted children to be "accidentally born", that adolescent family life was often fraught with financial, social and interpersonal problems, that unfinished secondary education was common, and social welfare dependency was widespread (pp.72-73). For these young mothers it is the beginning of "a vicious, self-perpetuating poverty cycle - a life of social dependency, lack of proper education, lack of social progress and little hope for anything better" (Norton and Bernstein, 1985, p.14).

2.5.5 Economic consequences.

Not only do schoolgirl pregnancies and births have adverse social consequences, they also have serious economic consequences. Evidence abounds that girls who become parents early in life, complete fewer years of schooling, have lower incomes, experience less job satisfaction, have fewer opportunities for job advancement, and are more inclined to abuse their children than those who postpone pregnancy until they are in their 20's (Pittman, 1986). Furstenberg *et al* make it clear that "early childbearing is a potent predictor of long-term welfare dependency" (1989, p.315). Their research also points strongly to the fact that early childbearing ultimately affected a woman's (and her children's) prospects of economic success as well as stable marriages in later life (1989, p.315).

There is surprisingly little research on the life course of children of teenage mothers. As a result, a limited amount of evidence has been marshalled to demonstrate the proposition that early childbearing in teenagers adversely affects the well-being of their offspring. However, the strongest empirical evidence in the literature points to the fact that teenage mothers were generally more likely to be economically disadvantaged, and their offspring were likely to grow up in disadvantaged neighbourhoods" (Furstenberg *et al*, 1989, p.316).

2.6 DIFFERING PERCEPTIONS ABOUT SEX EDUCATION

A review of the literature shows that the controversy over providing sex education (or sexuality education/education for sexual responsibility/family life education, as such instruction is now often called) in schools goes back to the 1960's and has not completely abated (Rogers, 1974; Zelnik and Kim, 1982; Jervis, 1987).

During the last decade, though, there have been growing signs worldwide among communities and their school systems of widespread support for sex education in schools. However, communities and their school systems differ in size, sophistication, and readiness to accept and implement sex education courses. Not only are there regional differences but also differences in the degree and kind of co-operation between a community and its school in terms of support for sex education programmes (Rogers, 1974, p.46).

According to Rogers, the most cogent reason for supporting school-based sex education appears to be "the manifest, appalling failure on the part of our culture as a whole to handle sex in a healthy manner, and on the part of the great majority of families to give their children a sound basis and adequate preparation for their sexuality..." (1974, p.29). In recent years, however, major arguments have been raging about the extent to which schools should be responsible for sex education. The question that is frequently asked is: Should sex education be primarily the responsibility of the school or should parents be the main influences on their children's views on the subject of sex?

2.6.1 Arguments for sex education.

The current high level of teenage sexual activity and pregnancy has resulted in many respected national health organisations, worldwide, expressing their support for school-based sex education (Pittman, 1987, pp.1-15). Parents and communities too have had to consider or reconsider providing sex education through the schools. One of the major arguments for sex education in schools is that many parents are unable to discuss sex with their children, either due to embarrassment, or because they believe that their children should not

be exposed to such matters. This argument is supported by Rogers (1974, p.30):

Many parents, even the best of parents, feel incompetent and inadequate. They feel ill prepared, factually or emotionally or both, to teach about sexual development, sex relations, and reproduction, with all their psychological, social, and ethical implications and consequences.

Proponents argue that sex education is necessary and worthwhile for a number of reasons (Botha, 1986; Jervis, 1987; Dickman and Gordon, 1988). They claim that there is a need to correct much of the misinformation about sexual matters learned within the peer group. Young people must have access to "clear, consistent and up-to-date information, simply presented and unaffected by prejudice", about the pleasures and pitfalls of all aspects of human relationships including sex (Armstrong, 1990, p.5). They argue that this will enable them to make responsible decisions, to the benefit of themselves and of others.

2.6.2 Arguments against sex education.

The institution of sex education courses in primary and secondary schools has been attacked on many grounds. It seems that the negative connotations associated with what has traditionally been termed "sex education" have been responsible in the past for most of the opposition to its introduction. According to Zelnik and Kim, opponents charge that "sex education gives license to immorality and is responsible for increasing sexual activity, pregnancy and abortion " among teenagers (1982, p.117). On the other hand proponents argue that there is no empirical proof for such accusations. "The argument that sex education *per se* in public schools is emotionally damaging to boys and girls has not been substantiated" (Rogers, 1974, p.35). In fact, it is believed that sex education does indeed reduce the rate of pregnancy by promoting more effective contraceptive practice (Marsiglio and Mott, 1986, p.131). Some tend to misconstrue the term "sex education" to mean a singular focus on the physical sex act and fear that it will encourage sexual experimentation among young people.

Most related studies, however, appear to indicate that the majority of parents/adults approve of sex education instruction in schools (Schiller, 1977; Marsiglio and Mott, 1986; Nash, 1990).

2.7 CURRENT APPROACHES TOWARDS THE TEACHING OF SEX EDUCATION IN SOUTH AFRICAN SCHOOLS

The Human Sciences Research Council Report (July 1981) on the practice of school guidance in South Africa, reveals definite shortcomings with regard to the provision of sex education or family life education in school classrooms. Annexure 1 (pp.146-150) of this report, which entails an analysis of school guidance syllabi for standard 5-10 for the White, Coloured and Black education departments in South Africa, reveals that emphasis is placed on four major components, namely, "Personal Development", "The pupil as a member of a family and of society", "The pupil and his education", and "The pupil and his career" with the exclusion of components or topics for the teaching of sex education.

No official policy towards sex education has been put forward by the White, Coloured, Black and Asian Education Departments (Correspondence B2, Appendix B). It appears that because of the relatively sensitive and taboo nature of the subject, as well as the language, religious and cultural diversity of the major population groups in South Africa, education departments tend to shy away from adopting a definite policy on the practice of sex education in schools.

The author's experience is that, despite the official silence on the subject, many school guidance teachers are offering sex education in their classes without the official approval of their respective departments. Some such teachers even claim that their superiors quietly support them, although not entitled to say anything official. These cases are, however, in the minority, and the vast majority of schoolchildren are probably not receiving any such education.

Some other disciplines do offer lessons on basic physiology and anatomy of reproduction (Botha, 1986, pp.92-96).

Because of certain shortcomings, the absence of properly structured sex education curricula, and possibly the lack of preparation of qualified teachers, when sex education is offered it is generally run by outside family planning agencies or clinics and health care personnel (Correspondence B3, Appendix B).

In recent years, due to the escalation in the numbers of school pregnancy cases countrywide, only two education departments in particular have taken bold steps in an attempt to remedy the problem. These are the Department of Education and Culture (Coloured Education) and the Department of Education and Training (Black Education) (Correspondence B2, and B7, Appendix B).

During the period 1980 to 1983 the Coloured Education Department commissioned the HSRC to conduct a survey on the feasibility of introducing sex education in Coloured schools. As late as 1990, the said department forwarded the proposed syllabus (entitled "Family Guidance", which includes sex education) to the Head Office of the Department of National Health in Pretoria for comment and approval (Pilot Programme for Family Guidance, Department of Education and Culture, 1987, pp.1-23, Appendix F). To date no official syllabi have been implemented. The Department of Education and Culture reports that official syllabi under the title "Core Programme for Family Guidance", will be implemented countrywide in Coloured schools in 1992 or soon thereafter.

Similarly, the Department of Education and Training (DET) commissioned the Department of National Health to undertake a pilot study on the desirability of its Family Planning division to do adolescent sexuality education in DET schools on an on-going basis. The findings of this pilot study reveal that the programme was widely supported by schools, pupils and parents in general (Bam, 1989, pp.33-36).

In the Cape Education Department it is believed that the School Programme for Adolescents by the youth education personnel of the Cape Provincial Administration Hospital and Health Services is supported. The programme is popular as it is based on the principles of "self-knowledge, value clarification, responsibility, improved communication and the need for further education and training in modern society" (Cape Provincial

Administration Hospital and Health Services's School Programme for Adolescents, 1989, pp.1-3).

At present the Orange Free State Education Department has formulated a family counselling programme similar to the Cape Province model. In the Natal Education Department little sex education is offered as part of a family guidance programme, as its policy "falls rather strictly within a Christian National context, in terms of what is proper and decent." (Botha, 1986, p.94).

The Transvaal Education Department, apparently, is perceived by health organisations as being least responsive to the need for sex education in its schools (Botha, 1986, p.96).

2.8 PREVENTION PROGRAMMES AND EVALUATION

A range of prevention programmes aimed at reducing pregnancy in school-age children and ameliorating its adverse effects, have emerged in the developed countries of the world and in South Africa in the decade of the eighties. Some of these will be looked at in outline and briefly evaluated in terms of their efficacy.

2.8.1 Attempts to resolve the problem abroad.

The problem of teenage pregnancies has attracted the attention of western nations for over a decade. The Alan Guttmacher Institute's research studies on the problem, the Louis Harris Poll of 1985 and the efforts of the Children's Defence Fund have brought pressure to bear on the United States of America and other developed countries in the world to take ameliorative action (Pittman, 1987, pp.1-15).

As a result a vast number of prevention programmes, ameliorative services and initiatives have emerged in recent years to combat the growing problem. These range from community outreach programmes to school-based, clinic-based and hospital-based health care programmes. The "Teen Choice Community Outreach Programme (New York)", a unique "on-site" programme for boys and girls in public schools, has met with reasonable success in the reduction

of teenage pregnancies (Summary Report for the Fall 1986 - Spring 1987 School Year, pp.1-13).

The "OCTOPUS" (Open Communication regarding Teens Or Parents Understanding Sexuality) programme, developed in Illinois, is well supported by parents and teenagers as the programme draws on "a community networking approach to involve the family and church with social services and public health to foster a sense of community-wide responsibility for teenage pregnancy prevention" (Isberner, 1988, p.10). Programme goals include "enhancement of self-esteem, clarification of personal values, increased self-reflection and assertiveness" (Summary Report for the Fall 1986 - Spring 1987 School Year, p.4). It is believed that, generally, the programme helps parents take an active role in teaching teenagers responsible behaviour through abstinence and responsible decision-making regarding sexual relations.

One of the more promising new model programmes is the well-designed, age-appropriate, and carefully evaluated "Georgia Social Inoculation Model". This model is fundamentally based on the principle of "Postponing Sexual Involvement, [and] the concept of 'immunisation' as a strategy for combating social and peer pressures toward negative health behaviours" (Howard, 1988, pp.3-6). It has yielded encouraging results in the reduction of early sexual activity and premature pregnancies in Georgia's schools, and is widely accepted by the public.

Similar to the above programme is the "Cooperative School/Hospital Education Programme" of the Grady Memorial Hospital in Atlanta, Georgia. Recent data indicates that the programme, implemented since 1983 with 18,000 eighth grade (std 6 in South Africa) youth, has been successful in assisting 13 and 14 year old girls in delaying first intercourse and thus preventing premature pregnancy (Health Education for Young Teens - Grady Memorial Hospital, 1988, pp.2-5).

Another popular programme is the "St. Paul Maternal and Child Health Programme", now known as Healthstart, of Minnesota. It is a basic high school clinic model which provides essential health services to adolescents within the school setting. One of its chief goals is "the reduction of adolescent pregnancy through appropriate and primary prevention counselling

involving a multi-disciplinary team of professional staff [health caring personnel]" (St. Paul School-Based Clinics - A Programme of Healthstart, 1989, pp.4-5).

According to Furstenberg *et al*, prevention programmes abroad have typically taken on the task of "educating teens about sexuality and contraception; changing attitudes (saying "No") about early sexual involvement; and providing contraceptive and family planning services" (1989, p.317). These authors believe that, in general, these prevention efforts have been limited in their success and difficult to evaluate because they are relatively new, recent and innovative. Also, as the range of services is still in an experimental phase, most of the assessments of these programmes appear to be impressionistic, and their real impact has yet to be evaluated.

Another problem is that "unlike Western Europe, contraceptive services are not uniformly available to teens in the United States" (Jones, Forrest, Goldman, Henshaw, Lincoln, Rosoff, Westoff and Wulf, 1985, pp.53-63).

2.8.2 Attempts to resolve the problem in South Africa.

There is mounting evidence from national surveys conducted by the HSRC and the Department of National Health, to suggest that many education departments are failing in their duty to provide school children with sex education programmes, family life guidance and educational counselling services (Botha, 1986, pp.92-96). Thus, in recent years, there has been a barrage of press reports (see Appendix G for examples of press reports) which have highlighted the call and need for the urgent institution of sex education programmes in South African public schools.

One report clearly states that a "lack of sex guidance in schools [is] blamed [for] schoolgirl pregnancies and backstreet abortions in South Africa" (Sunday Times, 11 August 1985, page unnumbered). Another article quotes that "All government education departments should investigate and set

up a balanced, responsible, co-ordinated programme of sex education, commencing in primary school" (emphasis added; Star, L.R., 18 June 1987, page unnumbered). Yet a third article entitled "A peek into teenage sexuality" reports that "one in five SA schoolgirls falls pregnant" each year, and that South African schools needed to look at the question of providing programmes which offered "practical life skills and contraceptive information" to youth (Sunday Tribune, 25 November 1990, p.2).

In the light of these circumstances, in the past few years (1985-1990), community health agencies and organisations such as FAMSA, Youth Education Centres, (C.P.A.), City Health Departments, Family Planning components of the Hospitals and Health Services, The Planned Parenthood Association of Southern Africa (Western Cape Region), as well as Women's Organisations of the Council for Population Development (Pretoria), have attempted to address the problem through a comprehensive focus on the teenagers, the role of the parents and the whole community (Correspondence B8, Appendix B).

Because of the apparent lack of sex education programmes at school and inadequate or little parental guidance in the home, these organisations have intensified their efforts to address the problem through providing services for the total health care needs (including contraception) of teenagers. Examples of some of these programmes which extend to include preventative measures against pregnancy, and family planning, are "The Adolescent Sexuality Education Programme" and "The National Family Planning Programme" of the Department of National Health and Population Development, the "School Programme for Adolescents" (C.P.A. Hospital and Health Services), the "Education for Living" and "Education for Adulthood" programmes of FAMSA, the "Educational Programme for Sexual Responsibility" as part of the Youth Education Programme (1990-1991) of the Planned Parenthood Association of Southern Africa (see Appendix F for a sample copy of one of the above programmes).

Although most of the above programmes appear to be welcomed by the wider community and even education departments, critics charge that the programmes have minimal impact on reducing the numbers of schoolgirl pregnancies. The recent findings of "The Soshanguve Pilot Study in Adolescent Education" on the desirability of implementing sex education in schools, suggest that the

major reason for many of these "outside" programmes failing, is the lack of co-ordination amongst these organisations/agencies and the schools (Bam, 1989, p.38). The lack of co-ordination appears to be compounded by the fact that a maze of education departmental rules and regulations apply when such programmes are offered on an *ad hoc* basis.

It appears therefore that education departments will need to establish a community networking approach with these health organisations and agencies whose vital role is necessary in assisting schools to control fertility rates in their school populations.

2.9 CONCLUSION

A review of pertinent literature reveals a dearth of information specifically on schoolgirl pregnancies. While it was appreciated that previous studies had generated valuable insights into the problem of teenage pregnancies, a closer examination reveals that relatively few had included precise information on how schools might proceed with their prevention.

Despite the apparent lack of practical literature, the search for related literature was invaluable to the author as it enabled him to define the frontiers of his proposed field study, and to conceptualise a specific framework needed for reporting his findings.

CHAPTER THREE

METHODOLOGY

- 3.1 The Design of the Study
- 3.2 The Questionnaire as the Research Instrument
- 3.3 The Sample and Sampling Procedures
- 3.4 Administration of the Research Questionnaire
- 3.5 Analysis of Data
- 3.6 Conclusion

CHAPTER THREE

METHODOLOGY

3.1 THE DESIGN OF THE STUDY

In the present study an attempt was made to explore and describe the problem of schoolgirl pregnancies with emphasis on the role the school can play in their prevention. Being both an explorative and descriptive investigation in nature, the basic aim was to determine the views and attitudes of a broad spectrum of subjects.

Black and Champion express the belief that "exploratory research has one of its chief merits the discovery of potentially significant factors that may be assessed in great detail and depth ..." (1976, p.78). Descriptive research, on the other hand, Ary (1979) maintains,

... describes and interprets what is. It is concerned with conditions or relationships that exist; practices that prevail; beliefs, points of view, or attitudes that are held; processes that are going on; effects that are being felt; or trends that are developing. Its major purpose is to tell what is.

(p.25)

Pre-research planning and research activities were thoughtfully conceived early in 1988 from brief exploratory visits to and consultations with representatives of community health care personnel and agencies that work closely with adolescent youth. The visits were arranged with the following institutions and professional organisations:

- (i) Community Psychiatric Services : Cape Provincial Administration.
- (ii) Community Social Workers : Department of Education and Culture (Administration : House of Representatives).
- (iii) Department of National Health : Family Planning Section.
- (iv) East London Child and Family Welfare Society.
- (v) FAMSA (Family and Marital Association of S.A.)
- (vi) Frere Maternity Hospital : Family Planning Clinic.

- (vii) Gynaecologists : East London Medical Centre.
- (viii) School Clinic : Cape Education Department.
- (ix) School Nursing Services : Department of Education and Culture
(Administration : House of Representatives).
- (x) Youth Centre : Family Planning Clinic.

The major purposes of these exploratory visits were to elicit interest in the author's subject of study and to discover what aspects of the subject and related issues the author might feasibly research. The discussions ranged from typical concerns about adolescent pregnancies to serious decision-making questions. An intuitive grasp of the nature, purpose and scope of the study was gained after an analysis of an extensive information profile embracing the range of issues to be addressed. The valuable input from these initial exploratory visits generated tentative hypotheses and generalisations. Thereafter a review of the pertinent literature guided and shaped the hypotheses in final formulation.

3.2 THE QUESTIONNAIRE AS THE RESEARCH INSTRUMENT

In this study, an anonymous, self-administered structured questionnaire constituted the main focus of the investigation for the specific purpose of obtaining the relevant data.

A number of practical considerations led to the decision to conduct a questionnaire-based study in place of an interview-based one:

1. Because of the sensitive nature of the topic and subject matter, the author was of the opinion that the school authorities would not grant permission to conduct individual interviews.
2. The nature and size of the sample sought made it impractical to conduct an interview-based study, as it would have been too time consuming.
3. The research questionnaire allows subjects to express themselves in writing and this was deemed appropriate in the present context of clarifying ideas, views, opinions, attitudes and values pertaining to a complex problem.
4. It was anticipated that the anonymous and confidential nature of the

questionnaire would ensure a greater number of valid answers by the respondents. Sorensen (1973) confirms that "the questionnaire is preferable since it avoids the embarrassment of direct questioning and so enhances the validity of the responses" (cited in Dreyer, 1980, p.18).

5. "A questionnaire", writes Lovell and Lawson, (1970, p.86), "has the advantage of applying certain restrictions upon a situation [as] it asks specific questions which call for specific answers; these answers can be classified; the information contained in the responses can be quantified." The questionnaire, would have the distinct advantage of providing information quickly, and in precise form for the purposes of the present investigation.
6. The structured questionnaire is an accepted tool in various disciplines, and would meet both the theoretical and practical requirements of the present investigation within the accepted boundaries of reliability and validity.

Before the research instrument was employed in the research process, the author was clear as to the basic assumptions and limitations underlying its use. Rochford, in the University of Cape Town's Manual for Students on Research Methods for Higher Degrees, emphasises that "because the field of education [and research] is so complex, vast, unstable, diverse and multi-disciplinary, there is no one basic methodology which can reveal all the truth that is to be known." (emphasis added; 1983, p.39).

Further, Cohen and Manion (1989, p.106) express the view that "an ideal questionnaire is unambiguous and uniformly workable. Its design must minimise potential errors from respondents and coders. And since people's participation in surveys is voluntary, a questionnaire has to help in engaging their interest, encouraging their co-operation, and eliciting answers as close as possible to the truth".

The selection and ordering of questions/statements was deemed to be of paramount importance. As Lovell and Lawson write, "presenting respondents with carefully selected and ordered questions is the only practical way to elicit the data required to confirm or disconfirm a hypothesis" (1970, p.32). For this reason the questionnaire comprised a series of questions in

which their order, number and grouping were carefully considered. In the compilation of the research instrument, basically the following techniques were used:

- (i) The closed form technique
- (ii) The fixed alternative or forced-choice technique
- (iii) The multiple-choice technique
- (iv) The omnibus technique
- (v) The self-report technique (embracing the Open-Ended Essay)

A simple, coded, predominantly forced-choice questionnaire comprising six sections was constructed. For the sake of brevity the questions and statements were limited to 64 items (see Appendix H for complete details of the Research Questionnaire). The content and format of the questionnaire were guided and shaped by an in-depth study of the related literature (Craig and Richter-Strydom, 1982; Olivier, 1987).

It was envisaged that the design of the questionnaire would permit a systematic assessment of the wide range of issues to be addressed.

In Section A general personal information was asked. The demographic variables were kept to a minimum in order that the request to complete the questionnaire might be viewed as less of an intrusion. Biographical information (Questions 1-6) on sex, date of birth, home language, present occupational status and religious group was obtained.

Section B (Questions 7-12) was intended to elicit views on the current nature and description of the problem of schoolgirl pregnancies.

Section C, entailing a combined Sexual Knowledge Questionnaire (SKQ) and Reproductive Physiology Questionnaire (RPQ), (Questions 13-20), aimed at determining the respondents' views on the sexual activity of adolescent schoolgirls as well as the latter's knowledge of conception.

In Section D, entailing the Sexual Knowledge Questionnaire (SKQ), (Questions 21-38), the major concern was to tap baseline data on the young adolescent girls' education, attitudes to pre-marital sex and sexual experience.

Section E, entailing the Contraceptive Knowledge Questionnaire (CKQ), (Questions 39-53), was designed to explore the respondents' views, ideas and values on young schoolgirls' knowledge, attitudes and practices with respect to contraception.

Sections C, D and E were of particular importance for understanding the predisposing factors to pregnancy.

In Section F, (Questions 54-63), an attempt was made to tap the respondents' views, suggestions and proposals for pregnancy prevention strategies in context of the school.

The Open-Ended Essay, (Question 64, a separate self-report section embedded within the structure of Section F), which constituted a major focus in the investigation, considerably widened the scope to allow the subjects to formulate their own ideas and hypotheses about possible solutions to the problem of schoolgirl pregnancies.

As Konopka (1976, p.4) emphasises, "the open-ended question allows the informant's own frame of reference to shine through rather than imposing one upon her *apriori*" (p.4). This section would permit the subjects to articulate their own perceptions and understanding of the problem. In essence this section shifted the emphasis to encompass the broader field of prevention.

On the whole the questionnaire can be seen to be well-balanced as it includes a reasonable number of techniques to explore the specific parameters of the subject matter and to illuminate the subject under enquiry in different ways.

Six core sections included a total of 64 questions which were considered to be the optimum number necessary. As far as possible the questions/statements were grouped according to the topic. It was anticipated that such a structure would facilitate the analysis and presentation of the findings, and preserve the 'gestalt' of the research design. All questions in the six sections were scored using a pre-determined key drawn on the basis of current literature. Respondents were required to place a cross (x) in the

appropriate block in the key. Also, the number of non-respondents to any particular question could be readily reflected in the analysis of the data.

Full-scale research activities focusing on data collection, were thus initiated through the administration of the above structured questionnaire between 1988-89. During the second quarter of 1990, research efforts centred on data analysis and the beginning of substantive and methodological findings. At the end of 1990, research activities involved continuing data analysis of the open-ended essays and working on the findings of the present study.

3.3 THE SAMPLE AND SAMPLING PROCEDURES

The main aim of this study is to explore the understanding and attitudes of a broad spectrum of those connected to the problem of schoolgirl pregnancies. The sample was thus chosen so as to represent these particular constituencies.

As the focus of the study is schoolgirls it is clear that one of the subject groupings must be schoolgirls themselves. Furthermore, it was important to include a number of actual schoolgirl pregnancy cases in this sample. Those most closely linked to these girls and thus with any pregnancies which might result, are the parents. Parents of both sets of schoolgirls were therefore included. A number of professional members of the community are often involved in cases of schoolgirl pregnancies and so were thought to be important sources of information. These included secondary school teachers, the clergy and health care personnel. No doubt there are also others who are also associated with the problem, but the nature of this study limited the number of subjects to be included.

In order to be statistically respectable, 30 subjects were chosen for each of the sample groups. Firstly, the 30 "ordinary" schoolgirls were selected from the secondary school where the author teaches. Senior schoolgirls were chosen as they comprised part of the age group most at risk and, importantly, they were considered to be more able to respond with maturity and clarity than would juniors. Because of the sensitive nature of this study, it was decided to make pupil participation entirely voluntary. The

school authorities also felt that this would prevent any potential parental objections. The broad outline of the study was explained to Std 8, 9 and 10 girls, and volunteers were invited to participate in completing the questionnaire. The first ten volunteers from each standard were accepted as subjects. This manner of selection has some important implications which need to be borne in mind in interpreting the data later. Do these 30 girls represent the Std 8, 9 and 10 girls at this school? This is debatable for, strictly speaking, they were not chosen randomly. Volunteers probably tend to have particular characteristics which distinguish them from their non-volunteering counterparts, and the subject nature of this particular study may have a special influence on this aspect.

A group of 30 primigravid ex-schoolgirls (schoolgirls who fell pregnant while at school) were randomly selected from a list of such pupils who had been at the author's school. Three of these subjects, however, refused to participate in the study.

It was both convenient and possibly of research interest to choose parents of the girls included in the sample. It was obviously appropriate to involve parents of teenage schoolgirls, and convenient to choose those whose daughters had already expressed a willingness to participate in the study. The parents of the three unmarried mothers who refused to participate, also declined to complete the questionnaire.

Teachers are clearly integrally involved in the lives of pupils, and in particular in any preventative educational programmes which may be envisaged. The teachers involved were volunteers in the same way as the pupils were. Unfortunately, four teachers later withdrew.

Because of their direct involvement with the community and school, and the important role which the church plays in the social and moral lives of its members, the clergy were considered to be an important group to consult. Unfortunately the clergy themselves did not appear to be interested in the issue of schoolgirl pregnancies for only 17 of the 30 approached by the author agreed to be part of the study.

A broad range of health care professionals have an interest and involvement in this problem area, and all 30 consulted by the author proved to be enthusiastic participants. Table 8 details the individuals involved.

TABLE 8: Health Care Professionals.

Clinic Administrators:School Clinic (Cape Education Department).	2
Community Social Workers:Department of Education and Culture.	4
Education Advisers:ITEC (Independent Teachers' Enrichment Centre).	2
Family Planning Personnel/Clinicians:Youth Centre.	3
Gynaecologists:E.L. Medical Centre.	2
Medical Doctors (Private).	1
Nurses:Frere Hospital.	6
Nurse-Clinicians:Frere Maternity Hospital (Family Planning Clinic).	2
Psychiatric Nurses:Community Psychiatric Services.	2
School Nurses:School Nursing Services (Department of Education and Culture).	1
Social Workers:E.L. Child and Family Welfare Society.	1
Social Workers:FAMSA.	1
Teacher Psychologists (Author's School.)	1
Youth Education Advisers:Department of National Health (Family Planning Section).	2
TOTAL	30

All pupils, ex-pupils and parents were Coloured, while teachers, clergy and health care professionals were a mixture of White, Coloured, Black and Asian.

In summary, 187 of the envisaged 210 subjects (see Table 9 below) participated in the study, which amounts to an 89% response rate. This can be considered an excellent return for any response rate above 80% is deemed to be extremely good (Best and Kahn, 1987; Kaschula, 1987).

TABLE 9: Constitution of the Final Sample.

GROUP 1 : Senior Schoolgirls	30
GROUP 2 : Ex-Schoolgirl Pregancy Cases	27
GROUP 3 : Parents of Group 1	30
GROUP 4 : Parents of Group 2	27
GROUP 5 : School Teachers	26
GROUP 6 : Clergy Members	17
GROUP 7 : Health Care Professionals	30
TOTAL	187

3.4 ADMINISTRATION OF THE RESEARCH QUESTIONNAIRE

A total of 210 questionnaires (formulated in both English and Afrikaans) were self-administered to the total sample in the final quarter of 1988 and in the first quarter of 1989 (see Appendix H and Appendix I for a copy of the questionnaire and covering letter respectively). This procedure had the advantage of affording the author an opportunity to establish rapport and explain the purpose of the study.

In the case of the schoolgirls the questionnaires were group-administered in the presence of the resident head of department of Guidance. The instructions printed on the front cover of the questionnaire were read out and explained to the subjects. The author told the girls that, "The questionnaire is part of a research study. I hope to make certain suggestions from your answers. When you have completed your questionnaire together with your comments/ideas on the last page, please put up your hand and I will collect your responses".

They were urged to be open, honest and frank about their answers, and to offer as much detail as possible in the final open-ended essay. The confidential and anonymous nature of the questionnaire and their responses was emphasised. All pupils returned their completed questionnaires and were thanked for participating voluntarily in the research.

Similar instructions and rules also applied to the remaining six groups in the sample surveyed outside the school. Mutually suitable times were arranged for personal but informal visits to each of the subjects. The questionnaires were self-administered on a Wednesday and collected at the end of the same week. The author made a concerted effort to monitor the progress made by the respondents in filling out the questionnaires. In the case of outstanding questionnaires, a follow-up was staged through a courteous letter of reminder or telephonic reminder.

3.5 ANALYSIS OF DATA

Most responses were recorded in English. The few responses to the questionnaire which were written in Afrikaans were carefully translated into English with the assistance of the head of department of Afrikaans at the author's school.

The 187 completed questionnaires were collected, given assessment numbers and codified according to the subjects' occupational groups, e.g. G1, G2 and so on. The data was then collated and entered on a personal computer. Standard summary statistics, entailing the use of frequency distributions and percentages, were employed in carrying out the analysis for each item in the questionnaire. Thus, a separate table was structured for each of the 64 items respectively in the questionnaire. The results and discussion are presented in the order in which the tables for the 64 items appear in the questionnaire. It needs to be remembered that care must be taken in attempting to make any statistically significant comparisons between particular groups whose numbers are very small (e.g. breakdown of Clergy numbers are too small to be used quantitatively).

From a total of 187 questionnaires collected, 177 brief but fairly comprehensive essays were received. The respondents generally formulated their ideas and descriptions in complete sentences one below the other. In some cases a few brief structured paragraphs were supplied. In other instances point-form commentaries were written.

A few general points need to be emphasised about how the written comments were analysed. The details are as follows:

1. The wealth of information obtained through the open-ended essays was subjected to content analysis.
2. The entire texts for each of the seven respective subject groups were read and re-read in order to formulate certain response categories or themes with a focus on the aims of this study.
3. Once all the essays were read, various "common themes [were] allowed to emerge" (Euvrard, 1987, p.29).
4. The most important groups of themes were summarised in the form of statements which captured "the essence of [the respondents'] expressions", and which either supported or refuted the research hypotheses of this study (Euvrard, 1987, p.29).
5. These were then placed under certain definite categories or headings, itemised as follows:
 - (a) Support for School-Based Sex Education.
 - (b) Parent-Child Communication.
 - (c) Parent-School Partnership.
 - (d) Curricular Content.
 - (e) Contraception and Contraceptive Information.
 - (f) Community Intervention.
 - (g) Moral Education.

(see Appendix J for a record of full responses for the above categories).
6. The next step entailed drawing up a table of responses for each of the seven broad categories. Each table of response in turn contained the consolidated responses for each respective subject group. In all, seven tables of responses were structured.
7. For the purpose of convenience, each respondent in the respective subject groups was given a fictitious first name only, e.g. Clive, John, Ruth and so on.

8. As the majority of comments were given in complete sentences, each sentence was numbered as a line e.g. L1, L5, L9 etc. for the purposes of clarification.

9. Any reference made to a particular line comment would involve an indication of the respondent's name, the particular group to which he/she belongs, together with the relevant line number and the page number of the reference: (For example, Clive G1.L8.180, indicates the line comment of Clive in Group 1, line 8, page 180).

3.6 CONCLUSION

The exploratory investigation which was thorough, although painstaking, proceeded as planned. The replies to the structured questionnaire and the final open-ended essay, suggest that all relevant factors pertaining to the hypotheses had been accounted for. They further suggest that the subjects had shown a keen interest in making their personal contributions towards the study.

In conclusion, the research instrument, on certain levels, succeeded in emphasising two important facets of the investigation: firstly, a global focus for understanding the nature of the problem (through the structured questionnaire); and secondly a specific focus for eliciting comments and ideas for prevention (through the open-ended essay).

CHAPTER FOUR

RESULTS AND DISCUSSION

- 4.1 Biographical Details of the Sample
- 4.2 The Description of the Problem
- 4.3 The Sexual Activity and Knowledge of Conception of Adolescent Schoolgirls
- 4.4 The Education, Attitudes to Pre-Marital Sex and Sexual Experience of Adolescent Schoolgirls
- 4.5 The Knowledge, Attitudes and Practice with respect to Contraception of Adolescent Schoolgirls
- 4.6 The Problem of Schoolgirl Pregnancies and What Can Be Done
- 4.7 The Final Open-Ended Question (Categories/Topics)
 - 4.7.1 Support of School-Based Sex Education
 - 4.7.2 Parent-Child Communication
 - 4.7.3 Parent-School Partnership
 - 4.7.4 Curricular Content
 - 4.7.5 Contraception and Contraceptive Information
 - 4.7.6 Community Intervention
 - 4.7.7 Moral Education
- 4.8 Conclusion

CHAPTER FOUR

RESULTS AND DISCUSSION

In this penultimate chapter, the results follow in the order in which the items appear in the questionnaire, and are discussed accordingly. In this interpretation, the stated aims in Chapter One were carefully borne in mind.

4.1 BIOGRAPHICAL DETAILS OF THE SAMPLE

Gender (Q1)

TABLE 10:

	<u>MALE</u>		<u>FEMALE</u>	
	No	%	No	%
G1 (S) (Schoolgirls)	-	-	30	100
G2 (ES) (Ex-schoolgirls)	-	-	27	100
G3 (P) (Parents of G1)	-	-	30	100
G4 (PES) (Parents of G2)	-	-	27	100
G5 (T) (Teachers)	6	23.1	20	76.9
G6 (C) (Clergy)	14	82	3	17.6
G7 (HCP) (Health Care Professionals)	4	13.3	26	86.7
TOTALS	24	12.8%	163	87.1%
SAMPLE TOTAL = 187				

The total sample was 187 of which the majority of subjects, 163 (87.1%) were female, and 24 (12.8%) were males.

Age (Q2 and Q3)

TABLE 11:

	<u>Mean Age in Years.</u>
G1 (S)	16.9
G2 (ES)	15.4
G3 (P)	43.7
G4 (PES)	47.2
G5 (T)	31.7
G6 (C)	38
G7 (HCP)	36.1

It is interesting to note that the average difference in age between G1(S) and their parents G3(P) is less than that between G2(ES) and their parents G4(PES). Is this 'increased "generation gap" of the latter parent-child relationships at all pertinent to the issue of the characteristics of those schoolgirls who fall pregnant?

Home Language (Q4)

TABLE 12:

	<u>English</u>		<u>Afrikaans</u>		<u>Other</u>	
	No	%	No	%	No	%
G1 (S)	30	100	-	-	-	-
G2 (ES)	24	88.8	3	11.1	-	-
G3 (P)	30	100	-	-	-	-
G4 (PES)	24	88.8	3	11.1	-	-
G5 (T)	24	92.3	2	7.6	-	-
G6 (C)	16	94.1	1	5.8	-	-
G7 (HCP)	30	100	-	-	-	-
TOTALS	178	95.2%	9	4.8%	-	-

Religious Affiliation (Q6)

TABLE 13:

	<u>Catholic</u>		<u>Protestant</u>		<u>Dutch</u>		<u>Other</u>	
	No	%	No	%	<u>Reform</u>		No	%
					No	%		
G1 (S)	10	33.3	11	36.6	-	-	9	30
G2 (ES)	13	48.1	7	25.9	2	7.4	5	18.5
G3 (P)	9	30	11	36.6	1	3.3	9	30
G4 (PES)	8	29.6	9	33.3	6	22.2	4	14.8
G5 (T)	6	23	13	50	2	7.6	5	19.2
G6 (C)	4	23.5	8	47	2	11.7	3	17.6
G7 (HCP)	4	13.3	17	56.6	2	6.6	7	23.3
TOTALS	54	28.8%	76	40.6%	15	8%	42	22.4%

Nearly half of the schoolgirl pregnancy cases are Catholic, a church denomination which has an historical record of being strongly against contraception, whereas only a third of the "ordinary" schoolgirls are Catholic. Is affiliation to the Roman Catholic Church, a significant variable?

Summary Discussion

The sample consists predominantly of English, Christian females, although representing different occupational positions and differing in age.

4.2 THE DESCRIPTION OF THE PROBLEM

Are schoolgirl pregnancies a problem at school? (Q7)

TABLE 14:

	<u>YES</u>		<u>NO</u>		<u>DON'T KNOW</u>		<u>NON-RESPONDENTS</u>	
	No	%	No	%	No	%	No	%
G1 (S)	28	93.3	-	-	2	6.6	-	-
G2 (ES)	23	85.1	1	3.7	3	11.1	-	-
G3 (P)	30	100	-	-	-	-	-	-
G4 (PES)	26	96.2	1	3.7	-	-	-	-
G5 (T)	25	96.1	1	3.8	-	-	-	-
G6 (C)	15	88.2	-	-	2	11.7	-	-
G7 (HCP)	29	96.6	1	3.3	-	-	-	-
TOTALS	176	94.1%	4	2.1%	7	3.7%	-	-

Is the number of schoolgirl pregnancies increasing? (Q8)

TABLE 15:

	<u>YES</u>		<u>NO</u>		<u>DON'T KNOW</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	27	90.0	-	-	3	10.0	-	-
G2 (ES)	26	96.2	-	-	1	3.7	-	-
G3 (P)	28	93.3	-	-	1	3.3	1	3.3
G4 (PES)	24	88.8	1	3.7	2	7.4	-	-
G5 (T)	24	92.3	-	-	2	7.6	-	-
G6 (C)	14	82.3	-	-	3	17.6	-	-
G7 (HCP)	29	96.6	-	-	1	3.3	-	-
TOTALS	172	91.9%	1	0.53%	13	6.9%	1	0.53%

Are those schoolgirls falling pregnant nowadays younger than they used to be? (Q9)

TABLE 16:

	<u>YES</u>		<u>NO</u>		<u>DON'T KNOW</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	28	93.3	-	-	2	6.6	-	-
G2 (ES)	24	88.8	1	3.7	2	7.4	-	-
G3 (P)	29	96.6	-	-	1	3.3	-	-
G4 (PES)	7	100	-	-	-	-	-	-
G5 (T)	23	88.4	-	-	3	11.5	-	-
G6 (C)	13	76.4	1	5.8	3	17.6	-	-
G7 (HCP)	27	90	2	6.6	1	3.3	-	-
TOTALS	171	91.4%	4	2.1%	12	6.4%	-	-

Will the problem become worse if it is left to sort itself out? (Q10)

TABLE 17:

	<u>YES</u>		<u>NO</u>		<u>DON'T KNOW</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	26	86.6	2	-	2	-	-	-
G2 (ES)	23	85.1	1	-	3	-	-	-
G3 (P)	29	96.6	1	-	-	-	-	-
G4 (PES)	27	100	-	-	-	-	-	-
G5 (T)	25	96.1	-	-	1	3.8	-	-
G6 (C)	17	100	-	-	-	-	-	-
G7 (HCP)	30	100	-	-	-	-	-	-
TOTALS	177	94.6%	4	2.1%	6	3.2%	-	-

Does the pregnancy problem need urgent attention? (Q11)

TABLE 18:

	<u>YES</u>		<u>NO</u>		<u>DON'T KNOW</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	30	100	-	-	-	-	-	-
G2 (ES)	25	92.5	-	-	2	7.4	-	-
G3 (P)	30	100	-	-	-	-	-	-
G4 (PES)	27	100	-	-	-	-	-	-
G5 (T)	25	96.1	-	-	1	3.8	-	-
G6 (C)	17	100	-	-	-	-	-	-
G7 (HCP)	29	96.6	1	3.3	-	-	-	-
TOTALS	183	97.8%	1	0.53%	3	1.6%	-	-

Should the school and the community show greater interest in the problem? (Q12)

TABLE 19:

	<u>YES</u>		<u>NO</u>		<u>DON'T KNOW</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	29	96.6	-	-	1	3.3	-	-
G2 (ES)	25	92.5	-	-	2	7.4	-	-
G3 (P)	30	100	-	-	-	-	-	-
G4 (PES)	27	100	-	-	-	-	-	-
G5 (T)	26	100	-	-	-	-	-	-
G6 (C)	17	100	-	-	-	-	-	-
G7 (HCP)	29	96.6	-	-	-	-	-	-
TOTALS	184	98.3%	-	-	3	1.6%	-	-

Summary Discussion

There is overwhelming agreement on the part of all parties that schoolgirl pregnancies are a problem at school, that numbers are increasing, that these single mothers are younger nowadays than they used to be, and that the problem will worsen if left unaddressed. Consequently all parties feel that urgent attention needs to be given to this issue and that the school and the community need to get involved.

4.3 THE SEXUAL ACTIVITY AND KNOWLEDGE OF CONCEPTION OF ADOLESCENT SCHOOLGIRLS

The focus of this section was on determining the views on key issues through the combined so-called Sexual Knowledge Questionnaire (SKQ) and Reproductive Physiology Questionnaire (RPQ).

Schoolgirls begin dating boys - (Q13)

TABLE 20:

	<u>TOTAL</u>	<u>SAMPLE</u>
	No	%
*before the age of 11	15	8
*between 11-13	94	50.3
*between 14-16	61	32.7
*between 17-19	9	4.8
*between 19 and more	2	1
non-respondents	6	3.2
TOTALS	187	100%

Note:

See corresponding Table 20A in Appendix K for full details.

Roughly half of all groups reported that schoolgirls begin dating boys between 11-13 years. However, in contrast to the rest of the groups, only a quarter of the ex-schoolgirls (G2) reported 11-13 years.

A consideration of the responses shows that generally more subjects overall tend to agree upon the age-category 11-13 years.

Adolescent schoolgirls think they know more about sex than they really do. (Q14)

TABLE 21:

	<u>TRUE</u>		<u>FALSE</u>		<u>NOT SURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	23	76.6	1	3.3	6	20	-	-
G2 (ES)	19	70.3	1	3.7	6	22.2	1	3.7
G3 (P)	25	83.3	1	3.3	4	13.3	-	-
G4 (PES)	17	62.9	1	3.7	6	22.2	3	11.1
G5 (T)	24	92.3	-	-	2	7.6	-	-
G6 (C)	15	88.2	1	5.8	1	5.8	-	-
G7 (HCP)	25	83.3	2	6.6	2	6.6	1	3.3
TOTALS	148	79.1%	7	3.7%	27	14.4%	5	2.6%

Fewer ex-schoolgirls and their parents in contrast to "ordinary" schoolgirls, their parents and the rest of the groups, accepted the above statement.

Adolescent girls think that a girl is physically capable of becoming pregnant before her first (monthly) period. (Q15)

TABLE 22:

	<u>TRUE</u>		<u>FALSE</u>		<u>NOT SURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	7	23.3	12	40	11	36.6	-	-
G2 (ES)	9	33.3	8	29.6	9	33.3	1	3.7
G3 (P)	9	30	6	20	15	50	-	-
G4 (PES)	7	25.9	6	22.2	12	44.4	2	7.4
G5 (T)	5	19.2	14	53.8	7	26.9	-	-
G6 (C)	1	5.8	8	47	8	47	-	-
G7 (HCP)	3	10	15	50	12	40	-	-
TOTALS	41	21.9%	69	36.8%	74	39.5%	3	1.6%

According to medical evidence, a girl is not physically capable of becoming pregnant before her first menstrual (monthly) period. The responses to this question show that more "ordinary" schoolgirls, teachers, clergy members and health care professionals, in comparison with their counterparts, rejected than accepted the statement. However, a close scrutiny of the responses obtained shows that generally more subjects were not sure whether the above statement was true or false.

It should be borne in mind that as the overall percentages obtained in the present sample are rather small, it cannot be said with any degree of certainty whether adolescent girls know when it is the "fertile" period for conceiving a baby or not.

Adolescent girls think that a girl can become pregnant during her first menstrual (monthly) period. (Q16)

TABLE 23:

	<u>TRUE</u>		<u>FALSE</u>		<u>NOT SURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	9	30	10	33.3	11	36.6	-	-
G2 (ES)	14	51.8	7	25.9	6	22.2	-	-
G3 (P)	11	36.6	6	20	12	40	1	3.3
G4 (PES)	8	29.6	5	18.5	10	37	4	14.8
G5 (T)	4	15.3	8	30.7	14	53.8	-	-
G6 (C)	5	29.4	6	35.2	6	35.2	-	-
G7 (HCP)	9	30	7	23.3	14	46.6	-	-
TOTALS	60	32%	49	26.2%	73	39%	5	2.6%

Generally more ex-schoolgirls, their parents and "ordinary" parents, in comparison with their counterparts who reported "False", agreed with the above statement.

However, approximately the same number of subjects were not sure about the above statement. Again, as the overall percentages are too small to make any statistically significant deductions, it cannot be said for certain whether adolescent girls think that a girl is capable of conceiving a child during her menstrual period or not. Medical evidence, however, does show that a girl can become pregnant during her menstrual period.

Adolescent girls think that a girl can become pregnant without full intercourse taking place (without going all the way). (Q17)

TABLE 24:

	<u>TRUE</u>		<u>FALSE</u>		<u>NOT SURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	12	40	7	23.3	11	36.6	-	-
G2 (ES)	12	44.4	7	25.9	8	29.6	-	-
G3 (P)	9	30	10	33.3	11	36.6	-	-
G4 (PES)	14	51.8	5	18.5	5	18.5	3	11.1
G5 (T)	5	19.2	14	53.8	7	26.9	-	-
G6 (C)	3	17.6	9	52.9	5	29.4	-	-
G7 (HCP)	10	33.3	12	40	8	26.6	-	-
TOTALS	65	34.7%	64	34.2%	55	29.4%	3	1.6%

In both sets of schoolgirls and parents, respectively, more subjects in comparison with their counterparts and the rest of the groups, were in agreement with the statement. School teachers, the clergy and health care professionals in particular, rejected the statement.

A close examination of the reported data indicates that the responses were about equally spread as approximately one third accepted the statement, one third rejected the statement and one third were not sure.

Also, there appears to be a polarisation of opinion between the sample comprising both sets of schoolgirls and their parents, and the sample comprising the professional persons (namely teachers, clergy and health care personnel).

Most adolescent schoolgirls know when it is the "safe period" for having sex. (Q18)

TABLE 25:

	<u>TRUE</u>		<u>FALSE</u>		<u>NOT SURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	6	20	13	43.3	11	36.6	-	-
G2 (ES)	10	37	14	51.8	3	11.1	-	-
G3 (P)	4	13.3	18	60	8	26.6	-	-
G4 (PES)	7	25.9	11	40.7	8	29.6	1	3.7
G5 (T)	1	3.8	19	73	6	23	-	-
G6 (C)	1	5.8	13	76.4	3	17.6	-	-
G7 (HCP)	5	16.6	19	63.3	6	20	-	-
TOTALS	34	18.1%	107	57.2%	45	24%	1	0.53%

Marginally more than half the sample, including the schoolgirls (the "actors"), seem to think that most adolescent girls know about the "safe period".

The implication of this result is that those young girls lacking a knowledge of the "safe period", may indeed be at risk of falling pregnant. Proof of this is the growing number of young girls who currently fall pregnant whilst at school.

Most adolescent girls are aware of the dangers of having sex at an early age. (Q19)

TABLE 26:

	<u>TRUE</u>		<u>FALSE</u>		<u>NOT SURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	14	46.4	13	43.3	3	10	-	-
G2 (ES)	17	62.9	7	25.9	2	7.4	1	3.7
G3 (P)	13	43.3	10	33.3	7	23.3	-	-
G4 (PES)	18	66.6	5	18.5	4	14.8	-	-
G5 (T)	4	15.3	19	73	2	7.6	1	3.8
G6 (C)	2	11.7	12	70.5	2	11.7	1	5.8
G7 (HCP)	9	30	20	66.6	1	3.3	-	-
TOTALS	77	41.1%	86	45.9%	21	11.2%	3	1.6%

A consideration of the responses shows that subjects were approximately equally split on this issue. Although both sets of pupils and parents appear to support the statement, in contrast the teachers, clergy and health care professionals strongly reject the view that most girls are aware of the dangers of early sex. The question arises: if adolescent girls were indeed knowledgeable about early sex and the inherent risks involved, why then the problem of teenage pregnancies?

Schoolgirls know everything about becoming pregnant and how a baby is conceived/made. (Q20)

TABLE 27:

	<u>TOTAL</u>	<u>SAMPLE</u>
	No	%
*before the age of 11	69	36.8
*between 11-13	97	51.8
*between 14-16	20	10.6
non-respondents	1	0.53

Notes:

1. Percentages sum to more than 100%, since subjects could check more than one category.
2. See corresponding Table 27A in Appendix K for full details.

With the exception of the parents of ex-schools who think differently, the rest of the groups, particularly the clergy and health care professionals, reported the age-group 11-13 years.

It can be assumed that the answer "between 11-13" is reasonably accurate as it concurs with the findings of Sapire (1986), Rigg (1987), and Furstenberg *et al* (1989), who claim that, generally, girls become knowledgeable about sexual matters and conception at the age of 12,5 years.

Summary Discussion

In discussing this section, several points need to be emphasised.

On the basis of the evidence presented, the overall impression gained is that the early onset of puberty (approximately 12.5 years in girls), the

early pattern of dating (between 11-13 years), and the interest in sexual matters, at this age, are possible factors leading to early sex awareness/activities in young girls. It can therefore be reasonably assumed that early sexuality may be seen as a precursor to premature and unintended pregnancy in adolescent schoolgirls.

Also, judging by the performance of all seven groups in the SKQ and RPQ, the results prove that the state of the subjects' sexual knowledge and knowledge of conception is generally lacking. In absolute terms the responses are not particularly reassuring since all seven groups (pupils and adults alike) seem to reflect considerable doubt with regard to basic reproductive physiology knowledge. A more valid conclusion would be that a lack of knowledge about sexual activity and conception probably extends beyond the school population and into the wider community.

4.4 THE EDUCATION, ATTITUDES TO PRE-MARITAL SEX AND SEXUAL EXPERIENCE OF ADOLESCENT SCHOOLGIRLS

This section, which comprised a comprehensive eighteen-itemed Sexual Knowledge Questionnaire (SKQ), was aimed at tapping baseline data relating to the young adolescent girls' education, attitudes to pre-marital sex, and their sexual experience.

Do most young girls have an adequate understanding of the reproductive system in the female body? (Q21)

TABLE 28:

	<u>YES</u>		<u>NO</u>		<u>UNSURE</u>		<u>NON-RESP.</u>	
	No	%	No	%	No	%	No	%
G1 (S)	6	20	19	63.3	5	16.6	-	-
G2 (ES)	4	14.8	19	70.3	3	11.1	1	3.7
G3 (P)	3	10	22	73.3	4	13.3	1	3.3
G4 (PES)	7	25.9	16	59.2	3	11.1	1	3.7
G5 (T)	1	3.8	21	80.7	4	15.3	-	-
G6 (C)	-	-	16	94.1	1	5.8	-	-
G7 (HCP)	4	13.3	25	83.3	1	3.3	-	-
TOTALS	25	13.3%	138	73.7%	21	11.2%	3	1.6%

A clear majority endorse the view that, today, most young girls lack an adequate understanding of the female reproductive system. The question arises: Is the lack of sex education a cause of schoolgirl pregnancies? It is interesting to note that most related studies (Craig and Richter-Strydom, 1982; Remafedi, 1988; Nash, 1990; McGibbon, 1990) identify a lack of sex education as an important causative factor in teenage pregnancies.

The age at which most girls first find out about sex and love-making. (Q22)

TABLE 29:

	<u>TOTAL</u>	<u>SAMPLE</u>
	No	%
*10 years and younger	11	5.9
*11-13 years	90	48.1
*14-16 years	79	42.2
*17 years and older	6	3.2
non-respondents	1	0.53

Notes:

1. Percentages sum to more than 100%, since subjects could check more than one category.
2. See corresponding Table 29A in Appendix K for full details.

The responses reflect that most subjects tend to believe that girls seem to acquire a knowledge about sex and love-making at a fairly early age in life.

This is borne out by the fact that in this question marginally more subjects report the age-group 11-13 years in comparison with their counterparts who report the age-group 14-16 years.

The answer 11-13 years appears to be reasonably acceptable as remarkably similar numbers of subjects reported the same age-group (11-13 years) respectively in two previous questions (Q 13 and Q 14) based on related issues.

Source from which teenage girls usually first find out about sex and love-making. (Q23)

TABLE 30:

	<u>TOTAL</u>	<u>SAMPLE</u>
	No	%
*from mother/father	13	6.9
*from brother/sister/relative	2	1
*from friends at school	135	72.1
*from a sex education programme at school	19	10.1
*from magazines/books	49	26.2
*other	10	5.3
non-respondents	2	1

Notes:

1. Percentages sum to more than 100%, since subjects could check more than one category.
2. See corresponding Table 30A in Appendix K for full details.

A great number of subjects, particularly in the adult groups as compared with those in the pupil groups, endorse the view that friends at school remain the most important source of information.

Comparative figures reflect that relatively few subjects reported "from magazines/books" and an insignificant number of "ordinary" schoolgirls, ex-schoolgirls and their parents, however, reported "mother/father" as the source.

On the basis of the responses received, one cannot rule out the fact that friends/peers who are centrally placed in the lives of school children, constitute an important factor in the informal transmission and acquisition of information (and misinformation) about sex and related matters.

Is sex talked about freely by teenagers today? (Q24)

TABLE 31:

	<u>YES</u>		<u>NO</u>		<u>DON'T</u> <u>KNOW</u>		<u>NON-</u> <u>RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	19	63.3	4	13.3	7	23.3	-	-
G2 (ES)	16	59.2	7	25.9	3	11.1	1	3.7
G3 (P)	21	70	5	16.6	4	13.3	-	-
G4 (PES)	17	62.9	6	22.2	4	14.8	-	-
G5 (T)	16	61.5	7	26.9	3	11.5	-	-
G6 (C)	10	58.8	4	23.5	3	17.6	-	-
G7 (HCP)	23	76.6	2	6.6	5	16.6	-	-
TOTALS	122	65.2%	35	18.7%	29	15.5%	1	0.53%

Generally all groups, including relatively larger numbers of "ordinary" schoolgirls and ex-schoolgirls (teenagers themselves), as opposed to their counterparts who hold different views, agree that the topic of sex is freely spoken about by today's teenagers.

Do most girls talk openly about sex with their mother/father? (Q25)

TABLE 32:

	<u>YES</u>		<u>NO</u>		<u>DON'T</u> <u>KNOW</u>		<u>NON-</u> <u>RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	3	10	23	76.6	4	13.3	-	-
G2 (ES)	2	7.4	24	88.8	1	3.7	-	-
G3 (P)	3	10	26	86.6	1	3.3	-	-
G4 (PES)	1	3.7	24	88.8	1	3.7	1	3.7
G5 (T)	-	-	21	80.7	4	15.3	1	3.8
G6 (C)	-	-	16	94.1	-	-	1	5.8
G7 (HCP)	-	-	29	96.6	1	3.3	-	-
TOTALS	9	4.8%	163	87.1%	12	6.4%	3	1.6%

An overwhelming majority (over 85%), including both sets of parents, are in agreement that the topic of sex is not openly discussed by girls with their parents.

Do most parents talk openly about sex with their children? (Q26)

TABLE 33:

	<u>YES</u>		<u>NO</u>		<u>DON'T</u> <u>KNOW</u>		<u>NON-</u> <u>RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	3	10	24	80	3	10	-	-
G2 (ES)	3	11.1	24	88.8	-	-	-	-
G3 (P)	2	6.6	27	90	1	3.3	-	-
G4 (PES)	6	22.2	18	66.6	2	7.4	1	3.7
G5 (T)	1	3.8	22	84.6	2	7.6	1	3.8
G6 (C)	-	-	16	94.1	-	-	1	5.8
G7 (HCP)	-	-	27	90	3	10	-	-
TOTALS	15	8%	158	84.4%	11	5.8%	3	1.6%

The overall pattern of responses to this question was similar to the previous question. Again, more than 80% of the subjects, with slightly higher percentages recorded for the adult groups, are convinced that most parents do not discuss sex openly with their children.

A consideration of the responses to both Q 25 and Q 26 tend to show that parent-child communication about sexual matters is lacking in the home.

Do you think teenagers have enough opportunity to acquire sex information for themselves? (Q27)

TABLE 34:

	<u>YES</u>		<u>NO</u>		<u>DON'T</u> <u>KNOW</u>		<u>NON-</u> <u>RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	11	36.6	16	53.3	3	10	-	-
G2 (ES)	5	18.5	13	48.1	9	33.3	-	-
G3 (P)	19	63.3	8	26.6	3	10	-	-
G4 (PES)	12	44.4	9	33.3	5	18.5	1	3.7
G5 (T)	8	30.7	15	57.6	2	7.6	1	3.8
G6 (C)	5	29.4	10	58.8	1	5.8	1	5.8
G7 (HCP)	5	16.6	23	76.6	2	6.6	-	-
TOTALS	65	34.7%	94	50.2%	25	13.3%	3	1.6%

Roughly half of all groups, with the exception of both groups of parents, express the view that teenagers do not have enough opportunity to acquire information about sex for themselves.

Do those young girls who engage in sex do so because everyone is "doing it" today (i.e. it is the "in thing")? (Q28)

TABLE 35:

	<u>YES</u>		<u>NO</u>		<u>DON'T</u> <u>KNOW</u>		<u>NON-</u> <u>RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	12	40	5	16.6	13	43.3	-	-
G2 (ES)	14	51.8	6	22.2	6	22.2	1	3.7
G3 (P)	15	50	5	16.6	10	33.3	-	-
G4 (PES)	12	44.4	2	7.4	11	40.7	2	7.4
G5 (T)	15	57.6	3	11.5	7	26.9	1	3.8
G6 (C)	9	52.9	1	5.8	6	35.2	1	5.8
G7 (HCP)	23	76.6	3	10	3	10	1	3.3
TOTALS	100	53.4%	25	13.3%	56	29.9%	6	3.2%

Just over half of all groups report that those girls who engage in sex do so as they believe everyone is "doing it" or that it is the "in thing" today. A fairly large number of health care professionals, in comparison with the rest of the sample, perhaps because of their professional experience in the field, strongly endorse this view. The findings here tend to suggest that peer pressure is a factor predisposing young girls to pre-marital sex.

Do you think the fear of pregnancy would stop a girl from having sex?
(Q29)

TABLE 36:

	<u>YES</u>		<u>NO</u>		<u>DON'T</u> <u>KNOW</u>		<u>NON-</u> <u>RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	11	36.6	14	46.6	5	16.6	-	-
G2 (ES)	7	25.9	11	40.7	8	29.6	1	3.7
G3 (P)	13	43.3	11	36.6	6	20	-	-
G4 (PES)	6	22.2	13	48.1	7	25.9	1	3.7
G5 (T)	3	11.5	18	69.2	4	15.3	1	3.8
G6 (C)	4	23.5	11	64.7	1	5.8	1	5.8
G7 (HCP)	5	16.6	21	70	4	13.3	-	-
TOTALS	49	26.2%	99	52.9%	35	18.7%	4	2.1%

A consideration of the responses indicate that just over half of all the groups, with fairly high percentages of responses obtained from subjects from the helping professions, think that a fear of pregnancy would not deter a girl from engaging in sexual intercourse.

At which age do most schoolgirls begin to engage in sexual intercourse?
(Q30)

TABLE 37:

	<u>TOTAL</u>	<u>SAMPLE</u>
	No	%
*12-13 years	30	16
*14-16 years	114	60.9
*17-18 years	8	4.2
*19 years and older	4	2.1
*cannot say	30	16
non-respondents	1	0.53
TOTALS	187	100%

Notes :

See corresponding Table 37A in Appendix K for full details.

Well over half the number of subjects in the total sample tend to agree that the age is 14-16 years. The reported data also show that more "ordinary" schoolgirls and ex-schoolgirls (the "actors" themselves), in comparison with their counterparts who think differently, seem to agree upon the age-category 14-16 years. This age-category appears to be a fairly good estimate as the age-range for pregnancy cases at the author's school is 13-19 years, and the mean age for ex-schoolgirl pregnancy cases in the present sample is 15,4 years.

Do girls often engage in sex because they feel embarrassed about being a virgin? (Q31)

TABLE 38:

	<u>YES</u>		<u>NO</u>		<u>DON'T</u> <u>KNOW</u>		<u>NON-</u> <u>RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	8	26.6	11	36.6	11	36.6	-	-
G2 (ES)	6	22.2	7	25.9	14	51.8	-	-
G3 (P)	7	23.3	9	30	14	46.6	-	-
G4 (PES)	3	11.1	5	18.5	17	62.9	2	7.4
G5 (T)	1	3.8	7	26.9	17	65.3	1	3.8
G6 (C)	3	17.6	6	35.2	7	41.1	1	5.8
G7 (HCP)	10	33.3	9	30	10	33.3	1	3.3
TOTALS	38	20.3%	54	28.8%	90	48.1%	5	2.6%

The responses obtained reveal that nearly half the number of subjects in the total sample expressed uncertainty about the question. This finding suggests that the issue of virginity being an embarrassment in young girls cannot be considered a factor predisposing them to sexual activity. It is interesting to note that in comparison to this study's findings, some related studies (Konopka, 1976; Dreyer, 1980; Cuenod, 1987) do in fact cite the issue of virginity as being a "burden" in the lives of young girls, and a precursor to early sexual activity.

Do girls think that it is often "old-fashioned" not to have sex before marriage? (Q32)

TABLE 39:

	<u>YES</u>		<u>NO</u>		<u>DON'T</u> <u>KNOW</u>		<u>NON-</u> <u>RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	14	46.6	10	33.3	6	20	-	-
G2 (ES)	11	40.7	9	33.3	7	25.9	-	-
G3 (P)	17	56.6	7	23.3	6	20	-	-
G4 (PES)	18	66.6	8	29.6	1	3.7	-	-
G5 (T)	12	46.1	5	19.2	8	30.7	1	3.8
G6 (C)	6	35.2	3	17.6	7	41.1	1	5.8
G7 (HCP)	14	46.6	9	30	6	20	1	3.3
TOTALS	92	49.1%	51	27.2%	41	21.9%	3	1.6%

A majority of subjects, comprising almost half of all groups, expressed the view that girls think that it is often "old-fashioned" not to engage in pre-marital sex.

A close examination of the reported data shows that the parents of the ex-schoolgirl pregnancy cases in particular seem to strongly endorse the same view. The findings here tend to concur with those of Meikle (1984). He argues that, given the current liberal climate of opinion with regard to sexual matters, modern youth tend to think it "old-fashioned" not to indulge in pre-marital sex, and thus pre-marital sex may be relatively acceptable to today's adolescents (Meikle, 1984, p.94).

Do you think boys today put pressure on girls to have sexual intercourse with them? (Q33)

TABLE 40:

	<u>YES</u>		<u>NO</u>		<u>DON'T KNOW</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	24	80	4	13.3	2	6.6	-	-
G2 (ES)	22	81.4	3	11.1	2	7.4	-	-
G3 (P)	22	73.3	4	13.3	4	13.3	-	-
G4 (PES)	19	70.3	-	-	8	29.6	-	-
G5 (T)	21	80.7	2	7.6	3	11.5	-	-
G6 (C)	15	88.2	1	5.8	-	-	1	5.8
G7 (HCP)	27	90	-	-	3	10	-	-
TOTALS	150	80.2%	14	7.4%	22	11.7%	1	0.53%

A great majority (80%) of subjects endorse the view that boys put pressure on girls to engage in sexual activity. As this opinion is apparently commonly held by subjects across the board, it appears that peer-group pressure is a strong factor predisposing girls to early sexual activity and the risk of pregnancy.

It should be noted that this study's findings concur with those of previous researchers, namely Ross (1979), Craig and Richter-Strydom (1982), and Koegh (1988), who abundantly cite peer-group pressure as an important reason for sexual activity and premature pregnancy in adolescents.

Would most parents approve of an adolescent indulging in pre-marital sex?
(Q34)

TABLE 41:

	<u>YES</u>		<u>NO</u>		<u>DON'T KNOW</u>		<u>NON- RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	1	3.3	22	73.3	7	23.3	-	-
G2 (ES)	1	3.7	23	85.1	3	11.1	-	-
G3 (P)	4	13.3	22	73.3	3	10	1	3.3
G4 (PES)	1	3.7	24	88.8	2	7.4	-	-
G5 (T)	-	-	25	96.1	1	3.8	-	-
G6 (C)	-	-	16	94.1	-	-	1	5.8
G7 (HCP)	-	-	29	96.6	1	3.3	-	-
TOTALS	7	3.7%	161	86%	17	9%	2	1%

All parties (with a response rate of over 80%) very strongly agree that most parents would disapprove of the practice of pre-marital sex in adolescents. Particularly the adult groups, which comprised mostly parents themselves, strongly endorsed the same view.

Which of the following girls would most likely engage in sex? (Q35)

TABLE 42:

	TOTAL	SAMPLE
	No	%
*a girl coming from a poor home	12	6.4
*a girl who lacks love from her parents/because of broken family	94	50.2
*a girl who does badly at school- therefore sex is an escape	13	6.9
*a girl whose friends influence her into having sex	76	40.6
*increased opportunity in home/ outside for sexual contacts	30	16
*another reason (explain)	18	9.6
non-respondents	5	2.6

Notes:

1. Percentages sum to more than 100%, since subjects could check more than one category.
2. See corresponding Table 42A in Appendix K for full details.

A consideration of the groups' responses reveals the following three most frequently cited answers in order of merit: firstly, "a girl who lacks love from her parents/because of broken family"; secondly, "a girl whose friends influence her into having sex"; thirdly, "increased opportunity in home/outside for sexual contacts".

In addition, a few respondents supplied other reasons. For example, in G1 (Senior schoolgirls), comments were: "her boyfriend encourages her" or "peer-pressure is too great"; in G4 (Parent of ex-schoolgirl): "a girl [who]

is in love and fears losing her only man ..."; in G7 (Health care professional): "being misinformed about sex".

Having sex before marriage nowadays is: (Q36)

TABLE 43:

	<u>TOTAL</u>	<u>SAMPLE</u>
	No	%
*all right if one is in love	16	8.6
*immoral, sinful and therefore wrong	96	51.3
*a normal part of a youth's growing up	16	8.6
*a personal matter	51	27.3
*another reason (explain)	6	3.2
non-respondents	2	1
TOTALS	187	100%

Notes:

See corresponding Table 43A in Appendix K for full details.

In this multiple-choice question just over half of all groups express the view that sex is "immoral, sinful and therefore wrong".

However, in contrast, just over a quarter of the "ordinary" schoolgirls and ex-schoolgirls think it is a "personal matter", while others think differently.

The general impression gained here is that more subjects disapprove of pre-marital sex, possibly on moral or religious grounds. However, Meikle (1984) argues that the fact of the matter is that in reality teenagers will

still choose to indulge in pre-marital sex, given the liberal and permissive climate of opinion with regard to sexual behaviour (pp. 90-94).

One may assume, therefore, that it is doubtful whether morality or religion will place safe checks on sex before marriage nowadays.

Boys believe that the responsibility for contraception rests with girls?
(Q37)

TABLE 44:

	<u>AGREE</u>		<u>DISAGREE</u>		<u>UNSURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	18	60	3	10	9	30	-	-
G2 (ES)	16	59.2	6	22.2	5	18.5	-	-
G3 (P)	16	53.3	7	23.3	7	23.3	-	-
G4 (PES)	17	62.9	8	29.6	2	7.4	-	-
G5 (T)	20	76.9	4	15.3	2	7.6	-	-
G6 (C)	13	76.4	2	11.7	1	5.8	1	5.8
G7 (HCP)	22	73.3	5	16.6	2	6.6	1	3.3
TOTALS	122	65.2%	35	18.7%	28	14.9%	2	1%

Over 60% of all groups seem to be convinced that boys believe that the responsibility for contraception rests with the girls.

A comparison of figures reflects that more "ordinary" schoolgirls and ex-schoolgirls express the same view.

The result here seems to suggest that boys do not appear to accept joint responsibility for preventing a pregnancy, and expect contraception to be the sole responsibility of the girl.

Which of the following do you think is the main reason for young boys and girls engaging in sex? (Q38)

TABLE 45:

	<u>TOTAL</u>	<u>SAMPLE</u>
	No	%
*"too much" sexual freedom	58	31
*"tolerant" attitude on the part of the Church	3	1.6
*increased opportunities for meeting the opposite sex	35	18.7
*approval by parents	8	4.2
*boredom with school	8	4.2
*the mass media (T.V., films, magazines, literature)	45	24
*poor quality of life in the Township	39	20.8
*another reason (explain)	20	10.6
non-respondents	9	4.8

Notes:

1. Percentages sum to more than 100%, since subjects could check more than one category.
2. See corresponding Table 45A in Appendix K for full details.

An examination of the responses obtained in the table above, shows that greater percentages of subjects in the total sample identify basically the following four main reasons in order of importance:

1. "'too much' sexual freedom".
2. "the mass media (T.V., films, magazines, literature)".
3. "poor quality of life in the Township".
4. "increased opportunity for meeting the opposite sex".

In G2 (ES), another reason offered was, "There is a lack of communication between parents and teenagers". In G3 (P), the comment was, "I think that peer pressure is the main reason". In G7 (HCP), the reason given was, "experimenting with sex or peer pressure".

On the basis of the evidence presented, it appears that a lack of parental caring concern or inadequate parental discipline, exposure to sexual stimuli through the mass media, poor socio-economic conditions, and a lack of supervised time or after-school recreation, are possible factors predisposing young adolescents to sexual intercourse.

Summary Discussion.

This section offered a general understanding of some key areas of concern regarding the education, attitudes to pre-marital sex and sexual experience of adolescent schoolgirls through a so-called Sexual Knowledge Questionnaire (SKQ). Generally, the results based on the SKQ in this section identified the following possible causative factors associated with premature pregnancy in young girls. These are: The commencement of sexual intercourse at a young age (14-16 years); a lack of adequate understanding of the female reproductive system; a lack of communication on sexual matters between teenagers and parents at home; inaccurate information (or misinformation) from friends at school; peer-group pressure; a lack of responsible decision-making skills; and too much sexual freedom.

The above assessment again confirms the notion that sexual activity in adolescent girls tends to begin at an early age, and that a lack of sex education appears to be a contributory factor in adolescent pregnancies.

This result also emphasises the need for schools to provide timely and accurate preventative sex education programmes to pupils at an early age. Zabin, Hardy, Streett and King caution:

It seems clear that initiatives to protect them (adolescent girls) from the effects of early sexual intercourse, will have to be directed to them at prepubertal ages since their youthful sexual activity is certainly a precursor of conceptions that develop immediately following puberty.

(1984, p.423)

On the basis of the data presented, it may be construed that the problem of pregnancies in school-age children is predictable as it is known at what stage in their lives adolescent girls usually tend to become sexually active. Secondly, the problem could possibly be prevented if schools were to follow up the proposal made by Zabin *et al* (1984) above.

4.5 THE KNOWLEDGE, ATTITUDES AND PRACTICE WITH RESPECT TO CONTRACEPTION OF ADOLESCENT SCHOOLGIRLS

This section of the investigation aimed at determining the subjects' views on what schoolgirls know about contraception and their use, and whether they are adequately protected against the risks of falling pregnant.

Are young girls adequately informed about contraception? (Q39)

TABLE 46:

	<u>YES</u>		<u>NO</u>		<u>DON'T KNOW</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	8	26.6	15	50	7	23.3	-	-
G2 (ES)	6	22.2	18	66.6	3	11.1	-	-
G3 (P)	5	16.6	21	70	4	13.3	-	-
G4 (PES)	8	29.6	16	59.2	2	7.4	1	3.7
G5 (T)	-	-	23	88.4	3	11.5	-	-
G6 (C)	1	5.8	14	82.3	2	11.7	-	-
G7 (HCP)	8	26.6	20	66.6	2	6.6	-	-
TOTALS	36	19.2%	127	67.9%	23	12.2%	1	0.53%

Well over 60% of all groups express the view that young girls are inadequately informed about contraception.

It stands to reason that those girls who will be indulging in pre-marital sex or are already sexually active, and who do not use any form of contraception, face the risk of becoming pregnant.

The result emphasises the need for the school to provide adolescents and especially those who wish to contracept, with accurate and complete information about contraception. In this way adolescents will have adequate means of protection against pregnancy.

Also, in comparison to the "ordinary" schoolgirls, more ex-schoolgirl pregnancy cases, perhaps out of experience, vouch for the fact that young girls do not have an adequate knowledge about contraception.

Do you think adolescent girls know about most of the following birth control methods? (1. Condom, 2. Pill, 3. Withdrawal, 4. Cream/Jelly, 5. Foam, 6. Rhythm, 7. Diaphragm, 8. IUD/Coil, 9. Other. (Q40)

TABLE 47:

	<u>YES</u>		<u>NO</u>		<u>CAN'T ANSWER</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	9	30	14	46.6	7	23.3	-	-
G2 (ES)	6	22.2	13	48.1	8	29.6	-	-
G3 (P)	8	26.6	18	60	4	13.3	-	-
G4 (PES)	10	37	11	40.7	4	14.8	2	7.4
G5 (T)	1	3.8	20	76.9	5	19.2	-	-
G6 (C)	1	5.8	13	76.4	3	17.6	-	-
G7 (HCP)	10	33.3	18	60	2	6.6	-	-
TOTALS	45	24%	107	57.2%	33	17.6%	2	1%

Roughly half of all groups agree that adolescent girls do not have a knowledge of the above-listed contraceptive methods. This result also seems to suggest the need for schools to provide adolescents with contraceptive education through sex education programmes.

How frequently do sexually active schoolgirls use birth control? (Q41)

TABLE 48:

	<u>Total</u>	<u>Sample</u>
	No	%
*not at all	16	8.5
*sometimes	54	28.8
*most times	12	6.4
*every time	2	1
*don't know	99	52.9
*other reason (state)	4	2.1
non-respondents	-	-
TOTALS	187	100%

Note:

See corresponding Table 48A in Appendix K for full details.

On the basis of the responses received, just over a quarter of the sample seem to think that birth control methods are used sometimes.

However, roughly half of all groups, including a relatively high percentage of subjects in both sets of schoolgirls (the "actors") were not able to say how often sexually active schoolgirls used birth control methods.

Additional reasons given were, for example, G2 (Ex-schoolgirl pregnancy case): "They are afraid their friends, teachers and parents will disapprove"; G7 (Health care professionals): "They are normally shy to attend clinics" or "They fear that their parents could find out".

An examination of the responses in the present sample seems to suggest that it is not possible to accurately assess the frequency of use of contraceptive methods by sexually active schoolgirls. .

Who do you think should be responsible for contraception? (Q42)

TABLE 49:

	<u>Total</u>	<u>Sample</u>
	No	%
*the girl	26	13.9
*the boy	1	0.53
*both girl and boy	135	72.1
*don't know	21	11.2
non-respondents	4	2.1
TOTALS	187	100%

Note:

See corresponding Table 49A in Appendix K for full details.

A clear majority (over 70%) agree that "both girl and boy" should be responsible for contraception. In contrast to the other groups, almost all health care professionals and school teachers, and a high percentage of "ordinary" schoolgirls, endorse the same idea. The result seems to suggest that there is generally greater support for both sexes to assume joint responsibility for contraception.

Many sexually active teenagers prefer not to use contraceptives. (Q43)

TABLE 50:

	<u>TRUE</u>		<u>FALSE</u>		<u>NOT SURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	12	40	5	16.6	13	43.3	-	-
G2 (ES)	16	59.2	4	14.8	7	25.9	-	-
G3 (P)	15	50	2	6.6	13	43.3	-	-
G4 (PES)	15	55.5	2	7.4	10	37	-	-
G5 (T)	6	23	1	3.8	19	73	-	-
G6 (C)	3	17.6	5	29.4	8	47	1	5.8
G7 (HCP)	15	50	8	26.6	7	23.3	-	-
TOTALS	82	43.8%	27	14.5%	77	41.1%	1	0.53%

Roughly 40% of all groups agree that many sexually active teenagers prefer not to use contraceptives. Also, roughly 40% of all groups were not sure about the statement. The result indicates that it is not possible to say with a great degree of certainty whether sexually active teenagers prefer to use contraceptives or not.

They don't use contraceptives because of - (Q44)

TABLE 51:

	<u>Total</u>	<u>Sample</u>
	No	%
*Religious beliefs	21	11.2
*Failing to accept that they are indeed having intercourse	29	15.5
*Inability to get hold of any	15	8
*Bad planning	27	14.4
*The belief that parents would disapprove of sex	48	25.6
*The fear that it is dangerous	30	16
*A lack of factual knowledge about using them	62	33.1
non-respondents	3	1.6

Notes:

1. Percentages sum to more than 100%, since subjects could check more than one category.
2. See corresponding Table 51A in Appendix K for full details.

The responses to this question reflect that proportionately more subjects tend to agree that "A lack of factual knowledge about using them" is the main reason. "The belief that parents would disapprove of sex", was ranked second, and "The fear that it is dangerous", was ranked third.

This result tends to suggest that girls generally do not use contraceptive methods because of a lack of contraceptive knowledge.

Many schoolgirls do not know how and where to obtain contraceptives. (Q45)

TABLE 52:

	<u>AGREE</u>		<u>DISAGREE</u>		<u>UNSURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	18	60	7	23.3	5	16.6	-	-
G2 (ES)	9	33.3	13	48.1	5	18.5	-	-
G3 (P)	17	56.6	8	26.6	5	16.6	-	-
G4 (PES)	13	48.1	12	44.4	2	7.4	-	-
G5 (T)	9	34.6	11	42.3	6	23	-	-
G6 (C)	5	29.4	8	47	3	17.6	1	5.8
G7 (HCP)	11	36.6	17	56.6	2	6.6	-	-
TOTALS	82	43.8%	76	40.6%	28	14.9%	1	0.53%

The responses in the total sample indicate that subjects were about equally split on the issue as roughly 40% agreed and roughly 40% disagreed with the statement. Although any definite conclusion(s) cannot be drawn about the result, it can be assumed that, even though girls might know how and where to obtain contraceptives, they generally do not appear to acquire them as they do not know how to use them. The implications for the provision of sex education (including contraceptive education and contraceptive use as a component) in schools seems obvious.

A girl not using birth control is most likely to get pregnant if she has sex frequently. (Q46)

TABLE 53:

	<u>AGREE</u>		<u>DISAGREE</u>		<u>UNSURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	25	83.3	-	-	5	16.6	-	-
G2 (ES)	26	96.2	-	-	1	3.7	-	-
G3 (P)	29	96.6	-	-	1	3.3	-	-
G4 (PES)	25	92.5	2	7.4	-	-	-	-
G5 (T)	25	96.1	-	-	1	3.8	-	-
G6 (C)	14	82.3	1	5.8	1	5.8	1	5.8
G7 (HCP)	29	96.6	-	-	-	-	1	3.3
TOTALS	173	92.5%	3	1.6%	9	4.8%	2	1%

An overwhelming majority (just over 90%) of subjects across the board are convinced that the risk of falling pregnant is great for a sexually active girl who does not use birth control methods.

Many schoolgirls fall pregnant because they believe that sex relationships are a sign of maturity. (Q47)

TABLE 54:

	<u>AGREE</u>		<u>DISAGREE</u>		<u>UNSURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	17	56.6	7	23.3	6	20	-	-
G2 (ES)	16	59.2	7	25.9	4	14.8	-	-
G3 (P)	23	76.6	2	6.6	5	16.6	-	-
G4 (PES)	17	62.9	6	22.2	4	14.8	-	-
G5 (T)	13	50	7	26.9	6	23	-	-
G6 (C)	10	58.8	4	23.5	3	17.6	-	-
G7 (HCP)	15	50	8	26.6	7	23.3	-	-
TOTALS	111	59.3%	41	21.9%	35	18.7%	-	-

Over 50% of all groups tend to agree that many schoolgirls fall pregnant because they believe that sex relationships are a sign of maturity. Admittedly, this question was rather obscure, and perhaps an unfair or bad choice. However, one implication of the result might be that many schoolgirls while acting out adult roles during their adolescence (as portrayed, for example, through the mass media), become unfortunate pregnancy cases.

Many young girls think that sexual intercourse is the best way to show someone you love them. (Q48)

TABLE 55:

	<u>AGREE</u>		<u>DISAGREE</u>		<u>UNSURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	21	70	8	26.6	1	3.3	-	-
G2 (ES)	20	74	4	14.8	3	11.1	-	-
G3 (P)	24	80	2	6.6	4	13.3	-	-
G4 (PES)	20	74	3	11.1	2	7.4	2	7.4
G5 (T)	21	80.7	2	7.6	2	7.6	1	3.8
G6 (C)	13	76.4	2	11.7	1	5.8	1	5.8
G7 (HCP)	26	86.6	1	3.3	3	10	-	-
TOTALS	145	77.5%	22	11.7%	16	8.5%	4	2.1%

A clear majority, constituting over 70% of all groups, endorse the view that young girls think that sexual intercourse is the best way to show someone you love them. The implication of this result is that many girls, because they fear losing their "man", are perhaps influenced or "pressured" into engaging in sexual intercourse. Compliance, for example, would mean being accepted or loved by the boy; non-compliance would mean rejection or losing the boy.

Teenagers are misinformed about the "facts of life". (Q49)

TABLE 56:

	<u>AGREE</u>		<u>DISAGREE</u>		<u>UNSURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	22	73.3	4	13.3	4	13.3	-	-
G2 (ES)	19	70.3	3	11.1	5	18.5	-	-
G3 (P)	22	73.3	3	10	5	16.6	-	-
G4 (PES)	20	74	3	11.1	3	11.1	1	3.7
G5 (T)	21	80.7	4	15.3	1	3.8	-	-
G6 (C)	14	82.3	1	5.8	1	5.8	1	5.8
G7 (HCP)	27	90	1	3.3	2	6.6	-	-
TOTALS	145	77.5%	19	10.1%	21	11.2%	2	1%

At least seventy percent of each group are convinced that teenagers today are not informed about the "facts of life". On the basis of the reported data by the schoolgirls and ex-schoolgirls themselves, the evidence has an important implication for school practice, namely that there is a definite need for schools (and parents) to teach children the "facts of life" through sex education.

Sexually active girls are not adequately protected against the possibility of falling pregnant. (Q50)

TABLE 57:

	<u>AGREE</u>		<u>DISAGREE</u>		<u>UNSURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	23	76.6	1	3.3	6	20	-	-
G2 (ES)	22	81.4	1	3.7	4	14.8	-	-
G3 (P)	25	83.3	2	6.6	3	10	-	-
G4 (PES)	19	70.3	5	18.5	2	7.4	1	3.7
G5 (T)	21	80.7	3	11.5	1	3.8	1	3.8
G6 (C)	15	88.2	1	5.8	-	-	1	5.8
G7 (HCP)	27	90	3	10	-	-	-	-
TOTALS	152	81.2%	16	8.5%	16	8.5%	3	1.6%

A response rate of 80% across the board shows that all parties seem to agree that sexually active girls are inadequately protected against the risk of pregnancy. The result emphasises the need for schools and the helping professions to provide such girls with a clear understanding of contraceptive methods and their uses, and how and where to obtain them.

Young boys and girls think sex is fun - you don't have to take it seriously. (Q51)

TABLE 58:

	<u>AGREE</u>		<u>DISAGREE</u>		<u>UNSURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	24	80	2	6.6	4	13.3	-	-
G2 (ES)	20	74	3	11.1	4	14.8	-	-
G3 (P)	27	90	1	3.3	1	3.3	1	3.3
G4 (PES)	22	81.4	1	3.7	2	7.4	2	7.4
G5 (T)	21	80.7	-	-	4	15.3	1	3.8
G6 (C)	14	82.3	1	5.8	-	-	2	11.7
G7 (HCP)	26	86.6	2	6.6	2	6.6	-	-
TOTALS	154	82.3%	10	5.3%	17	9%	6	3.2%

As an endorsement rate of 80% was received by all parties, the general view seems to be that young boys and girls believe that sex is fun. The impression gained here is that adolescent boys and girls appear to resort to sexual experimentation (perhaps out of natural curiosity), without knowing the pitfalls or serious consequences of their actions. The result has implications for schools and parents to become involved in teaching adolescents proper decision-making skills for assuming sexual responsibility in their lives.

These days it is O.K. for a girl to have sex with a steady boyfriend. (Q52)

TABLE 59:

	<u>AGREE</u>		<u>DISAGREE</u>		<u>UNSURE</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	3	10	22	73.3	5	16.6	-	-
G2 (ES)	9	3.3	8	29.6	9	33.3	1	3.7
G3 (P)	4	13.3	24	80	2	6.6	-	-
G4 (PES)	11	40.7	11	40.7	3	11.1	2	7.4
G5 (T)	11	42.3	10	38.4	4	15.3	1	3.8
G6 (C)	6	35.2	9	52.9	-	-	2	11.7
G7 (HCP)	10	33.3	16	53.3	3	10	1	3.3
TOTALS	54	28.8%	100	53.4%	26	13.9%	7	3.7%

Mostly "ordinary" schoolgirls, their parents, the clergy and health care professionals showed strong disagreement with the statement that it is all right for a girl to indulge in sexual intercourse with her steady boyfriend.

The responses for those ex-schoolgirls who agreed or disagreed or were unsure, were about equally spread. Also, the parents of ex-schoolgirls, and the teachers were about equally split on the issue. The overall impression gained is that the above statement is generally rejected.

Think of schoolgirls who have recently had a baby. Close your eyes for a brief moment and try to focus attention on them. Now kindly read the following statements and place a Y for Yes or N for No in the block to describe them. (Q53)

TABLE 60:

		<u>Total</u>	<u>Sample</u>
		No	%
53.1	The girls were pleased to have the babies.	Y 38 N 108	20.3 57.7
53.2	Their boyfriends were pleased about the baby.	Y 35 N 109	18.7 58.2
53.3	The girls' parents were pleased about their babies.	Y 16 N 129	8.5 68.9
53.4	Most people were upset/disappointed about them.	Y 156 N 10	83.4 5.3
53.5	The girls did not know about birth control.	Y 71 N 80	37.9 42.7
53.6	They blamed the boys for not using contraceptives.	Y 66 N 75	35.2 40.1
53.7	They planned to go back to school after they had the babies.	Y 84 N 66	44.9 35.2
53.8	They got married because they were pregnant.	Y 74 N 76	39.5 40.6
	non-respondents	8	4.2

Notes:

1. Percentages sum to more than 100%, since subjects could check more than one category.
2. See corresponding Table 60A in Appendix K for full details.

This detailed question aimed at gauging, through a number of statements, the reactions of the subjects to schoolgirls who had recently conceived a child. It must be noted that not all subjects slotted in answers for each respective statement. A few omissions were noted in some categories. Only eight subjects (4.2%) did not respond at all to this question. A close examination of the summary of responses reveals that, generally, more subjects supported the view that most people would be upset or disappointed, and that the young girls themselves, including the parents and the boyfriends would not be pleased about the offspring.

Summary Discussion.

The focus of attention in this section was on the narrower field of contraception. The results based on the Contraceptive Knowledge Questionnaire (CKQ) indicate that adolescents generally seem to be inadequately informed about contraception.

Also, the evidence based on the present sample suggests that it is not possible to accurately assess whether many adolescents prefer using contraceptives or not and how frequently they are used. However, one may safely assume that in practice, not only is the general level of understanding about contraception rather poor, but that they do not appear to use contraceptives at all. Previous research (Meikle, 1984) shows that adolescents today fail to plan ahead or do not appear to take contraceptive precautions as there is "the romantic belief that [contraceptives] somehow interfere with the spontaneity of sex" (p.95).

On the basis of the evidence presented, it appears that a lack of contraceptive knowledge and contraceptive use, may be seen as a precursor to pregnancies.

4.6 THE PROBLEM OF SCHOOLGIRL PREGNANCIES AND WHAT CAN BE DONE

In this final section, the main aim was to establish what the subjects say can be done to ameliorate or possibly prevent the problem.

Do you think there is an urgent need on the part of the School, Parents and the Community to look seriously into the problem of pregnancies? (Q54)

TABLE 61:

	<u>YES</u>		<u>NO</u>		<u>DON'T</u> <u>KNOW</u>		<u>NON-</u> <u>RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	30	100	-	-	-	-	-	-
G2 (ES)	24	88.8	-	-	3	11.1	-	-
G3 (P)	30	100	-	-	-	-	-	-
G4 (PES)	27	100	-	-	-	-	-	-
G5 (T)	26	100	-	-	-	-	-	-
G6 (C)	17	100	-	-	-	-	-	-
G7 (HCP)	30	100	-	-	-	-	-	-
TOTALS	184	98.3%	-	-	3	1.6%	-	-

Practically all subjects in all groups agreed that there was an urgent need for the school, parents and community to intervene in an effort to address the problem of schoolgirl pregnancies.

Who should be the source of information about sex for school children?
(Q55)

TABLE 62:

	<u>Total</u>	<u>Sample</u>
	No	%
*The church	8	4.2
*The school	26	13.9
*The parents	54	28.8
*Community organisations	21	11.2
*The school in co-operation with parents	121	64.7
non-respondents	2	1

Notes:

1. Percentages sum to more than 100%, since subjects could check more than one category.
2. See corresponding Table 62A in Appendix K for full details.

Well over half of all groups with an overall response rate of 64%, think that the school and parents should assume co-responsibility for providing sex information (sex education) to school children.

In contrast, the reported data indicate that slightly over a quarter of the total sample think that the parents alone should be the source of information. The role of the church in this task, however, is not seen as important.

Should boys and girls be told about contraception? (Q56)

TABLE 63:

	<u>YES</u>		<u>NO</u>		<u>DON'T</u> <u>KNOW</u>		<u>NON-</u> <u>RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	27	90	1	3.3	2	6.6	-	-
G2 (ES)	26	96.2	-	-	1	3.7	-	-
G3 (P)	28	93.3	1	3.3	1	3.3	-	-
G4 (PES)	27	100	-	-	-	-	-	-
G5 (T)	24	92.3	-	-	2	7.6	-	-
G6 (C)	13	76.4	2	11.7	2	11.7	-	-
G7 (HCP)	30	100	-	-	-	-	-	-
TOTALS	175	93.5%	4	2.1%	8	4.2%	-	-

An overwhelming majority with practically all ex-schoolgirl pregnancy cases, the parents of these ex-schoolgirls, and health care professionals endorse the idea that both sexes, boys and girls, should be informed about contraception. A perusal of the responses shows that the clergy members also endorse the same idea. However, it should be borne in mind that clergy numbers are rather small to be statistically significant.

When should sex education begin? (Q57)

TABLE 64:

	<u>Total</u>	<u>Sample</u>
	No	%
*before puberty begins	73	39
*between 10-12 years	55	29.4
*between 13-14 years	44	23.5
*between 15-16 years	2	1
*between 17-18 years	-	-
*18 years and after	13	6.9
non-respondents	-	-

Notes:

1. Percentages sum to more than 100%, since subjects could check more than one category.
2. See corresponding Table 64A in Appendix K for full details.

A perusal of the responses shows that proportionately more subjects, especially both sets of schoolgirls, the clergy and health care professionals, are of the opinion that sex education should begin before the onset of puberty.

However, roughly a quarter of the total sample think that between 10-12 years and between 13-14 years, respectively, are the appropriate ages for starting sex education.

Do you think providing school-based sex education programmes could help in reducing the number of unwanted pregnancies? (Q58)

TABLE 65:

	<u>YES</u>		<u>NO</u>		<u>DON'T KNOW</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	28	93.3	1	3.3	1	3.3	-	-
G2 (ES)	23	85.1	2	7.4	2	7.7	-	-
G3 (P)	29	96.6	-	-	1	3.3	-	-
G4 (PES)	23	85.1	3	11.1	1	3.7	-	-
G5 (T)	23	88.4	1	3.8	2	7.6	-	-
G6 (C)	15	88.2	-	-	2	11.7	-	-
G7 HCP)	28	93.3	-	-	2	6.6	-	-
TOTALS	169	90.3%	7	3.7%	11	5.8%	-	-

Well over 80% of all groups seem to be convinced that the provision of school-based sex education programmes can help in curbing the number of unwanted pregnancies. There is therefore widespread support for school-based sex education as a preventative measure.

As the school is the only social institution that reaches all youths, should it see the teaching of family life and sex education programmes as being its responsibility? (Q59)

TABLE 66:

	<u>YES</u>		<u>NO</u>		<u>DON'T</u> <u>KNOW</u>		<u>NON-</u> <u>RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	23	76.6	2	6.6	5	16.6	-	-
G2 (ES)	18	66.6	2	7.4	6	22.2	1	0.53
G3 (P)	23	76.6	3	10	4	13.3	-	-
G4 (PES)	23	85.1	1	3.7	3	11.1	-	-
G5 (T)	21	80.7	4	15.3	1	3.8	-	-
G6 (C)	14	82.3	2	11.7	1	5.8	-	-
G7 (HCP)	27	90	2	6.6	1	3.3	-	-
TOTALS	149	79.6%	16	8.5%	21	11.2%	1	0.53%

A clear majority (over 70%), with proportionately more subjects in the adult groups, agree that the teaching of family life and sex education should be the responsibility of the school. The implication of this result is that the role of the school in the intervention strategy is generally regarded as important.

Should parents and outside community organisations be consulted in setting up sex education programmes jointly? (Q60)

TABLE 67:

	<u>YES</u>		<u>NO</u>		<u>DON'T</u> <u>KNOW</u>		<u>NON-</u> <u>RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	25	83.3	1	3.3	4	13.3	-	-
G2 (ES)	23	85.1	-	-	4	14.8	-	-
G3 (P)	28	93.3	1	3.3	1	3.3	-	-
G4 (PES)	24	88.8	-	-	2	7.4	1	3.7
G5 (T)	24	92.3	-	-	2	7.6	-	-
G6 (C)	17	100	-	-	-	-	-	-
G7 (HCP)	29	96.6	-	-	-	-	1	3.3
TOTALS	170	90.9%	2	1%	13	6.9%	2	1%

Ninety percent of all groups, with practically all "ordinary" parents, school teachers, clergy members and health care professionals, express the view that there should be joint consultation with parents and outside community organisations when embarking upon a sex education programme.

Should schools be allowed to present parents with course outlines on sex education to urge them to follow up with their children at home? (Q61)

TABLE 68:

	<u>YES</u>		<u>NO</u>		<u>DON'T KNOW</u>		<u>NON-RESP</u>	
	No	%	No	%	No	%	No	%
G1 (S)	26	86.6	-	-	4	13.3	-	-
G2 (ES)	20	74	3	11.1	4	14.8	-	-
G3 (P)	29	96.6	-	-	1	3.3	-	-
G4 (PES)	20	74	2	7.4	2	7.4	3	11.1
G5 (T)	25	96.1	-	-	1	3.8	-	-
G6 (C)	17	100	-	-	-	-	-	-
G7 (HCP)	28	93.3	-	-	1	3.3	1	3.3
TOTALS	165	88.2%	5	2.6	13	6.9%	4	2.1%

Over 80% of all groups, with predominantly "ordinary" parents, school teachers and the clergy, support the idea that parents follow up course outlines on sex education with their children at home. The responses tend to suggest that there is widespread support for a partnership between parents and the school in the task of providing sex education.

Which of the following do you consider to be the most important factors for discussion in a sex education programme? Fill in the blocks as follows:

1. (VI) Very Important
2. (I) Important
3. (NI) Not Important (Q62)

TABLE 69:

Items 62.1 - 62.12			<u>TOTAL</u>	<u>SAMPLE</u>
			No	%
62.1	The Reproductive System in the Male and Female, and how it works; Pregnancy and Childbirth.	1. VI	125	66.8
		2. I	35	18.7
		3. NI	7	3.7
62.2	Contraceptive methods-who is to use them and where they can be obtained.	1. VI	83	44.3
		2. I	70	37.4
		3. NI	10	5.3
62.3	Intelligent choice of a Sexual Life-Style.	1. VI	55	29.4
		2. I	67	35.8
		3. NI	42	22.4
62.4	Help available for pregnant girls.	1. VI	79	42.2
		2. I	68	36.3
		3. NI	13	6.9
62.5	Sexually Transmitted Diseases (STDs).	1. VI	118	63.1
		2. I	40	21.3
		3. NI	5	2.6
62.6	The Advantages of Delaying the First Pregnancy.	1. VI	102	54.5
		2. I	36	19.2
		3. NI	22	11.7
62.7	The Dangers of Having Sex too early.	1. VI	139	74.3
		2. I	28	14.9
		3. NI	-	-

62.8	Strategies for reducing unwanted/unintended pregnancies in schoolgirls.	1. VI	104	55.6
		2. I	46	24.5
		3. NI	12	6.4
62.9	Abortion.	1. VI	78	41.7
		2. I	40	21.3
		3. NI	44	23.5
62.10	How to use leisure time activities.	1. VI	74	39.5
		2. I	71	37.9
		3. NI	18	9.6
62.11	The Risks of falling pregnant and Consequences of Teenage of Pregnancy.	1. VI	129	68.9
		2. I	35	18.7
		3. NI	1	3.8
62.12	Improving Communication between Children and Parents. non-respondents	1. VI	137	73.2
		2. I	29	15.5
		3. NI	6	3.2
			4	2.1

Notes:

1. Percentages sum to more than 100%, since subjects could check more than one category.
2. See corresponding Tables 69A.1-69A.3 in Appendix K for full details.

An examination of the responses to the above question indicates that, generally, the following factors (or topics for discussion) were considered very important. These are given in rank order:

1. The dangers of having sex too early.
2. Improving communication between children and parents.
3. The risks of falling pregnant and consequences of teenage pregnancies.

4. The reproductive system in the male and female, and how it works; pregnancy and childbirth.
5. Sexually transmitted diseases.
6. Strategies for reducing unwanted/unintended pregnancies in schoolgirls.
7. The advantages of avoiding pregnancy.
8. Contraceptive methods - who is to use them and where they can be obtained.
9. Help available for pregnant girls.
10. Abortion.
11. How to use leisure time activities.
12. Intelligent choice of a sexual lifestyle.

In building support for Family Life Education and Sex Education Programmes in the public schools, who do you think would play an important role? In choosing your answer(s), place a cross in the appropriate block(s). (Q63)

TABLE 70:

	<u>Total</u>	<u>Sample</u>
	No	%
63.1 School Teachers	48	25.6
63.2 Clergy in the Community	33	17.6
62.3 School Nurses	74	39.5
63.4 Parents in the Community	59	31.5
63.5 Parents and Teachers	124	66.3
63.6 Persons from various Health Agencies in the Community	69	36.8
63.7 Adolescent and Youth Counsellors	80	42.7
63.8 School Psychologists	52	27.8
non-respondents	4	2.1

Notes:

1. Percentages sum to more than 100%, since subjects could check more than one category.
2. See corresponding Table 70A in Appendix K for full details.

A perusal of the responses here reveal the following general pattern of answers which appear in rank order:

1. Parents and Teachers.
2. Adolescent and Youth Counsellors.
3. School Nurses.

4. Persons from various Health Agencies in the Community.
5. Parents in the Community.
6. School Psychologists.
7. School Teachers.
8. Clergy in the Community.

The responses above show that, first and foremost, "parents and teachers" should play an important role. "Adolescent and Youth" counsellors, "school nurses" and "health agencies" are also ranked as important. However, this finding indicates that there is least support for "school teachers" alone, and the "clergy in the community". It appears therefore that any attempt to implement sex education programmes in schools, must take cognizance of the joint role of parents and teachers for the task.

4.7 THE FINAL OPEN-ENDED QUESTION - CATEGORIES/TOPICS - (Q64)

The following table shows the breakdown of group responses for the broad categories/topics generated by the open-ended essay:

TABLE 71: Breakdown of Group Responses for the Broad Categories.

BROAD CATEGORIES	G1	G2	G3	G4	G5	G6	G7	TOTAL
1. Support for School-Based Sex Education.	33	30	41	21	35	18	33	211
2. Parent-Child Communication.	52	26	15	16	25	11	22	167
3. Parent-School Partnership.	11	7	4	7	13	2	11	55
4. Curricular Content.	27	14	11	2	13	9	16	92
5. Contraception and Contraceptive Information.	12	10	15	11	6	2	4	60
6. Community Intervention.	8	2	16	12	13	12	19	82
7. Moral Education.	9	4	3	5	3	18	3	45
TOTALS	152	93	105	74	108	72	108	712

A relatively large number (177 in total) of essays reviewed, show that fairly comprehensive comments were written by respondents in an attempt to uncover important intervention dimensions on the subject matter under study.

The essays also illuminated the fact that the whole exercise provided the respondents with the opportunity and "the freedom ... to express [their] feelings as fully and as spontaneously as [they] chose" (Cohen and Manion, 1989, p.243).

A perusal of the above numbers of responses reflects that proportionately more written comments were received from G1, G5 and G7 respectively.

The categories or themes that emerged from the wealth of information in the Open-Ended Essay will each be presented in the form of a table of responses reflecting the collective statements/comments from each respective group. The tables of responses appear on the pages following this section.

* * * * *

4.7.1 SUPPORT FOR SCHOOL-BASED SEX EDUCATION

What follows is a selection of extracts from the open-ended essays which should serve to provide a qualitative understanding of some of the categories of responses.

TABLE 72:

G1 : Senior Schoolgirls.

"So my point of view is that SEX EDUCATION MUST BE TAUGHT IN EVERY SCHOOL."

Lee G1.L29

"The girls should be told about sex, when puberty begins."

Ronelle G1.L6

"Schools should have sex education programmes to bring about an awareness of the dangers of pre-marital sex and its consequences."

Ruth G1.L1

G2 : Ex-Schoolgirl Pregnancy Cases.

"Girls from the age of when they menstruate must have the necessary knowledge that they can become pregnant very easily."

Lola G2.L28

"The school, because most of the pupil's time is spent there, should play a major role...and sex education should be introduced as part of the school syllabus."

Florence G2.L9

G3 : Parents of Senior Schoolgirls.

"Today having such [sex education] programmes at school are of utmost importance."

Angel G3.L11

"As far as information about sex and the dangers thereof are concerned, this must be emphasised at the schools."

Jean G3.L25

"Talks should be held about sex with boys and girls."

Julie G3.L28

"Youth and adolescent advisers, teachers and parents must do something urgently otherwise the problem will become worse."

Verna G3.L39

G4 : Parents of Ex-Schoolgirl Pregnancy Cases.

"The best solution is to speak openly with the girls."

Bonita G4.L12

"The formulation of sex education programmes and their implementation are important."

Gerty G4.L9

G5 : School Teachers.

"Sex education at school must be implemented with proper objectives."

Angelo G5.L34

"In many cases early knowledge of sex could have prevented pregnancy."

John G5.L26

"We need a more "open" attitude towards sex education... openness would encourage children to feel confident..."

Faith G5.L22

G6 : Clergy.

"Make them aware of the consequences of pre-marital sex and pregnancies in formal sex education programmes."

Martin G6.L6

"Information and dialogue must start NOW."

Bob G6.L11

G7 : Health Care Professionals.

"Teens have to learn to cope with peer-group pressure."

Britt G7.L26

"Adolescents are hungry for accurate information - most are misinformed. They get information from their peers, the T.V. and the media."

Pearl G7.L3-4

"Choose the correct educator, otherwise the whole project falls flat."

Thomas G7.L2

"Providing school-based sex education programmes can help reduce the number of unwanted pregnancies."

Vanette G7.L18

"Sexual activity in its totality should be discussed frankly and honestly with both boys and girls..."

Tim G7.L18

The greatest number of comments (in all, 211) focused on the issue concerning the support for school-based sex education.

A large majority of subjects express concern about the problem and abundantly support the idea that urgent measures be taken by teachers, parents and health authorities to assist schools in formulating comprehensive sex education programmes.

A significant number of subjects in all groups also made specific suggestions or recommendations for implementing such programmes.

The most common proposals were, for example, that the sex education programmes be school-focused, adolescent-focused, and school-health linked.

4.7.2 PARENT-CHILD COMMUNICATION

TABLE 73:

G1 : Senior Schoolgirls.

"The parents have to tell their children about pre-marital sex."

Rhona G1.L10

"I think parents must talk openly about sex with their children."

Erica G1.L14

G2 : Ex-Schoolgirl Pregnancy Cases.

"Parents must share the blame for the problem, because they never speak openly with their children about sex."

Gail G2.L24

G3 : Parents of Senior Schoolgirls.

"It is the parents' duty to inform their children about sex before the puberty years."

Connie G3.L14

"Parents should speak openly about sex and also answer all questions."

Sheila G3.L5

G4 : Parents of Ex-Schoolgirl Pregnancy Cases.

"The problem is that the youth are shy to come out with their problems."

Gloria G4.L11

"As a parent of an ex-pupil pregnancy case I feel that parents must talk openly to children about sex, birth control measures..."

Lucy G4.L1

"Teenagers should be granted less sexual freedom."

Leslie G4.L5

G5 : School Teachers.

"Parents can attend sex education courses so that they in turn can educate their children at home."

Nadine G5.L25

"Neglecting the duty to talk to the child leads to his learning from the street...they should not think it taboo to discuss sex."

Alvera G5.L8-10

G6 : Clergy.

"It is first and foremost the parents' duty to communicate and provide information about sex to their children."

Solomon G6.L11

"Children who are unsupervised resort to experimentation."

Martin G6.L6

G7 : Health Care Professionals.

"Encourage open discussions between parent and child."

Pearl G7.L1

"There should be increased supervision of pupils' activities [and leisure time] by parents - pupils are left to their own devices too often. There should be frankness [in discussion] on the part of parents about sex and its sequelae."

Bev G7.L10-12

The topic/theme of parent-child communication featured prominently in the relatively large number of comments received.

All parties seem to endorse the idea that greater efforts be made by parents as primary sex educators, to communicate openly with their children about sexual matters.

Also, in addition to "ordinary" parents and parents of ex-schoolgirls, the young girls in this study have themselves indicated that communication about sexual matters should begin at puberty.

4.7.3 PARENT-SCHOOL PARTNERSHIP

TABLE 74:

G1 : Senior Schoolgirls.

"Firstly the parent and teacher should have meetings with nurses telling them how to go about the problem."

Lynn G1.L5

"Teachers and parents should get together and discuss training programmes for teenagers on using contraceptives and the dangers of having pre-marital sex."

Trish G1.L4

G2 : Ex-Schoolgirl Pregnancy Cases.

"Have meetings with parents...to discuss ways of solving the problem of schoolgirl pregnancies."

Fatima G2.L1

"The school should arrange to talk with parents whose daughters are affected by pregnancies."

Tay G2.L5

G3 : Parents of Senior Schoolgirls.

"The crux of the whole prevention strategy is getting the involvement of the parents."

Carol G3.L4

G4 : Parents of Ex-Schoolgirl Pregnancy Cases.

"The parents and teachers must get together and talk about how they can jointly take action at home and at school..."

Yve G4.L3

"Parents in the community should play a greater role in drawing up Sex Education Programmes with school nurses and the pupils."

Sylvia G4.L1

G5 : School Teachers.

"A concerted effort must be made by both parents and teachers to educate children about the physical changes that occur during puberty..."

Faith G5.L6

"Sex education programmes should be implemented in conjunction with the support of parents..."

Patrick G5.L1

G6 : Clergy.

"The school and parents... must jointly decide which intervention projects to tackle."

Theo G6.L1-2

G7 : Health Care Professionals.

"Involve parents in sex education programmes."

Vanette G7.L5

"Educate the parents to enable them to educate their children. This can be done by holding PTA meetings."

Chantelle G7.L2-3

A majority of subjects concede that representatives from schools can schedule meetings (PTA's) or offer forums for discussing prevention strategies. Generally, subjects show great enthusiasm and support for joint initiatives on the part of the school and parents to take on the challenge of pregnancy prevention.

4.7.4 CURRICULAR CONTENT

TABLE 75:

G1 : Senior Schoolgirls.

"Information about birth control, abortion, sex etc."

Sunita G1.L22

"...methods of contraception...the facts of life..."

Rose G1.L13

"Tell them about all Sexually Transmitted Diseases; Dangers of having sex too early; Strategies for reducing unwanted pregnancies; Risks of falling pregnant and the Consequences of Teenage Pregnancies."

Mary G1.L1-2

G2 : Ex-Schoolgirl Pregnancy Cases.

"Discuss and teach the facts of life."

Sandra G2.L1

"peer pressure."

Charmaine G2.L3

G3 : Parents of Senior Schoolgirls.

"...they [girls]... have the right to abstain from sex, and not to follow their friends or because it is the 'in thing'."

Dee G3.L6

"Girls should learn to say NO to boys."

Julie G3.L10

G4 : Parents of Ex-Schoolgirl Pregnancy Cases.

"...talk about the facts of life including sex."

Mandy G4.L2

G5 : School Teachers.

"They should be taught the facts of life."

Natalie G5.L6

"...relationships, responsible decision-making..."

Faith G5.L8

"...the use of contraceptives where and how to obtain them."

Nadine G5.L13

"...show films and disseminate literature on the problem."

Johanna G5.L10

G6 : Clergy.

"...the responsibility of the boy and girl to lead a pure life."

Jenny G6.L9

"The facts of life should be spelled out..."

Brian G6.L4

G7 : Health Care Professionals.

"...learning about physical changes in their bodies, emotional changes, responsibilities and decision-making, peer pressure, communication and relationships, teenage pregnancies and abortions, sexual behaviour and contraception and STD's."

Pearl G7.L2

In total, 177 essays generated some really excellent suggestions for topic areas that might feasibly be included in course content. The key messages that were emphasized were: fostering an awareness of the adolescent pregnancy problem; providing sexuality knowledge at puberty; the "facts of life"; understanding the health risks involved in pre-marital sex; knowledge of sex and conception; teaching decision-making skills; birth control methods; discussions on responsible, ethical and moral behaviour.

4.7.5 CONTRACEPTION AND CONTRACEPTIVE INFORMATION

TABLE 76:

G1 : Senior Schoolgirls.

"I think that sexually active pupils should be made aware of the contraceptives available."

Josey G1.L4

"Discussions concerning correct use of all birth control methods..."

Liz G1.L6

G2 : Ex-Schoolgirl Pregnancy Cases.

"Parents must allow their daughters to have injections if they are sexually active."

Dora G2.L9

"I do not think it is wise to encourage them to use contraceptives at it is like encouraging them to have sex."

Harriet G2.L7

G3 : Parents of Senior Schoolgirls.

"...explain birth control methods to them..."

Doreen G3.L4

"Teenagers can be protected by encouraging them to use contraceptives..."

Kate G3.L14

"Introducing contraceptives to be [made] available at school..."

Judy G3.L3

G4 : Parents of Ex-Schoolgirl Pregnancy Cases.

"Receiving information about contraceptive methods - to my mind there is no other solution."

Gertrude G4.L8

"...if you don't give them this protection, unwanted pregnancies will result."

Ray G4.L10

G5 : School Teachers.

"Inform boys and girls completely about the use of contraceptives - where and how to obtain them."

Nadine G5.L6

G6 : Clergy

"Contraception without sex education promotes promiscuity..."

Matthew G6.L1

G7 : Health Care Professionals.

"Health clinics can provide information on contraception."

Aletta G7.L3

"Family Planning nurse clinicians can give talks and explain and show contraceptive devices..."

Juanita G7.L2

"Stress the use of contraceptives if sex takes place."

Eric G7.L1

With the exception of the clergy, all groups generally show strong support for the provision of contraceptive education for adolescents at school.

Many young ex-schoolgirl pregnancy cases ("the actors") and their parents concede that, as significant pregnancy risks accompany unprotected first intercourse, any real solution to control fertility would be to make contraception available to young girls.

Additional comments on the issue show support for agency-based contraceptive information and counselling programmes that can offer young girls the necessary capacity and motivation to make contraceptive decisions in order to ensure adequate protection.

4.7.6 COMMUNITY INTERVENTION

TABLE 77:

G1 : Senior Schoolgirls.

"There should be more recreational activities and facilities..."

Sunita G1.L8

"Pupils should get frequent talks from Health Agencies about family planning...birth control methods..."

Pinky G1.L5

G2 : Ex-Schoolgirl Pregnancy Cases.

"The community, school, church and parents must aim to create more recreational functions and facilities for the pupils and youth."

Tay G2.L1

G3 : Parents of Senior Schoolgirls.

"The whole-hearted support and co-operation of the total community is essential."

Carol G3.L15

"Family Planning Clinics...at schools..."

Sharon G3.L1

G4 : Parents of Ex-Schoolgirl Pregnancy Cases.

"...the whole community and the health organisations can all make their contribution towards solving the problem."

Anthea G4.L9

"All interested parties must come together and have discussions on the problem and possible solutions."

Runa G4.L12

G5 : School Teachers.

"Sex education programmes should be run by various health agencies in the community."

Loretta G5.L1

G6 : Clergy

"Community workshops and seminars on the subject [awareness programmes] should be held."

William G6.L6

"Community involvement is vitally necessary."

Nolan G6.L1

G7 : Health Care Professionals.

"Involve and establish support groups to assist the community in dealing with the actual problem and prevention."

Lisa G7.L11

"FAMSA Education for Living Programme would be most valuable."

Elize G7.L5

The range of diverse comments relating to the topic of community intervention reflect that, as the problem of schoolgirl pregnancies affects the family, the school and society in general, it is necessary to address the problem on a huge scale in co-ordination with outside community organisations.

Parents of G1 ("ordinary" schoolgirls) and parents of G2 (ex-schoolgirl pregnancy cases), as well as health care professionals, offer specific proposals for utilising the total resources of the community for establishing support groups in tackling the problem.

In essence, all parties generally feel that greater community involvement and community networking with key health clinics and health organisations is crucial in the prevention effort.

4.7.7 MORAL EDUCATION

TABLE 78:

G1 : Senior Schoolgirls.

"The church should have special films and youth group discussions about sex."

Jo-Anne G1.L6

"Sex should be treated with openness and not as 'some dark evil'."

Liz G1.L8

G2 : Ex-Schoolgirl Pregnancy Cases.

"The Church should...advise young people on sexual matters."

Florence G2.L1

"Church must emphasise that sex before marriage is wrong."

Gwen G2.L4

G3 : Parents of Senior Schoolgirls.

"The Church must organise more youth activities for young people."

Connie G3.L2

G4 : Parents of Ex-Schoolgirl Pregnancy Cases.

"Pre-marital sex is wrong and sinful."

Berry G4.L1

G5 : School Teachers.

"...strengthening of the inner [spiritual] nature of the teenagers can lead to a more mature and responsible child."

Angelo G5.L2

G6 : Clergy.

"...that pre-marital sex is SIN and unacceptable..."

Solomon G6.L16

"...a clear understanding and commitment to biblical values-"

Andrew G6.L2

"The moral standards of the community must be improved."

Muriel G6.L14

G7 : Health Care Professionals.

"Parents must encourage their children to be more morally responsible."

Lisa G7.L2

Some 45 brief but pertinent comments on the theme of moral education were received. Basically the issue of pre-marital sex and the inculcation of sound moral values came sharply into focus. The reactions of the clergy, in particular, show that there is a strong commitment to the Church and the teachings of the Bible. This group also expounded the view "that pre-marital sex is SIN and unacceptable", and that young people must be taught to uphold high moral standards (G6.L16, G7.L12).

A consideration of the responses indicates that moral education, entailing teaching the youth ethical and morally responsible behaviour, is deemed important in any sex education programme.

Summary Discussion.

The primary purpose of this section was to gauge the views of subjects on possible solutions for the reduction or prevention of unplanned pregnancies.

This final section, including the responses in the open-ended essay, indicates that a wealth of diverse ideas, insights and understandings of the problem from a personal perspective was received from the seven groups of respondents. To sum, the evidence presented brings the following information to light. Firstly, the vast majority of subjects conceded that the school has a definite role to play in the prevention effort. Secondly, in planning sex education and family life education programmes, the joint role of the school and parents, with the support of outside community organisations, is important. Thirdly, there is overwhelming support for the implementation of school-based sex-education programmes. Fourthly, there is a consensus that sex-education, which has been advocated as a critical factor in ameliorating the problem, should begin before puberty.

In conclusion, it needs to be pointed out that the open-ended question complemented the questionnaire as a whole and possibly enhanced the reliability and validity of the wealth of data collected.

4.8 CONCLUSION

The author was pleased that the results of his investigation fitted into the previously constructed framework and that the discussion proceeded as envisaged.

An inspection of the aggregate data as depicted in the statistical tables and the full responses to the open-ended essay (Appendix J), reveals significant differences for each of the seven groups of subjects in the total sample. One can therefore reasonably accept that the responses obtained are not accidental, but are fairly accurate reflections of the groups' views on the different aspects of the problem.

Further, the aims of this research, as stated in Chapter 1, were in many instances supported by the data offered in this chapter and confirmed by the findings of related research. The author therefore believed that there was agreement between rationale and results in the present study.

The final chapter attempts to place the conclusions, implications and recommendations in a pedagogical perspective.

CHAPTER FIVE

CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

- 5.1 Introduction
- 5.2 Conclusions
- 5.3 Implications
- 5.4 Recommendations to Aid the Implementation of Sex Education as a Component of School Guidance
 - 5.4.1 Rationale
 - 5.4.2 Implementation
 - 5.4.2.1 Role of the School in Initiating, Enlisting Support for and Expanding School-Based Sex Education
 - 5.4.2.2 Suggestions for Designing the Sex Education Curriculum
 - 5.4.2.3 Guidelines for the Teaching of Sex Education
- 5.5 Future Considerations
- 5.6 Limitations of this Study

CHAPTER FIVE

CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The main aim of this study, as stated in Chapter One, was to explore the problem of schoolgirl pregnancies and to suggest the role the school might play in their prevention. On the basis of the results of this study, the most important conclusions will be drawn, the implications for education will be considered, and major recommendations for action will be made.

5.2 CONCLUSIONS

There are clearly many levels on which the problem requires attention. While the present study has highlighted certain predisposing factors such as early sexual maturity, peer-group pressure, lack of sexual knowledge and lack of contraceptive knowledge to premature pregnancy, it has identified schoolgirl pregnancies as a compelling, predictable, and preventable problem (Chapter 4, p.90).

Secondly, its findings call for urgent, targeted efforts for the provision of sex education programmes with the involvement of both girls and boys. Thirdly, it cites the school as a central location in the lives of the young girls and boys, and as the ideal place for the presentation of such programmes. Fourthly, this study's findings mandate greater concern and involvement on the part of the school, the parents and the community to assume leading roles in undertaking preventative intervention strategies for reducing the number of premature and often unwanted schoolgirl pregnancies (Chapter 4, pp.109, 112, 143).

5.3 IMPLICATIONS

The main implications of the reported data are as follows:

- (i) Schools cannot safely ignore questions concerning the problem, as a serious responsibility rests on the shoulders of the teachers and

all those concerned with the education of the school children "to aid, help and guide [these] changing, searching, unfolding personalities on their way to a realistic, visible and defined adulthood" (Kalafatich, 1975, p.120).

- (ii) There is a need for teachers/educators to be aware of the acute demand for accurate, factual and complete information through school-based sex education programmes.
- (iii) Such information should be presented in a manner that is acceptable, realistic, clear, non-judgemental, and sensitive to young audiences.
- (iv) Any conceptual plan of action on the advisability of including a sex education programme in the school curriculum must take into account the joint role of both the parents and the health care personnel in the community for formulating such a programme (Chapter 4, p.143).

5.4 RECOMMENDATIONS TO AID THE IMPLEMENTATION OF SEX EDUCATION AS A COMPONENT OF SCHOOL GUIDANCE

Firstly, the recommendations made in this section attempt to give a broad perspective to school authorities and teachers/educators of Guidance who wish to understand further how the school in particular might play a more meaningful, educative role in the prevention effort. Secondly, it should be borne in mind that the recommendations made are intended as guidelines (not prescriptions) for future action and direction.

5.4.1 Rationale.

The inclusion of a well-structured sex education programme as a component of Guidance and Family Life Education should become a priority in pregnancy prevention for the whole school-going population. Here the school in particular has a unique opportunity to play an instrumental role in its implementation.

Justification for the above view is based on the following reasons:

1. It appears that parents at home are not fulfilling their proper role in providing sex education for their children (Meikle, 1984; Dickman and Gordon, 1988).
2. School children are already exposed to a form of sex education through the mass media and often misinformed peers.
3. Early and comprehensive sex education is vital for helping adolescents make informed and responsible decisions resulting in the primary prevention of premature pregnancies (Pittman, 1986).
4. The ability to avoid an unintended pregnancy is dependent upon two things: the capacity to delay early sexual activity and first pregnancy, and the motivation or desire to do so. Here the school can play a meaningful role in developing school-based sex education that can provide teenagers with both the capacity and motivation they need to delay early sexual activity and thereby curb premature pregnancy.
5. The school is the optimum location for all pupils' sex education since it is already geared for large-scale instruction.
6. As the school is already implicated in the problem and its sequelae, it seems logical that it should be concerned with the prevention effort in the first place and locate preventative programmes within the school setting.

5.4.2 Implementation.

5.4.2.1 Role of the school in initiating, enlisting support for and expanding school-based sex education.

A programme of sex education is "too important a process to be left to chance and equally too complicated to approach in an unstructured manner, or only when circumstances appear to indicate a need" (Preliminary Content for a Secondary School Sexuality Education Programme, 1987, p.3).

In implementing such a programme successfully, the following crucial steps are deemed necessary:

Step 1: The impetus should come from the school which can, as the first step, prepare and publicize a statement of its needs for sex education, and the school's philosophical position on the issue.

Step 2: The school can send a circular notice about its proposed programme inviting parents and community leaders to attend an orientation meeting to acquaint them with the entire programme.

Step 3: The school should enlist community support in the planning process as the implementation of a sex education programme is unlikely to be met by a neutral response from the community if initiated by the school alone. For any real solution it is important that the school acknowledges co-responsibility with the parents and community leaders for tackling a sensitive issue and task that presupposes very clearly defined educational goals.

Step 4: The school can hold regular discussion forums at Parent, Teachers' Association meetings (PTA's) where specific emphasis can be placed on the changing needs and perceptions about the problem that affects all communities. It can also emphasize that all concerned parties become actively involved in supporting the school in its efforts to address the problem on a regular basis.

Step 5: The school can play an important role in becoming the focal point for pregnancy prevention proposals and expanding school-based sex education by

- (i) launching new attempts to re-examine current school policies and curricula relating to sex education;
- (ii) offering timely and accurate sexuality specific information;

- (iii) supplementing the formal instruction with more personal and informal opportunities for open discussion, guidance and counselling;
- (iv) linking knowledge-based sex education programmes with direct preventative health and clinic services;
- (v) building community support for broader initiatives that encompass health care education, family life planning and education, responsible decision-making skills, and communicative skills in relationships (particularly with reference to parent-child relationships);
- (vi) fostering a community networking approach to involve concerned and supportive parents, teachers, administrators, clergy groups, social and health services, and community organisations to counter opposition efforts which are often alleged to be instigated by persons outside the community.

5.4.2.2 Suggestions for designing the sex education programme.

In designing the programme the following points should be borne in mind:

A curriculum advisory committee comprising of a variety of persons with different skills and expertise, such as a school curriculum consultant, trained teachers, guidance counsellors, school psychologists, school nurses, social workers, and other relevant health care professionals can assist in devising the proposed curriculum.

A parent advisory committee, including the clergy, community and civic leaders can then be set up to review the proposed curriculum. Since parents and their communities have their own ethical, moral and religious positions on the subject, it is important that the school designs the programme **with** them so that it reflects their needs, attitudes, values and standards on the issue. In this way, also, a parent-school partnership can be fostered for co-ordinating the programme effectively.

As the prevailing perception of sex education is generally one of suspicion and foreboding by parents and the community, the school has a challenging opportunity to change this perception. For example, in the design of the programme, the school can alter the focus from "sex" (which often implies a singular focus on the physical sex act) to "sexuality" which tends to broaden the focus to include the education of the "whole" person, and one that explores relationships and behaviour within the context of family societal, cultural, religious, moral and ethical values (Sex Education Update, 1990, p.1). In other words there is a need for a programme that is holistic and emphasizes that sexuality is normal, important and can be a planned responsibility. In this way sexuality education can be seen as a preventative approach to make school children aware of the significance of their sexuality, and to encourage sound social and moral attitudes, practices and personal behaviour (see Fig. 4 and Fig. 5 below which best describe sexuality education).

FIGURE 4: Education for Human Sexuality.

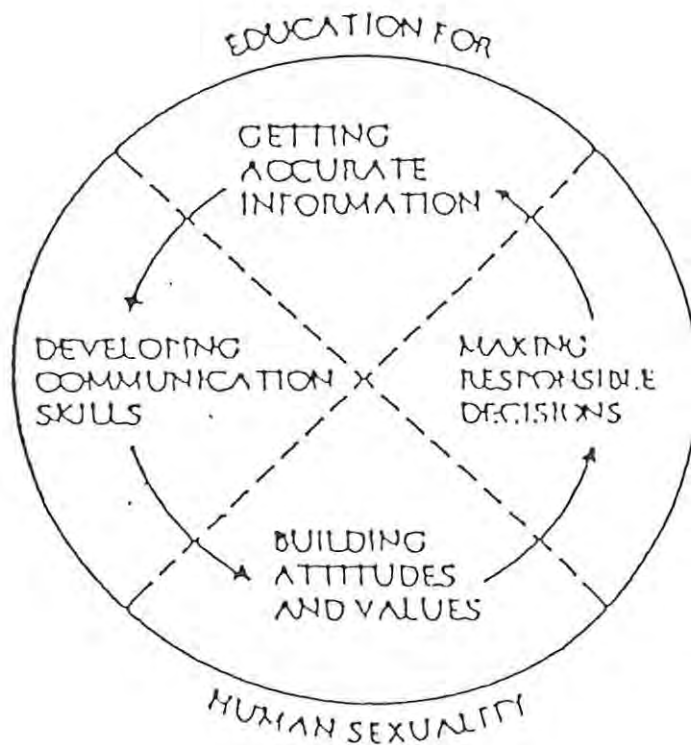
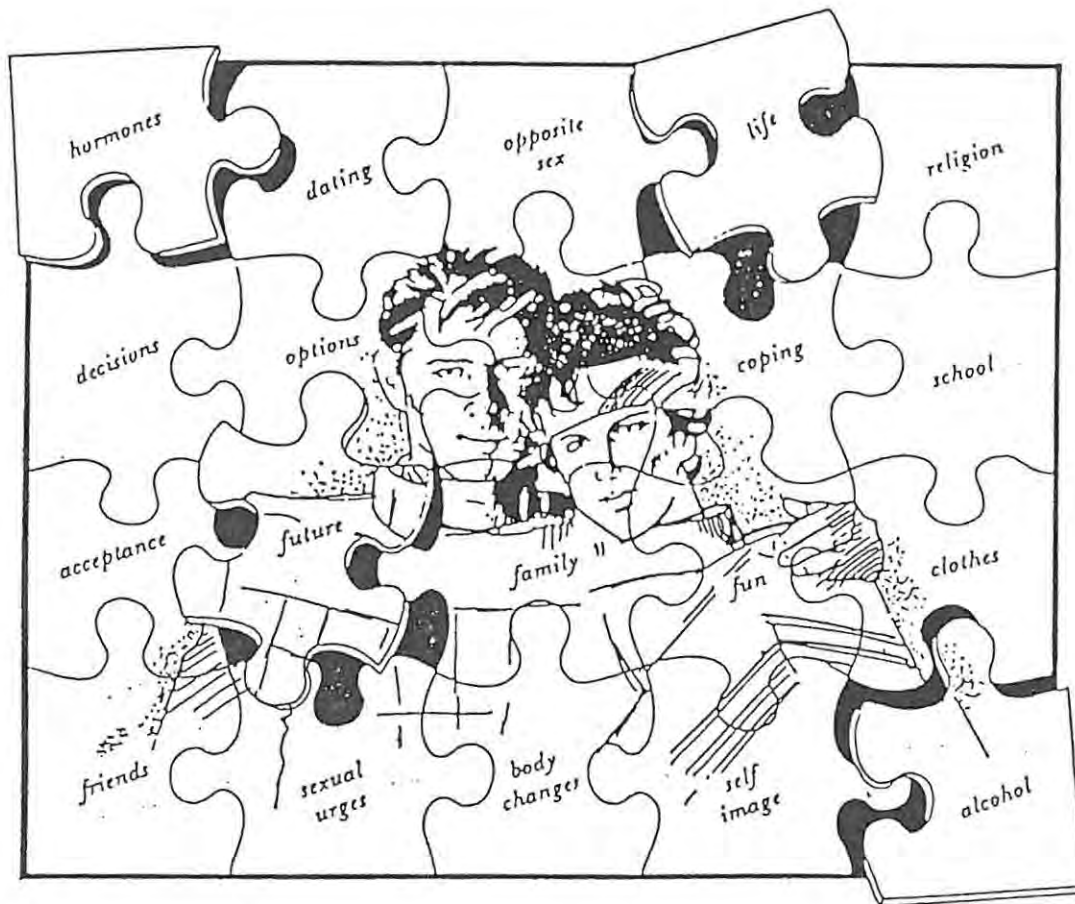


FIGURE 5: Sexuality Education - education of the Whole Person.



Source: Sex Education Update, 1990, p.1 (Fig. 4 and Fig. 5).

In the design of the programme, the formulation of clearly stated objectives that would provide some overall direction, are necessary. The following broad sex education objectives, as suggested by Rogers (1974, p.37), are deemed necessary:

1. To provide for the individual an adequate knowledge of his own physical, mental and emotional maturation processes as related to sex.

2. To minimize fears and anxieties relative to individual sexual development and adjustments.
3. To develop objective and understanding attitudes toward sex in all of its various manifestations-in the individual and in others.
4. To give the individual insight concerning his relationships to members of both sexes and to help him understand his obligations and responsibilities to others.
5. To provide an appreciation of the positive satisfaction that wholesome human relations can bring in both individual and family living.
6. To build an understanding of the need for the moral values that are essential to provide rational bases for making decisions.
7. To provide enough knowledge about the misuses of sex to enable the individual to protect himself against exploitation and against injury to his physical and mental health.
8. To provide the understanding and conditioning that will enable each individual to utilize his sexuality effectively and creatively in his several roles e.g., as spouse, parent, community member, and citizen.

In addition to programme goals, as outlined above, content is important. Researchers in the field (Pittman, 1986; Howard, 1988; Bam, 1989) generally subscribe to the following broad content areas which they believe prevention programmes should have built into their formats. It should be noted that many of the content areas listed below tend to overlap with those suggested by the sample population in this study's findings (see Appendix J). These are:

- * The physiological, psychological and cultural foundations of human development, sexuality and reproduction at various stages of growth.
- * Development of an understanding of the physical, mental, emotional,

- * Development of an understanding of the physical, mental, emotional, social, economic and psychological aspects of close personal relationships.
- * Development of values clarification, decision-making skills, communication skills, coping skills, assertiveness training, problem-solving skills and "refusal" skills.
- * Exposure to various life options, positive role models.
- * Health and sex education, family living, personal growth and enhanced self-esteem, and preparation for adulthood.
- * Contraceptive education and confidential access to contraceptive methods.
- * Importance of moral living and high ethical standards of personal conduct.
- * Opportunity for pupils to acquire a knowledge that will support the development of responsible personal behaviour and in establishing strong family life for themselves in the future.

Since it is virtually impossible to devise programme content that will be acceptable to and serve the needs of all schools and their communities, the author suggests the following four model programmes for sex education. The content is divided into phases which provide age-appropriate learning experiences for meeting the needs of pupils during a particular phase of development, and is practical and flexible enough to be adapted in South African schools. The four model programmes are:

- (i) A Suggested Curriculum (for a Family Life Education Programme), in Dickman and Gordon, 1988, pp.20-22.
- (ii) Pilot Programme for Family Guidance, 1987, pp.1-23.

(iii) Preliminary Content for a Secondary School Sexuality Education Programme, 1987, pp.1-7.

(iv) The Adolescent Sexuality Education Programme, 1989, pp.1-32.

As space precludes a detailed preview of the above-mentioned model programmes, see Appendix F for a complete exposition of the programmes. Also, see Appendix L for a selected annotated bibliography for possible ideas for devising programme content.

However, it must be borne in mind that these programmes are suggested curriculum guidelines, and are by no means to be considered as syllabi to be slavishly followed in schools. Secondly, they are intended to serve as a springboard for schools wanting to develop a sex education programme as a component of Guidance and Family Life Education.

5.4.2.3 Guidelines for the teaching of sex education.

Although content is important, process and approach in the teaching of sex education are more so. It is of paramount importance that a suitably trained teacher or guidance counsellor in the field of sex education be selected for the task.

Using a team approach, such a trained person can then head or co-ordinate the programme with other supporting teachers who possess a sufficient knowledge and perception of the significance of sex education, and who are comfortable with teaching the subject. It is recommended, also, that such a team attend, on a regular basis, in-service training courses in Sexuality and Family Life Education currently offered, for example, by the Department of National Health and Population Development and by The Planned Parenthood Association of Southern Africa, for further guidelines on revising, updating and improving content and approach.

Also, a team approach to sex education guidance can offer stimulating possibilities for cross-curricular input in other subject areas/disciplines such as Biology, Science, the languages, Home Economics, and Physical Education. With the passing of time the idea of sex education should become

team, and provided that there is diligent planning and co-ordination, the way can be opened up for the teaching of some really well-designed and exemplary school sex education programmes.

It is of fundamental importance that intervention programmes be aimed at children before the onset of puberty. There are good reasons why many of the "facts of life" should be taught to children at an early age. An unpublished paper of the Natal Education Department entitled "Sexuality Education as a Component of Guidance and Family Life Education", 1987, pp.2-3, points out that starting sex education early at home and at school can be justified on the following grounds:

1. It is easier and more natural to introduce younger children to correct and complete information about their bodies, about conception, birth, menstruation, male and female reproductive organs and the like, rather than waiting for adolescence when they are more likely to be mischievous and least likely to be receptive.
2. Teaching young children the "facts of life" serves to prevent damaging anxieties about natural processes. Also, they need to know that their sexual development and sexual feelings and fantasies are normal and natural parts of their development, and that they can and should ask questions when they have a problem.
3. Sexuality education [in the broader sense] is a preventative approach. One of its primary objects is to encourage abstinence and responsible, considerate behaviour among young people ...[who] should be comfortable with the concept of sexuality education by the time they reach adolescence.

Ideally, topics or subjects discussed in the classroom should stimulate pupils to continue discussions at home. One practical way for schools to stimulate such discussions is to present parents with samples of course material/course outlines which can be followed up with their children at home. Parents could find this a learning experience for themselves as much as for their children.

Some parents may require the school's help on how to communicate with their children on sexual matters or other sensitive issues. Schools can therefore facilitate a greater understanding between parents and children through scheduling parent education programmes/adult education programmes designed to bridge the generation gap. In addition to improving parent-child communication skills, special workshops and seminars focusing on encouraging parent involvement as a prime objective of the programme can be held over a few weeks.

5.5 FUTURE CONSIDERATIONS

In addition to a scheme of practical suggestions for prevention programmes, there is a need for a basic reorientation of the school's view of the problem, namely a change of heart and a wholly positive approach to the problem.

Schools cannot afford to adopt an apathetic attitude to a perceived growing social problem nor the luxury of leisurely change as their communities live through a rapidly changing world. Addressing the problem and providing sex education should not be looked upon as the private domain of family planning clinics, hospitals, or health organisations, but the responsibility of every school, every parent and every community.

As the general "adult" view of the situation appears to be a problem-orientated one, there is a need to see the situation from the point of view of the adolescents themselves. Regardless of the schools' educational objectives, their priority should be to assist children in attaining a comfortable acceptance of their own sexuality and in pursuing satisfying and meaningful lives. As such, schools need to expand their perspectives on the problem to include a world ten or even twenty years into the future.

In conclusion, it is the author's contention that **information remains the key to prevention**, and that the **community school provides the best hope** for equipping young boys and girls in many ways with knowledge, insight and understanding regarding human sexuality, themselves and their relationships with others so that they "can make [rational and self-protecting] decisions

and choices from a position of strength rather than ignorance" (Rogers, 1974, p.41).

5.6 LIMITATIONS OF THIS STUDY

This exploratory field study involving a micro-analysis on a sample of 187 subjects drawn from one city, invariably has certain limitations. Firstly, because the study purports to be 'situation specific', it cannot claim to have presented data that are generalisable to other regions, as no impression could be gained in this study of subjects in other regions. There is therefore a need to verify this study's findings in further similar investigations covering other regions or settings and possibly encompassing a bigger sample.

Secondly, although every effort was made to achieve a representative sample as possible, there was some under-representation as far as Group 6 (clergy members) was concerned as only 17 (56,7%) out of a possible total of 30 respondents answered the questionnaire (Chapter 3, p.49).

Further, it should be borne in mind that the pupil sample entailed subjects who were school pupils as well as ex-schoolgirl primigravidae drawn from Standard 8 through to Standard 10 with an age range of 13-19 years. This possibly imposed a further limitation in this study.

In summary, despite the above possible limitations, the author expresses the confidence that definite conclusions can be arrived at about the target population within the specific context of this study. He, however, has borne in mind Rochford's remarks that "conclusions made at the end of a thesis or other piece of research, are always tentative, and are never superior to the hypotheses, observations, data and assumptions on which they are based. They may, in the future, be verified, modified or refuted by further research, conducted in a spirit of tolerance, fairness, justice and freedom" (1983, p.38).

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APPENDICES

(A - L)

APPENDIX A

CONTENTS

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APPENDIX A

A GLOSSARY OF CONCEPTS/TERMS AND THEIR DEFINITIONS

An analysis of the subject matter of this study necessitates a clarification of certain concepts and terms. Also there is little uniformity in the terminology generally used in defining certain concepts e.g. adolescent, puberty, sex education, peer group and so on. These definitions may differ from writer to writer in terms of interpretation and implementation. However, in most definitions professional people in the field subscribe to the following explanations which merit attention.

<u>Concept/Term</u>	<u>Explanations</u>
1. abstinence	: avoidance of sexual intercourse (and sometimes considered to be a means of birth control)
2. adolescence	: the term "adolescence" is a nebulous term with widely differing connotations. From a developmental point of view adolescence is regarded as the period between the beginning of puberty and the attainment of adulthood. Many writers subdivide the adolescent period further into early, middle or late adolescence. In this study the more inclusive term "adolescence" (which includes puberty as the beginning of adolescence) will be used to denote the group of secondary school pupils involved in the pupil sample. It is generally the period from approximately 12 years to about 22 years (12-21 for girls; 13-22 for boys) (Dreyer, 1980, p. 14).
3. adolescent/teenage births/pregnancies	: the percentage of the total number of children born alive to mothers under the age of 20 years.
4. ambivalence (about contraceptive use)	: an adolescent's mixed feelings about using contraception.

5. conception : the beginning of pregnancy when sperm and ovum unite (fertilisation).
6. contraception : the practice of birth control: the term used in this way means "to stop conception" or "to keep from having a baby" including birth control techniques (Konopka, 1966, p.54).
7. culture : the sum total of all the experiences and expectations with which a person grows up. (Konopka, 1966, p.12).
8. double standard : Evalyn (1966) explains the term in context of sexual standards, asserting that premarital intercourse is acceptable for men, but it is unacceptable for women (cited in Semmens and Krantz, 1970, p.128).
9. height of fundus : When a pregnant girl cannot conceal her pregnancy any longer; the bulging stomach is readily visible.
10. menarche : the beginning of menstrual periods at puberty.
11. menses : the vaginal bleeding which results from the shedding of the lining of the womb (uterus) each month during menstruation.
12. promiscuity : frequent, casual sexual intercourse with more than one partner, without a close or intimate relationship.
13. primigravidae : girls/females (usually adolescent girls) who have fallen pregnant for the first time.
14. puberty : under the term "puberty" is understood physical maturation (about 12-13 years for girls and about 13-14 years for boys), the period at which the reproductive functions reach an effective stage. (Dreyer, 1980, p.14).

15. senior secondary phase : refers to the last 3 years of secondary school generally known as standards 8,9 and 10 (in South Africa).
16. sex education : although some writers make a distinction between the terms "sex education", "(human) sexuality education" and "family life education", the three terms will be used interchangeably in this work. However, where possible, the term "sex education" will be used exclusively to avoid confusion. For many writers the term "sex education" is too narrow. Instead the terms "family life/family living/sexuality education" are used interchangeably to refer to courses or curricula. (McKay, 1984, p.26).
- Others use the terms "family life/family living" to mean something even broader than sexuality education, including such topics as family economics, parenting skills and childcare. Sex education, generally, is a reference to learning programmes designed to help children understand human reproduction and sexual behaviour (Dacey, 1982, p.461).
17. sexuality education : a learning process which includes discussions of responsibility and ethical behaviour, stressing the importance of understanding sexuality in all its aspects - human growth, sexual development, social relationships and decision-making, as well as information on the biology of reproduction (The Planned Parenthood Federation of America, 1982, p.1).

APPENDIX B

CONTENTS

Correspondence B1 - B8, pp.176-187

APPENDIX B
CORRESPONDENCE
B1 - B8

B1

DEPARTEMENT VAN NASIONALE GESONDHEID
EN BEVOLKINGSONTWIKKELING



DEPARTMENT OF NATIONAL HEALTH AND
POPULATION DEVELOPMENT

GW 14 13

Republiek van Suid-Afrika

Republic of South Africa

Faks:	Telegramadres:	Navier/Enquiries:
Fax:	Telegraphic address: "SAGWEP"	Mrs V Charleston
Teleks:	Privaatsak X63	Verwysing/Reference: 18/7/1
Telex:	Private Bag	
Telefoon:	0001 Pretoria	
Telephone: 3255100x451		

Mr I M Kooverjee
PO Box 7182
EAST LONDON
5200

1990

Dear Mr Kooverjee

Thank you for your telephone enquiry last week. We share your concern regarding the problem of teenage pregnancy.

Statistics collected by our department show that on a nationwide basis as many as 74% of teenage girls become pregnant before their 20th birthday, while the latest figures we have for East London show that 17.1% of all births in that area were to teenage girls. This figure is believed to be much higher this year but the processing of more recent data is not yet complete.

I am enclosing for your information a copy of a paper presented by one of our staff which highlights the background to the establishment of adolescent services within the Family Planning programme, together with a variety of literature regarding sexuality - in particular, teenage sexuality.

Our department has an excellent programme on sexuality education which prepares teachers, nurses, etc. to give this kind of education. Should you require details of this please let me know.

Further information can also be obtained from the Family Planning component of CPA Hospital and Health Services.

Yours faithfully

DIRECTOR-GENERAL

DEPARTEMENT VAN NASIONALE GESONDHEID
EN BEVOLKINGSONTWIKKELING



DEPARTMENT OF NATIONAL HEALTH AND
POPULATION DEVELOPMENT

GW 1/6.1.3

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Private Bag
0001 Pretoria

Navrae/Enquiries: Mrs V Charleston
Verwysing/Reference: 18/1/1

Mr I M Kooverjee
P O Box 7182
EAST LONDON
5200

90/07/24

Dear Mr Kooverjee

re: SEXUALITY EDUCATION

Your letter of 16th June and previous telephonic communication refers.

We are glad to hear of your concern regarding the need to provide sexuality education for our youth and hope that the information already forwarded to you will be of assistance.

Unfortunately we are not in a position to confirm whether an official syllabus for sexuality education exists for White, Coloured and Indian Education Departments as this does not fall within our area of jurisdiction. We are, however, aware that the Transvaal Education Department has been giving serious attention to this matter. In addition the House of Representatives' Department of Education and Culture last year forwarded to us a proposed syllabus for Family Guidance which included sexuality education. We suggest, therefore, that you contact your Head Office for further information in this regard.

As regards the sexuality education syllabus approved for use by the Department of Education and Training it is not possible to send you a copy as it is designed to be used by members of our Department, or other suitable, selected personnel who have received special training for this purpose. However if you would like a member of our staff to call on you and discuss the possibility of running such a training programme may we suggest you contact Miss R Plenaar in our regional office in Port Elizabeth, telephone 56-0220. She will arrange that a member of our staff meets with you to discuss your specific needs.

We will forward to her a copy of your letter so that she is fully informed.

Yours sincerely

DIRECTOR-GENERAL

Address

.....
.....
.....

Dear Parent

The Department of National Health and Population Development is presently involved in giving talks at schools, to groups of teenagers. The topics are presented by trained Youth Educators. The topics they discuss include:-

- (a) Human anatomy, menstruation, conception and pregnancy
- (b) Psychological development in adolescence
- (c) Consequences of sexual involvement
- (d) Self-esteem, values and norms in personal relations
- (e) Communication skills and decision making
- (f) Responsible parenthood

If You have any objections to your son or daughter being involved in this programme, please complete this form and return it to the school.

Thank you for your co-operation.

Yours sincerely

PRINCIPAL

Cut here and return signed bottom portion to school

Name of School:
Your Surname:
Your Daughter/Son's Name:
Your Daughter/Son's Age:

No, my daughter/son may not attend the discussions led by the advisers of the Department of National Health and Population Development.

Signature: Date:

DEPARTEMENT VAN NASIONALE GESONDHEID
EN BEVOLKINGSONTWIKKELINGDEPARTMENT OF NATIONAL HEALTH AND
POPULATION DEVELOPMENT

Republiek van Suid-Afrika

Republic of South Africa

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Telegramadres: "SAGWEP"
Telegraphic address:Privaatpak X828
Private Bag
0001 Pretoria

Pretmed Building

Navrae • Enquiries: Mrs S S Macala

Verwysing • Reference: 31/9/1(8771)

Mr I M Kooverjee
P O Box 7182
EAST LONDON
5200

05/07/91

Dear Sir

POPULATION DEVELOPMENT

You wrote to us asking for the latest statistics on teenage pregnancies in RSA.

The latest statistics which our office has are for 1989 - 1990 combined.

RSA 1989 - 1990 :

Whites	: 5,9
Coloureds	: 12,8
Asians	: 8,2
Blacks	: 16,5

At regional level they are:

Region	Whites	Coloureds	Blacks	Asians
A	3,0	12,9	4,6	5,6
B	4,3	13,5	11,0	-
C	5,8	13,4	13,7	-
D	4,9	12,8	5,5	6,0
E	5,3	10,9	8,8	9,0
F	7,5	12,0	13,1	-
G	6,0	-	22,3	-
H	6,8	11,6	9,6	5,1
J	7,0	12,9	7,7	-

We hope that this information will assist you in your research. We wish to receive a copy of your research when it has been completed.

Yours faithfully


DIRECTOR GENERAL

Frere Hospital
Private Bag 9047
East London
5200

20 July 1988

Dr D.A. Williamson
Deputy Medical Superintendent
Frere Hospital

Dear Dr Williamson

RE : TEENAGE PREGNANCIES

Further to our telecommunication I enclose a breakdown of teenage pregnancies in our Obstetric Unit over the past 6 years, divided into 12 to 16 and 17 to 19 categories.

As you see, there has been a downward trend in percentages since 1982, but this does not appear to be really significant, and we still have large numbers in the 12 to 16 group.

I have endeavoured to find out the position as far as sex education programs are concerned. It appears that these are in the hands of the Family Planning authorities, and the person to contact would be Mrs Keough. The former program run by doctors has been stopped.

Yours sincerely,



DR B.C. UYS
DEPARTMENT OF OBSTETRICS & GYNAECOLOGY
FRERE HOSPITAL
EAST LONDON

BCU/

MINUTE

REPUBLIEK VAN SUID-AFRIKA



REPUBLIC OF SOUTH AFRICA

Vanw. No./Ref. No.

Navvrae/Enquiries: HISS I. J. SUTER
Tel. No. 43.9857 ex. 239

KANTOOR VAN DIE—OFFICE OF THE

YOUTH EDUCATION
C.P.A. (HOSPITAL AND HEALTH SERVICES)
EAST LONDON 1988

Die/The

STATISTICS OF COLOURED TEENAGE PREGNANCIES (13-19 YEARS)

1982	25%	OF ALL COLOURED BIRTHS AT FERGIE HOSPITAL WERE FROM ADOLESCENTS.
1983	17%	" " " " " " " " " " " "
1984	17%	" " " " " " " " " " " "
	68,2%	OF ALL TEENAGE DELIVERIES
1985	21,9%	" " " " " " " " " " " "
	20,3%	OF ALL TEENAGE DELIVERIES
1986	18%	" " " " " " " " " " " "
	= 16,1%	OF ALL TEENAGE DELIVERIES
1987	18%	" " " " " " " " " " " "
	= 11%	OF ALL TEENAGE DELIVERIES

TEENAGE PREGNANCY RATE (E.C. AREA - UP TO CATHLAM) 1988

Whites	7.2	is expected to be 6 by year 2015. Per 1000 adolescents (19 and younger)
Coloureds	15.7	
Asiatics	5.7	
Blacks	14.7	

TEENAGE PREGNANCY RATE FOR R.S.A.

	1980	1985	
Whites	8.7	7.6	Per 1000 (ORDINARY) ADOLESCENTS (19 AND YOUNGER)
Coloureds	17.2	14.8	
Asiatics	22.6	10.5	
Blacks	14.3	13.7	

ALL WOMEN TOTAL FERTILITY RATE FOR R.S.A.

	1980	1985	
Whites	2.1	2.1	Per 1000 WOMEN (ORDINARY WOMEN)
Coloureds	3.3	2.9	
Asiatics	2.7	2.4	
Blacks	5.2	4.5	

FRERE HOSPITAL - TEENAGE DELIVERIES

YEAR		WHITE	COLOURED	BLACK	ASIATIC	TOTAL	%	
1982	12-16	17	31	170	0	218		
	17-19	120	140	661	2	923		
		137	171	831	2	1141	22%	
							(COLOURED 25,6%)	
1983	12-16	19	33	136	2	190		
	17-19	113	123	408	5	649		
		132	156	544	7	839	16,5	
							(COLOURED 22,1%)	
1984	12-16	9	30	128	2	169		
	17-19	84	136	439	2	661		
		93	166	567	4	830	15,8	
							(COLOURED 22,8%)	
1985	12-16	14	22	134	3	173		
	17-19	75	139	399	4	614		
		89	161	533	7	790	15,8	
							(COLOURED 21,9%)	
1986	12-16	9	20	185	0	214		
	17-19	59	122	479	4	664		
		68	142	664	4	878	16,7	
							(COLOURED 18%)	
1987	12-16	14	30	175	0	219		
	17-19	58	125	584	5	772		
		72	155	759	5	991	17,7	
							(COLOURED 19,4%)	
1988	12-16	10	11	88	1	110		
	17-19	39	55	239	2	335		
		49	66	327	3	445	16,3	
							(COLOURED 18,1%)	

MINU'

RE: 'UBLIEK VAN SUID-AFRIKA



REPUBLIC OF SOUTH AFRICA

Verw. No./Ref. No.

KANTOOR VAN DIE—OFFICE OF THE

Navrae/Enquiries:

CHIEF DIR: Pop. Dev.

Tel. No.

P/BAG X 9015

EAST LONDON 18/6/1991

Die/The

PO Box 7182

EAST LONDON

5200

DEAR MR KOUARTEE

ENCLOSED PLEASE FIND THE 1990 FREAE TEENAGE
 DELIVERY FIGURES. MY CONTACT THERE, MISS B
 HADDAD IS NOW THOROUGHLY INTERESTED IN YOUR
 RESEARCH WHICH I HAVE TOLD HER ABOUT. SHE IS
 VERY KEEN TO OBTAIN SOME FEEDBACK FROM YOU
 WHEN POSSIBLE CONCERNING YOUR FINDINGS.

SHE IS IN THE MATERNITY SECTION OF FREAE
 HOSPITAL, P/BAG 9047, E. L. OR PHONE 27350
 AND ASK FOR MATERNITY AND THEN HER.

I HAVE GIVEN HERE RSA TEENAGE FIGURES, AND
 I SEE THESE DIFFER WITH THE OTHERS I
 GAVE YOU FROM ANOTHER REPORT. I WOULD
 IGNORE OUR NATIONAL ONES & USE THE ONES YOU
 HAVE — THESE ONES ARE A KIND OF DESHUFFLE OF
 DATA, AND ANYWAY, THEY DON'T GIVE VERY RECENT
 FIGURES. THE HANDWRITTEN FIGURES ARE
 'REGION 21 FIGURES' IE UP TO AND INCLUDING
 QUEENSTOWN

AND THAT'S ABOUT ALL I HAVE. TO GET MORE ONE
 WOULD HAVE TO GO FROM CLINIC TO CLINIC ETC WHICH
 IS NOT RELEVANT TO YOU NOW.

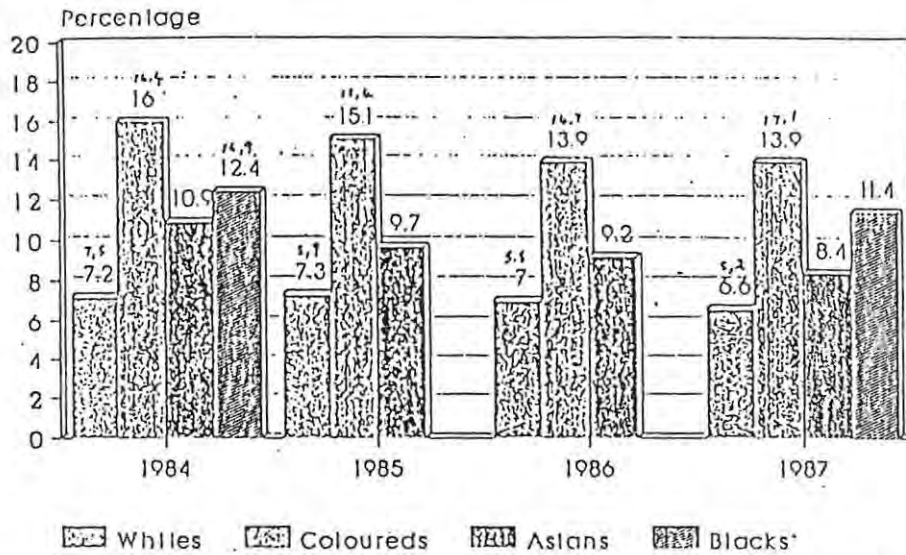
MEDICAL STAFF I HAVE SPOKEN TO REGARD FREAE
 HOSPITAL AS THE MAIN CATCHMENT HOSPITAL IN
 THIS AREA FOR ALL DELIVERIES, SO THEY ARE A GOOD
 REFLECTION.

PLEASE KEEP IN TOUCH CONCERNING QUERIES,
 RESULTS ETC.

REGARDS

JANET SLATER

TEENAGE BIRTHS: RSA



TOP FIGURES ARE FOR BONAER CORNU UP TO AND INCLUDING QUEENSTOWN AREA.

PRINTED FIGURES ARE RSA

*Blacks
1ST SURVEY: 1983-1985
2ND SURVEY: 1986-1989

RSA 2015 OBJECTIVE:

W - 3,2
C - 6
A - 5
B - 8,8

SOURCE, IDP MONITORING REPORT, 1981
DEPT NAT H & POP DEV.

TEENAGE BIRTHS - FRERE HOSPITAL

1985	W 7,2) C 21,9) B 18,0) A 11,5)	15,8
1986	W 5,9) C 18,0) B 20,3) A 7,0)	16,7
1987	W 6,6) C 19,4) B 20,8) A 8,5)	17,7
1988	W 7,3) C 21,7) B 19,9) A 9,7)	17,8
1989	W 6,6) C 22,0) B 20,1) A 10,6)	18,1
1990	W 5,2) C 22,1) B 18,9) A 23,5)	18,6

ADMINISTRASIE: RAAD VAN VERTEENWOORDIGERS
ADMINISTRATION: HOUSE OF REPRESENTATIVES



Republiek van Suid-Afrika
Republic of South Africa

DEPARTEMENT VAN ONDERWYS EN KULTUUR
DEPARTMENT OF EDUCATION AND CULTURE

Adresseer alle briewe aan die
UITVOERENDE DIREKTEUR

All communications to be
addressed to the
EXECUTIVE DIRECTOR

Navrae
Enquiries

MR. H. IVY

Verwysingsno.
Reference No.

7/52

LIBERTY LIFE TOWERS
ROELANDSIRAAT 37 ROELAND STREET
PRIVAATSAK/PRIVATE BAG 9008
KAAPSTAD/CAPE TOWN
8000

Mr. J. Kooverjee
P.O. Box 7182
EAST LONDON
5200

1988-08-15

Dear Sir

INFORMATION REGARDING SEX EDUCATION

In pursuance of my evenly numbered letter dated 13 July 1988, I enclose a copy of the Core Programme for Family Guidance, as well as a progress report on Family Guidance, for your use.

Yours faithfully

EXECUTIVE DIRECTOR: EDUCATION AND CULTURE



Telegramadres: "SAGWEP"
Telegraphic address:
Telex:
Telex:
Telephone: 3201080 X278
Telephone:

Privaatsak XEJ
Private Bag
0001 FICTORIA

Naviae Inquiries: Mrs M Cloete
Verwysing/Reference: 31/4/2/2/10/2

TO ALL WOMEN'S ORGANIZATIONS

16. 8. 89

POPULATION DEVELOPMENT OBJECTIVES AND THE ROLE OF THE WOMAN

The Work Committee of the Council for Population Development concerned with the role of the woman advises the Council and the Chief Directorate Population Development, from the point of view of the private sector, on matters relating to the role of the woman and how it can contribute to the achievement of the aims of population development.

Since 1987 several women's organizations focused on community and population development at a simposia held throughout the country. The priorities, identified at these simposia, were processed by this Work Committee with the aims of population development in South Africa in mind. It became apparent that several issues should receive immediate attention but the most irksome proved to be teenage pregnancies.

Women and women's organizations of all population groups regard teenage pregnancies and related teenage problems as an issue of public interest. It is universally accepted that women could play an important role in addressing this problem. The current statistics on births for mothers under 20 years, portrayed as a percentage of the total number of babies born for the different population groups, are as follows

Whites	- 7,0%
Asians	- 9,2%
Coloureds	- 14,0%
Blacks	- 14,7%

The abovementioned is just for actual births. The number of pregnancies which ended in an abortion or the death of the mother are not included. This complex problem needs a comprehensive focus on the teenager, the role of the parents and the whole community. Inadequate communication between parents and teenagers, insufficient schooling, ignorance and illiteracy of the mothers of teenagers are only a few underlying causes of a problem needing urgent attention.

This Work Committee decided to concentrate in 1990 specifically on teenage pregnancies and would like to put forward to you the suggestion that with your participation we could make it a country-wide attempt.

An illustrated storybook on teenage sexuality aimed at the illiterate teenager is being prepared and there are several brochures and videos available.

If your organization should accept the idea, this Work Committee is available to assist you in your planning with suggestions and a list of the available visual material.

For your convenience the telephone numbers of people to contact are given below:

- Mrs F Zerwick - Chairman of Work Committee
Tel: 05652 - 1421
- Mrs M Cloete - Official at the Department
Tel: 012 - 3201080 X278
- Mrs V Eloff - Official at the Department
Tel: 012 - 3201080 X277

We again supply you with the information paper sent to all women's organizations in September 1988. We also would like to thank those organizations who already reacted. Your positive attitude towards the Population Development Programme is appreciated.

We anxiously await your answer.

187

Yours faithfully

Sale Gwede

CHAIRMAN:
COUNCIL FOR POPULATION DEVELOPMENT

APPENDIX C

CONTENTS

Corresponding Full Tables on Teenage Deliveries at
Frere Hospital for the five-year period 1986-1990

[Tables : 6A (1986); 6B (1987); 6C (1988);
6D (1989); 6E (1990)], pp.188-191

APPENDIX C

FULL TABLES ON TEENAGE DELIVERIES AT
FRERE HOSPITAL (MAIN CATCHMENT AREA FOR
THE EAST LONDON REGION) FOR THE FIVE-YEAR PERIOD 1986-1990

TABLE 6A : Teenage Deliveries at Frere Hospital (1986).

AGE	WHITE	COLOURED	BLACK	ASIAN	TOTAL
12	-	-	-	-	-
13	-	-	1	-	1
14	1	1	10	-	12
15	3	3	43	-	49
16	5	16	131	-	152
17	14	25	138	2	179
18	18	51	173	-	242
19	27	46	168	2	243
TOTALS	68	142	664	4	878
Total No. Confine- ments	1156	791	3263	57	5267
% of Teenage Confine- ments	5.9	18.0	20.3	7.0	16.7

TABLE 6B : Teenage Deliveries at Frere Hospital (1987).

AGE	WHITE	COLOURED	BLACK	ASIAN	TOTAL
12	-	-	-	-	-
13	1	-	2	-	3
14	-	3	9	-	12
15	4	7	41	-	52
16	9	20	123	-	152
17	22	30	195	1	248
18	17	39	165	3	224
19	19	56	224	1	300
TOTALS	72	155	759	5	991
Total No. Confine- ments	1094	797	3642	59	5592
% of Teenage Confine- ments	6.6	19.4	20.8	8.5	17.7

TABLE 6C : Teenage Deliveries at Frere Hospital (1988).

AGE	WHITE	COLOURED	BLACK	ASIAN	TOTAL
12	-	-	1	-	1
13	-	-	2	-	2
14	-	4	6	-	10
15	2	12	45	-	59
16	5	15	106	-	126
17	11	31	135	2	179
18	16	50	217	-	273
19	37	40	208	1	286
TOTALS	71	152	710	3	936
Total No. Confine- ments	976	701	3558	31	5266
% of Teenage Confine- ments	7.3	21.7	19.9	9.7	17.8

TABLE 6D : Teenage Deliveries at Frere Hospital (1989).

AGE	WHITE	COLOURED	BLACK	ASIAN	TOTAL
12	-	-	-	-	-
13	-	-	2	-	2
14	-	3	12	-	15
15	1	7	59	1	68
16	6	17	133	1	157
17	9	34	174	-	217
18	18	48	223	1	290
19	32	53	272	2	359
TOTALS	66	162	875	5	1108
Total No. Confine- ments	995	734	4350	47	6126
% of Teenage Confine- ments	6.6	22.0	20.1	10.6	18.1

TABLE 6E : Teenage Deliveries at Frere Hospital (1990).

AGE	WHITE	COLOURED	BLACK	ASIAN	TOTAL
12	-	-	2	-	2
13	-	-	3	-	3
14	1	-	12	-	13
15	2	2	52	-	56
16	3	10	120	-	133
17	12	29	198	-	239
18	14	52	243	3	312
19	29	45	239	1	314
TOTALS	61	138	869	4	1072
Total No. Confine- ments	1174	655	4601	17	6447
% of Teenage Confine- ments	5.2	22.1	18.9	23.5	16.6

APPENDIX D

CONTENTS

In-School Survey:

Questionnaire administered in 1985, pp.192-193

APPENDIX E

CONTENTS

Brief Summary of Findings of
In-School Survey Conducted in 1985, pp.194-196

APPENDIX E

BRIEF SUMMARY OF FINDINGS OF IN-SCHOOL SURVEY CONDUCTED IN 1985

1. INTRODUCTION

This section contains the results and discussion, verbatim and as supplied by the Guidance Department of the author's school, of the subjects' responses to various questions contained in a simple questionnaire (See Appendix A).

The main purpose of the In-school study was to obtain views generally of pupils and parents on the subjects covering The Reproductive System of the Human Body, Sex, and Teenage Pregnancies.

A random sample of 837 subjects (pupils N=522 and parents N=315) participated in the questionnaire. The age range of pupils was 13-19 years.

2. RESULTS AND DISCUSSION OF QUESTIONNAIRE DATA

The results are described according to the sequence of questions in the questionnaire. The analysis of the results will be presented in accordance with the following categories:

The following categories and questions refer:

The Reproductive System

Question 1: Do you feel you have an adequate understanding of the act of intercourse?

Question 2: Do you have an adequate understanding of the Reproductive System in the male body and how it works?

Question 3: Do you have an adequate understanding of the Reproductive System in the female body and how it works?

The results and discussion are as follows:

On average 76,6% answered negatively. This is a clear indication that the pupils do not have a sound and clear understanding about the biological aspect of sexuality in its totality. This could possibly be rectified at school during guidance periods perhaps.

SEX

Question 4: When you have questions on sex, who do you ask?

The results and discussion are as follows:

Parents - 35%

Friends and other - 65%

It is clear that the children seek answers to their questions on sex elsewhere than their parents.

LEARNING ABOUT SEX

Question 5: From whom did you learn what you know about sex?

The results and discussion are as follows:

Parents - 14,8%

Literature - 25%

Friends and other - 60%

Once again it is proved that children learn what they know about sex from friends or other sources.

Parents play, once again, a minimal role.

SPEAKING ABOUT SEX

Question 6: How much do you and your friends "Talk Sex"?

The results and discussions are as follows:

Often - 48%

Seldom - 44%

Never - 7%

The majority of the children speak daily about sex. Perhaps if they were enlightened about sexuality on the whole it would not be such a novelty to them.

WHAT SHOULD BE DISCUSSED

Question 7: What ideas, problems do you think we should cover on sexuality?

The results and discussion are as follows:

In most cases the children left this question unanswered. Many felt sexuality in its totality should be discussed. Pre-marital sexual intercourse should be discussed and also its after-effects. The communication between parents and their children should also be discussed.

TEENAGE PREGNANCIES

Question 8: Why are there so many teenage pregnancies today?

Question 9: How can teenagers help solve this problem?

Question 10: How can adults help teenagers solve this problem?

The results and discussion are as follows:

Teenagers feel that contraceptives would solve teenage pregnancies. They feel that if parents spoke more freely about sexuality it would prevent unwanted pregnancies to a certain extent. They would then be enlightened on the consequences of pre-marital sexual intercourse.

Another aspect that came to light was that teenagers did not know "where to draw the line".

The pupils also felt that girls were too permissive.

The general feeling was that teenagers should stay at home and not frequent the discoteques.

The pupils further felt that the mass media influenced teenage pregnancies. They felt that too much sex was portrayed on TV, in films, in books, etc. This situation led to experimentation on the part of the teenagers.

SUMMARY

The majority of the pupils felt that parents should speak more freely to them about sex and not regard it as taboo.

APPENDIX F

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Copies of Four Model Programmes
to serve as Guidelines for Implementing
Sex Education in South African Schools, pp.197-263

APPENDIX F

COPIES OF FOUR MODEL PROGRAMMES TO SERVE AS GUIDELINES FOR IMPLEMENTING SEX EDUCATION IN SOUTH AFRICAN SCHOOLS

MODEL PROGRAMME 1

20

A SUGGESTED CURRICULUM

Outline of suggested topics and concepts for a family life education program. Emphasis is on the sexual dimensions of a family life curriculum, as well as on self-esteem and concern for others. Discussion of controversial issues should present all sides.

Early Grades (K-3) (Class 1 - Std 1)

1. Everyone is part of a family.
2. Not all families are the same.
3. Everyone is either male or female.
4. Boys and girls are different. What are the main differences?
5. What are the main differences between grown men and grown women?
6. But boys and girls, men and women, have more similarities than differences. Both sexes enjoy having fun and making friends. Both want to grow up healthy and educated and get a job they like. Most people want to marry someone they love and start a family of their own. Some people don't want to get married or have children, and that's all right, too.
7. How are babies born?
8. How do humans and lower animals and plants reproduce? What are the differences between reproduction in animals and in humans?
9. The correct terms for the main parts of the body: For example, the fetus grows in the uterus, not in the stomach.
10. Understanding that there is a growing process during gestation.
11. Parental roles and their significance for growing children.
12. Getting along with other people.
13. Human babies need love, time, and care in order to grow and develop.
14. All sexual behavior should be conducted in private.
15. No one other than yourself should touch or fondle your genitals—even someone you know. If anyone does or wants to, say no, then tell your mother, father, or someone else you trust right away. (This is not always easy for a child to do, but children need to know that if it happens to them it is not their fault.)

Middle Grades (4-6) (Std 2 - 4)

1. Both boys and girls need equal opportunities for growth and development. We need to accept and value people who have handicaps; who are not popular; who differ from us in religion, race, cultural, ethnic, or economic backgrounds. Prejudice, discrimination, and sexism are unfair and contrary to our democratic tradition.
2. Heredity. One sister (or brother) is different from another sister (or brother). Fraternal twins differ from each other.
3. Hormones that influence growth. Puberty.
4. The onset of menstruation.
5. Nocturnal emission (wet dreams).
6. Dispelling myths about masturbation.
7. Understanding the importance of responsible social behavior that is consistent with moral and ethical values.

8. Our main values come from family life. Schools provide supplementary facts and ideas that can help youngsters make decisions.
9. Family life can change, bringing joy or sorrow, or sometimes both. Some examples: birth of a baby, moving to a new home, breakup of a marriage, serious illness, death, loss of a job, poverty.
10. Becoming aware of individual differences in the rate and timing of physical changes.
11. Learning about sexually transmitted diseases, including AIDS.
12. How to prevent sexual abuse—understanding “right” and “wrong” touching (rather than “good” and “bad,” concepts that can be confusing to children).

Grades 7–9 (Junior High School) (Std 5 – 7)

1. Secondary sex characteristics and differing rates of development.
 - Boys—physical changes, seminal emissions, masturbation.
 - Girls—physical changes, menstrual cycle, masturbation.
2. Reproduction: male and female reproductive systems.
3. Interaction of heredity and environment.
4. Building relationships based on mutual respect, trust, caring.
5. Self-esteem means:
 - feeling good about oneself;
 - not exploiting anyone;
 - not making fun of anyone;
 - getting along in the family;
 - understanding that no one can make another person feel inferior without that person's consent.
6. Understanding the risks involved in sexual intercourse: unplanned pregnancy, sexually transmitted diseases (including AIDS), emotional problems, conflict with values of parents and society.
7. Understanding boy-girl relationships: readiness, dating (discuss kissing, petting, and sharing feelings), going steady—advantages and disadvantages, responsibilities.
8. The principles of birth control and the advantages of family planning.
9. Advantages of premarital abstinence. Acceptable ways of expressing affection without having sexual intercourse.
10. Disadvantages of just letting “it” happen.
11. Discussion of masturbation.
12. Peer and media pressure for sexual behavior at too early an age.

Grades 10–12 (Senior High School) (Std 8 – 10)

1. How do people know if they are really in love? Distinguish between mature and immature love experiences. Discuss trust, communication, jealousy, possessiveness, game playing, loyalty.
2. About 85 percent of girls who become pregnant as teenagers are eventually abandoned by the boys who impregnated them, although some couples marry—usually to cover the pregnancy. Also, teenage pregnancy leads to dropping out of school and limited future opportunities.
3. Understanding that the approach “If you love me, you’ll have sex with me,” is

- only a line. Sex is never a test of love. (Boys sometimes use affection to get sex, and girls sometimes use sex to get affection.)
4. Detailed explanation of sexually transmitted diseases, including AIDS
 5. Detailed review of birth control and the use of the condom.
 6. What parenthood means, including the ability to care for a child.
 7. Basic principles of parenting, including the concept of being "askable" parents in the area of sex education.
 8. Basic support for equality of the sexes.
 - Opposition to the double standard; sexism.
 - Emerging trends in sexual behavior, the women's movement, sex roles and sexual stereotyping, sex and the media.
 - Assertiveness training in the area of rights. I have a right to: say "no," refuse a date without feeling guilty, not be macho, say "yes," not to have to prove myself for the benefit of anyone else.
 9. Decision making based on appreciating values that enhance relationships.
 10. Understanding the social problems that affect the American family.
 11. Recognizing the need for concern for other people.
 12. Experiences before marriage will contribute to its success or failure.
 13. Appreciation of the wider role of sexuality as a healthy aspect of personality; understanding the distinction between sex and sexuality.
 14. Putting sex into perspective. Love and caring for another person is more important than sex appeal.
 15. Appreciating social and emotional problems related to sex:
 - conflict between the sex impulse and societal, parental, and religious values;
 - neurotic sexual behavior;
 - promiscuity;
 - incest;
 - prostitution;
 - rape; sexual abuse and sexual harassment;
 - adultery.
 16. Discussion of controversial issues like abortion, with all sides presented fairly.
 17. Appreciation and fairness in understanding people who have different life-styles or sex styles: single people, married couples who decide not to have children, homosexuals, celibates.
 18. Resources in the community for obtaining help for problems.
 19. Intimacy and trust; friends, lovers; fidelity. Sexual attraction is not the same as love.
 20. Dispelling myths like "once a boy starts he can't stop." (A female should not risk pregnancy, sexually transmitted diseases, or emotional insults because a male complains of pain in his genitals. Masturbation can relieve the "pain.")
 21. Advantages of abstinence in contrast with taking risks.
 22. Discussion (pro and con) of the double message: If you are going to have sex anyway, use contraceptives in addition to a condom.
 23. The influence on sexual behavior of pop culture, peer pressure, advertising, the media.
 24. The effect of substance abuse on sexual behavior.
 25. A good way to "test" a relationship is not having sexual intercourse.

MODEL PROGRAMME 2

ADMINISTRATION: HOUSE OF REPRESENTATIVES

DEPARTMENT OF EDUCATION AND CULTURE

CORE PROGRAMME FOR FAMILY GUIDANCE

(PILOT PROGRAMME)

INTRODUCTION

JANUARY 1987

INTRODUCTION

During the past few decades it has become very clear to those persons involved in the teaching and education of the child, that the nucleus of community life, namely the family, is slowly crumbling.

Several reasons may be advanced for this, for example, the increasing economic pressure on the family which compels both parents to become breadwinners and the fact that our children are constantly bombarded by the mass media and outside influences with the result that they grow up in a confused society where it is difficult to always know the accepted conduct in any given situation, especially where sexual matters are concerned.

It is realised more and more that our accepted norms and standards must be intensively placed under the spotlight and must be declared valid as educational principles, so that the youth may not only be led to proper adulthood, but so that they may integrate in the changing world in which they find themselves.

Because this matter is regarded very seriously by the Department, the Human Sciences Research Council, on the instruction of the then Administration of Coloured Affairs, conducted research during the period 1980 to 1983 into the question of education for responsibility with reference to sexual matters. A report was published with the title: Education for responsibility with reference to sexual matters: the desirability of sexual education at schools for Coloureds.

After the report had been released, the Department gave constant attention to this matter with a view to the expansion of its educational programme, to such an extent that a Core Programme for Family Guidance as a pilot programme reached its final stage.

The term "family guidance" expresses precisely what the programme entails: guidance to members of the family on their attitude and behaviour towards each other and towards members of other families, which obviously includes the relationship between the two sexes. The programme aims at bringing home attitudes to the youth, along accepted guidelines, such as respect for their parents, their relatives and friends, and members of the opposite sex. The chief aim/...

aim is to inculcate in the youth the values of a firm family relationship with everything that it embraces from an early age, as well as creating opportunities for individual help and guidance to the child in connection with intimately personal problems which are characteristic of definite stages in a person's development.

For this programme to succeed, and it is in fact possible, the parent, the child and the school will have to co-operate very closely: the parent because he/she is the primary educator, the child because he/she must be guided in a pedagogical-responsible manner, and the school because it is the secondary educator, and has particularly to give help and guidance to those parents who themselves cannot see their way clear to give their children sex education. The success of this programme will thus depend on the effectiveness of the communication between parents, children and teachers.

Particularly the school shall have to be prepared to make the necessary adaptations to be able to accommodate the programme and will have to work in close liaison with the parents, the church associations, the teachers' associations, the community and all interested parties, in other words, the school's attitude in respect of Family Guidance programmes shall have to be extremely positive.

It is a matter of great urgency for the Department that this programme which is attempted at each school, will be successfully carried out.

AIMS OF THE FAMILY GUIDANCE PROGRAMME

1. Positive personality development and character moulding of the child must be promoted through systematic and continuous guidance.
2. The child must be acquainted with acceptable and for him meaningful aesthetic, moral and religious life values which will contribute to the development of an own balanced life view.
The valid norms and standards must be accepted as an educational principle by which the child must be accompanied to proper adulthood.
The child must be educated to a realisation of, an appreciation of and an acceptance of moral norms and standards so that he may develop a conscience from which he may judge his own and other persons' behaviour.
3. The child must be led to realise that his personality development is closely related to his daily behavioural activities, and that this is determined by the choices which he exercises and the life goal that he strives after.
He must be developed to responsible behaviour and thus be provided with the necessary information concerning inter-personal relationships, so that in the course of time he may make decisions from a source of knowledge and not out of ignorance.
4. The educational task of the parent must be made easier, supported and supplemented, and the individuality of the child and his natural modesty regarding intimate personal matters must be taken into consideration.
The school as secondary educational institute must support the parents and provide assistance with regard to sex guidance, amongst others, - where the aim is to educate the child towards responsible behaviour.
Discussions with regard to sensitive subjects between teachers, parents and pupils must be encouraged so that the child may be led to discuss his personal problems frankly with his parents and his teachers.
5. The/...

5. The creation of a favourable climate in the family to promote communication between parent and child and to make it easier for the parent to perform his guidance task.
6. Promoting a narrow co-operation between parent, principal, teacher and other interested parties, that will contribute to the development of healthy personal relationships within and beyond the family bond.
7. The cultivation of a positive attitude towards the family as the foundation of a healthy community.
The child must be given insight on the important position occupied by the family in the community.
In addition, they must be taught of the responsibilities they have as children in the family and later as spouses and parents.
The child must be aware of social problems such as: over-population, lack of family planning, too early marriages, extra-marital babies, single parent problems, divorce, venereal disease, sexual perversions and precautionary measures.
8. The programme must be presented in such a manner that it will link with the particular needs of the particular community, school and pupil.
9. The transmission of accepted life values, namely that man is a responsible being, with a definite and meaningful life aim and a responsibility towards his fellow man and his Creator.

CORE PROGRAMME FOR FAMILY GUIDANCEJUNIOR PRIMARY (STANDARDS SUB A TO STD 1) (7 TO 10 YEARS)

1. The family
 - 1.1 Types of families
 - 1.1.1 Families differ according to size and composition.
 - 1.1.2 The composition of a family could change from time to time.
 - 1.1.3 The complete family: parents, brothers and sisters.
 - 1.1.4 The extended family: grandfather and/or grandmother, uncles, aunts.
 - 1.1.5 The single parent family.
 - 1.1.6 The child in the institution: orphanage, special school, reform school, school of industry.
 - 1.2 The Parents
 - 1.2.1 Fathers and mothers provide for their children.
 - 1.2.2 Different fathers do different types of work in order to provide for the needs of the family.
 - 1.2.3 Mothers work in the house or serve as breadwinners outside the house in order to provide for the family.
 - 1.2.4 A family's life style is influenced by the father and the mother's work.
 - 1.2.5 The role of the father and the mother in the family and in the community.
 - 1.3 The individual in the family
 - 1.3.1 How the child became a member of the family, in simple terms.
 - 1.3.2 Discovery and realisation of the self.
 - 1.4 Members of the family
 - 1.4.1 Members of the family help each other in several ways.
 - 1.4.2 Co-operation makes family life more pleasant.
 - 1.4.3 Each member of the family makes his contribution.
 - 1.4.4 All members of the family care for each other.
 - 1.4.5 Members of the family share their feelings, convictions and ideas with other members of the family.
 - 1.5 Other/...

1.5 Other families

- 1.5.1 Families in different countries live differently.
- 1.5.2 Families within the same country live differently.
- 1.5.3 Different families work together.

2. Feelings

2.1 Different types of feelings

- 2.1.1 Love for you parent.
- 2.1.2 Love for you brothers and sisters.
- 2.1.3 Love for other members of the family, for example, grandfather and grandmother.
- 2.1.4 Love for animals.
- 2.1.5 All hanker after love.
- 2.1.6 Feelings may be pleasant or unpleasant.
- 2.1.7 Failure, as well as success, is a manner of learning.

2.2 Decision-making and its consequences

- 2.2.1 Acceptance of consequences when a decision is taken.
- 2.2.2 Some consequences cause conflict.
- 2.2.3 Conflict can be solved.

2.3 Demography in simple terms

- 2.3.1 We are influenced by our environment.

3. Reproduction

3.1 Babies

- 3.1.1 Each baby has a father and a mother.
- 3.1.2 Babies grow within the mother in a special place.
- 3.1.3 Babies are dependent on the care of the family.
- 3.1.4 Human babies require more care than those of animals.
- 3.1.5 Adoption of babies in simple terms.

3.2 All living things reproduce themselves

- 3.2.1 Plants
- 3.2.2 Animals
- 3.2.3 People

- 3.3 Difference/...

- 3.3 Differences between the sexes
 - 3.3.1 Skills
 - 3.3.2 Tempo of growth and body proportions.
 - 3.3.3 Growth patterns: physical differences.

- 3.4 Acceptance of that which can and cannot be changed
 - 3.4.1 The body
 - 3.4.2 Sex
 - 3.4.3 Intelligence
 - 3.4.4 Environment

- 4. The development of acceptable relationships
 - 4.1 Individual differences
 - 4.1.1 People are in some respects similar and in other respects different.
 - 4.1.2 The concept development - physical and mental.
 - 4.1.3 Boys become fathers and girls become mothers.

 - 4.2 Growing up
 - 4.2.1 Growing up is more than just becoming older.
 - 4.2.2 Growing up ensures more priveleges.
 - 4.2.3 Growing up brings greater responsibility.

 - 4.3 Relationships
 - 4.3.1 Relationships with your parents, step-parents, brothers, sisters, step-brothers, step-sisters, other members of the family, peers, other adults.
 - 4.3.2 The difference between friends and strangers.
 - 4.3.3 Some characteristics make it easy to make friends, other characteristics make it more difficult.
 - 4.3.4 To take turns and co-operate help us to live happily with people.
 - 4.3.5 Sexual and child molesting.

 - 4.4 Acceptable/...

4.4 Acceptable social behaviour

- 4.4.1 The rights and privacy of other persons must be respected.
- 4.4.2 Respect for the property of other persons is important for harmonious co-existence.
- 4.4.3 Good manners and courtesy leads to benignity and consideration towards others.
- 4.4.4 Correct behaviour in the bathroom and toilet.
- 4.4.5 Safety after school and back home.

4.5 Self defence for boys and girls

SENIOR PRIMARY (STANDARDS 2 TO 4) (10 TO 13 YEARS)

1. The family
 - 1.1 How we think and feel about our family
 - 1.1.1 Mother, father, other children.
 - 1.1.2 Step-mother, step-father or foster parents.
 - 1.1.3 Other persons in the home, e.g. grandfather, grandmother, boarder.
 - 1.1.4 The adopted child or the foster child.
 - 1.1.5 The child in the institution: orphanage, reformatory, school of industry, special school.
 - 1.2 Types of families
 - 1.2.1 Large and small families.
 - 1.2.2 The extended family: grandfather and/or grandmother.
 - 1.2.3 The single-parent family.
 - 1.3 The influence of status in the family
 - 1.3.1 The responsibilities and privilege of an eldest or an only child.
 - 1.3.2 The advantages and disadvantages of an only brother and sisters, and an only daughter and brothers.
 - 1.4 Responsibilities towards the family
 - 1.4.1 The performance of tasks in the home.
 - 1.4.2 Consideration towards others.
 - 1.4.3 Help to brothers and sisters.
 - 1.5 The happy family
 - 1.5.1 Factors influencing family happiness.
 - 1.5.2 Attempt to understand each other.
 - 1.5.3 Consideration for differences between members of the family.
 - 1.5.4 Joint Planning: necessary for development and health.
 - 1.5.5 The prevention of unreasonable demands on the family.
 - 1.5.6 Family pride.
 - 1.5.7 The family's attitude to modern society.
 - 1.5.8 The dangers of smoke, and alcohol and drug-abuse.
2. Feelings/...

2. Feelings

2.1 Our abilities

- 2.1.1 Our strong and weak characteristics may be utilised positively in different situations.
- 2.1.2 Success has different meanings for different people, depending on their sex and age.
- 2.1.3 Learn to face reality.

2.2 Demography

- 2.2.1 Our environment influences our personalities.
- 2.2.2 Character traits that may be influenced by the environment.

2.3 Love

- 2.3.1 Different meanings of the word.
- 2.3.2 Friendship and love.

3. Reproduction

3.1 The origin of a family

- 3.1.1 Factors that are necessary for a family, e.g. mother, father, house, love, etc.
- 3.1.2 Family similarities.
- 3.1.3 Understanding of the wonder of reproduction by plants and animals.
- 3.1.4 Greater dependence of the human baby than babies of animals.
- 3.1.5 Living things create new life.

3.2 Bodily growth

- 3.2.1 The structure and function of cells.
- 3.2.2 Glands that influence growth.
- 3.2.3 Bodily growth differs from individual to individual.
- 3.2.4 Children do not develop at the same tempo: physically, mentally and emotionally.

3.3 Puberty: physical changes

- 3.3.1 Secondary sex characteristics
- 3.3.2 Physique
- 3.3.3 Voice change in boys.
- 3.3.4 Development of breasts in girls.

3.4 The/...

3.4 The sexual urge and reproduction

- 3.4.1 The origin of a sexual urge.
- 3.4.2 Various forms of sexual desires.
- 3.4.3 Control over urges.
- 3.4.4 Masturbation amongst boys and girls.
- 3.4.5 Nocturnal emissions with boys.
- 3.4.6 Menstruation with girls.
- 3.4.7 The reproductive organs and their functions.
- 3.4.8 Chromosomes, genes and the D.N.A. molecule.
- 3.4.9 Sex hormones and their importance for man.
- 3.4.10 Petting.
- 3.4.11 Sexual union: the physiology thereof according to modern research.
- 3.4.12 Fertility and pregnancy.
- 3.4.13 The birth of a baby.
- 3.4.14 Multiple births.
- 3.4.15 Disturbances in the sexual potential of man and woman.
- 3.4.16 Sterility.

3.5 Chastity

- 3.5.1 The meaning thereof for boys and girls.
- 3.5.2 Moral aspects regarding chastity.
- 3.5.3 Venereal disease: nature and causes.

4. Relationships

4.1 The acceptance of sex as a basic life function

- 4.1.1 Physical development and change in boys and girls.

4.2 Inter-personal relationships

- 4.2.1 Relationships at home.
- 4.2.2 Relationships at school: generally-correct conduct between boys and girls, good manners, considerations, etc.
- 4.2.3 The promotion of healthy human relations.
- 4.2.4 The development of a self-responsibility.
- 4.2.5 Characteristics of an ideal friendship.
- 4.2.6 The development and maintenance of good friendships.
- 4.2.7 The development of self interests with consideration for other persons.
- 4.2.8 The/...

- 4.2.8 The basic rules for good relationships.
- 4.2.9 Sexual and child molesting, e.g. rape and incest.

- 4.3 Accepted social behaviour
 - 4.3.1 The importance of a good first impression.
 - 4.3.2 Conduct to feel at ease in social situations.
 - 4.3.3 Code of conduct: conformity and alternative forms of behaviour.
 - 4.3.4 Exaggerated behaviour in respect of the opposite sex.
 - 4.3.5 Loneliness, discomfort and impatience.
 - 4.3.6 Acquaintance with the opposite sex.
 - 4.3.7 Etiquette.

- 4.4 Self defence for boys and girls

JUNIOR SECONDARY (STANDARDS 5 TO 7) (13 TO 16 YEARS)

1. The family
 - 1.1 The family as a basic institution
 - 1.1.1 Family structures.
 - 1.2 Functions of the family
 - 1.2.1 The functions change as the community changes.
 - 1.2.2 Traditional functions and responsibilities of the family.
 - 1.2.3 The family today.
 - 1.2.4 Prevention of accidents at home.
 - 1.2.5 Sickness and home nursing.
 - 1.3 Family relationships
 - 1.3.1 Tension in the family.
 - 1.3.2 Tension between parent and child.
 - 1.3.3 Brother-sister relationships, as well as relationships towards the adopted child and the foster child.
 - 1.4 Family happiness
 - 1.4.1 Factors influencing family happiness.
 - 1.4.2 Parental control.
 - 1.4.3 Daily problems.
 - 1.4.4 How a family adapts to problems and finds solutions.
 - 1.4.5 The solution of problems.
2. Feelings
 - 2.1 Emotions (Emotional life)
 - 2.1.1 New emotions are experienced during puberty.
 - 2.1.2 The expression of emotions of affection.
 - 2.1.3 Sexual attraction and love.
 - 2.2 Standards
 - 2.2.1 Standards and the importance thereof.
 - 2.2.2 Personal standards and popularity.
 - 2.3 Social/...

2.3 Social Behaviour

2.3.1 The development of a social conscience.

2.4 Demography

2.4.1 The need for self-control.

2.4.2 Responsibility.

3. Reproduction

3.1 Puberty

3.1.1 Physical development during the puberty years.

3.1.2 Elementary psychology of the puberty years and psycho-sexual development.

3.1.3 Masturbation by boys and girls.

3.1.4 Menstruation by girls:

3.1.4.1 The physiology thereof - a sign of sexual maturity.

3.1.4.2 The duration of puberty.

3.1.4.3 Information about the menstrual cycle.

3.1.4.4 The average commencement age.

3.1.4.5 Physical and mental changes.

3.1.4.6 Preparation for menstruation: the use and disposal of sanitary napkins.

3.1.4.7 Hygiene during menstruation.

3.1.4.8 Mental attitude towards menstruation.

3.1.5 The reproductive organs and their functions.

3.1.6 Chromosomes, genes and the D.N.A. molecule.

3.1.7 Sexual hormones and their importance for man.

3.1.8 Petting.

3.1.9 Sexual union: the physiology thereof according to modern research.

3.1.10 Fertility and pregnancy.

3.1.11 The birth of a baby.

3.1.12 Multiple births.

3.1.13 Preparatory measures.

3.1.14 Disturbances in the sexual potency of man and woman.

3.1.15 Sterility.

3.2 Marriage/...

3.2 Marriage

- 3.2.1 Responsible parentage.
- 3.2.2 The sex of the baby: determination and acceptance.
- 3.2.3 Baby and child care.
- 3.2.4 Divorce.

4. Relationships

4.1 What is personality?

- 4.1.1 The importance of knowing yourself.
- 4.1.2 Factors influencing your personality.
- 4.1.3 The role of heredity and environment in the development of personality.

4.2 Friendships

- 4.2.1 The value of friendships.
- 4.2.2 Qualities that promote friendships.

4.3 Adulthood

- 4.3.1 The meaning "growing up".
- 4.3.2 Problems that accompany the process of growing towards adulthood.

4.4 Code of behaviour

- 4.4.1 Right versus wrong: ethical and religious values.
- 4.4.2 Taking moral decisions.
- 4.4.3 Religion, character and conscience.

4.5 Different relationships

- 4.5.1 Relationships with parents/peers.
- 4.5.2 Boy-girl relationships.
- 4.5.3 The pupil-teacher relationships.

4.6 Different responsibilities

- 4.6.1 The role of the man/woman in contemporary society.
- 4.6.2 The role of the school in developing a pleasant and healthy personality in the pupil.
- 4.6.3 The role of the school to promote character development in pupils.

4.7 A philosophy/...

4.7 A philosophy of life

- 4.7.1 The meaning and purpose of life.
- 4.7.2 A philosophy of life and environmental influences.
- 4.7.3 The solution of your personal problems.
- 4.7.4 Misunderstandings.

4.8 "Dating"

- 4.8.1 Considerations in dating, e.g. age, types of dating, etiquette, etc.
- 4.8.2 Personal appearance and responsibilities of boy and girl.
- 4.8.3 Choice of a mate.
- 4.8.4 The attitude of the family towards dating.
- 4.8.5 The parents' opinion in respect of dating.

4.9 Courting

- 4.9.1 The advantages and disadvantages of a permanent relationship.
- 4.9.2 The discontinuation of a permanent relationship.

4.10 Acceptable social behaviour

- 4.10.1 Reasons for a moral code in the community.
- 4.10.2 Standards of behaviour.

4.11 Adolescence

- 4.11.1 Characteristics of adolescent boys and girls.
- 4.11.2 Adolescent boys and girls sometimes have similar problems.
- 4.11.3 Community activities for boys and girls to develop healthy relationships.
- 4.11.4 Self-discipline and responsibility.
- 4.11.5 How to get along with other persons.
- 4.11.6 The characteristics of an emotionally mature and well adapted person.
- 4.11.7 Emotional changes during adolescence

4.12 Deviant adolescent behaviour

- 4.12.1 Alcohol: drinking habits.
- 4.12.2 The smoking habit and drug abuse.
- 4.12.3 Youth gangs.

5. Human/...

- 5. Human sexuality
- 5.1 Masculinity and Femininity
- 5.1.1 The role of sexuality in our lives.
- 5.1.2 Changed roles of males and females in modern society.
- 5.1.3 Teenage society.

- 5.2 Codes of conduct peculiar to the two sexes
- 5.2.1 Different attitudes towards pre-marital sexual intercourse.
- 5.2.2 Living alone.
- 5.2.3 Co-habitation.
- 5.2.4 Socially acceptable behaviour.
- 5.2.5 A code of conduct for responsible sexual behaviour.
- 5.2.6 The moulding of responsible sexual behaviour.

- 5.3 Placing sexuality in perspective
- 5.3.1 The social consequences of sexual behaviour patterns.
- 5.3.2 Attitudes in respect of sexual-deviant behaviour.
- 5.3.3 Controversial social aspects related to sexuality, e.g. pornography, prostitution, immorality and abortions.
- 5.3.4 Venereal diseases: kinds, causes, symptoms, prevention.
- 5.3.5 Sexuality and advertisements.
- 5.3.6 Moral and social aspects of sexuality.
- 5.3.7 Incorrect information and stories regarding sexuality.
- 5.3.8 Limited or permissive types of sexual morality.
- 5.3.9 Contraception and abortion viewed from an ethical and religious point of view.
- 5.3.10 Population explosion as a problem of the world.
- 5.3.11 The aim and need for family planning.

- 5.4 Self defence for boys and girls

SENIOR SECONDARY (STANDARDS 8 TO 10) (16 TO 18 YEARS)

1. The family
 - 1.1 The similarities and differences of families
 - 1.1.1 The complete family.
 - 1.1.2 The extended family.
 - 1.1.3 The single-parent family.
 - 1.1.4 The child in the institution.
 - 1.2 The ideal family
 - 1.2.1 The role and responsibility of parents.
 - 1.2.2 The happy home: factors influencing family happiness.
 - 1.2.3 The protective function of the family.
 - 1.2.4 The family as the focal point for cultivating ideals and attitudes.
 - 1.3 Democracy in the family
 - 1.3.1 The importance of a family in the own and other communities and the changing role played by the family in modern times.
 - 1.3.2 The importance of the family for each individual member.
 - 1.3.3 The important role of the husband and wife respectively in the family.
 - 1.3.4 The family as medium for reciprocal love and camaraderie between husband and wife.
 - 1.3.5 The executive duties of the family.
 - 1.3.6 Relationships between members of the family.
 - 1.3.7 Family strife: prevention and solution.
 - 1.4 The structure of the family
 - 1.4.1 Influences which may strengthen or weaken the structure.
 - 1.4.2 Family life in the past and in modern society.
 - 1.4.3 How society supports the family: family laws.
2. Feelings
 - 2.1 Love
 - 2.1.1 Amorousness.
 - 2.1.2 Mutual attraction.
 - 2.1.3 Emotions.
 - 2.1.4 Affection.
 - 2.1.5 Romantic love.
 - 2.1.6 Adult love.
 - 2.2 Sexual/...

2.2 Sexual needs

- 2.2.1 The interdependence of personal and sexual factors.
- 2.2.2 Variations in directions and strength of sexual needs.

3. Marriage

3.1 Engagement

- 3.1.1 Courtship and the choice of a partner.
- 3.1.2 Factors to be considered when choosing a marriage partner.
- 3.1.3 Advantages and responsibilities of engagement.
- 3.1.4 Breaking off an engagement.

3.2 Different opinions on marriage

- 3.2.1 The secular opinion: marriage is merely a contract.
- 3.2.2 The biblical opinion: marriage is an institution of God.

3.3 Factors affecting a successful marriage

- 3.3.1 Adaptations to be made to ensure a happy marriage.
- 3.3.2 General conflict within the marriage.
- 3.3.3 Rules for constructive differences.
- 3.3.4 Pressure on a married couple in respect of social matters, e.g. religion, politics, social groups.

3.4 Readiness for a marriage

- 3.4.1 Maturity as a person.
- 3.4.2 Elements of growth in love.
- 3.4.3 Life aspirations or objectives.
- 3.4.4 The legal aspects.
- 3.4.5 Reproduction.
 - 3.4.5.1 The reproductive organs and their functions.
 - 3.4.5.2 Chromosomes, genes and the D.N.A. molecule.
 - 3.4.5.3 Sexual hormones and their importance to man.
 - 3.4.5.4 Sexual union: its physiology according to modern research.
 - 3.4.5.5 Fertility and pregnancy.
 - 3.4.5.6 The birth/...

- 3.4.5.6 The birth of a baby.
- 3.4.5.7 Multiple births.
- 3.4.5.8 Disturbances in the sexual potency of husband and wife.
- 3.4.5.9 Sterility.
- 3.4.6 The theory of inheritance and characteristics of heredity.
- 3.4.7 Hereditary factors and chromosomes.
- 3.4.8 Economic aspects.
- 3.4.9 Mental maturity for marriage.
- 3.4.10 Material preparation for marriage.

3.5 Married Life

- 3.5.1 The problem of housing.
- 3.5.2 Married life day by day.
- 3.5.3 The partnership: husband and wife.
- 3.5.4 Creating a home.
- 3.5.5 Preparation for parentage.
- 3.5.6 Family responsibilities.
- 3.5.7 Infant and child care.
- 3.5.8 Birth control: contraceptives.
- 3.5.9 Extra-marital children.
- 3.5.10 Adoption.
- 3.5.11 Abortions.

3.6 Divorce

- 3.6.1 General.
- 3.6.2 Causes.
- 3.6.3 Consequences.
- 3.6.4 Problems after divorce.

4. Human sexuality

4.1 Masculinity and Femininity

- 4.1.1 The place of sexuality in our lives.
- 4.1.2 Changing roles of males and females in modern society.
- 4.1.3 The society of the teenager.
- 4.2 Behaviour/...

4.2 Behaviour codes peculiar to the two sexes

- 4.2.1 Different attitudes to pre-marital sexual relations.
- 4.2.2 Venereal disease: types, causes, symptoms, precautions.
- 4.2.3 The influence of social stipulations on sexual and personal relationships.
- 4.2.4 The influence of sexual roles.
- 4.2.5 The role of the mass media with reference to pornography.
- 4.2.6 Living alone.
- 4.2.7 Co-habitation.
- 4.2.8 Socially acceptable behaviour.
- 4.2.9 A code of behaviour for responsible sexual behaviour.
- 4.2.10 The moulding of responsible sexual behaviour.

4.3 Placing sexuality in perspective

- 4.3.1 Laws relating to sexuality.
- 4.3.2 Social attitudes in respect of sexuality.
- 4.3.3 The social consequences of sexual behaviour patterns.
- 4.3.4 Attitudes towards deviant sexual behaviour.
- 4.3.5 Controversial social aspects in respect of sexuality, e.g. pornography, immorality, prostitution, extra-marital births and abortion.
- 4.3.6 Sexuality and advertisements.

4.4 Problems in early and late adolescence

- 4.4.1 Psycho-social development.
- 4.4.2 The development of a philosophy of life.
- 4.4.3 Specific changes which man experiences on reaching adulthood.
- 4.4.4 The place of sex in a person's life and his control thereof.
- 4.4.5 The basic needs of an adolescent in respect of developmental tasks which he must manage.
- 4.4.6 Educational and guidance bureaux in the community: where to find information.

4.5 Moral/...

- 4.5 Moral and social aspects of sexuality
 - 4.5.1 Incorrect information and stories in respect of sexuality.
 - 4.5.2 Limiting or permissive types of sexual morality.
 - 4.5.3 Contraceptives and abortion from an ethical and religious point of view.
 - 4.5.4 Population explosion as a world problem.

- 4.6 The aim and need for family planning
 - 4.6.1 Future projects of current population growth - disturbing statistics:
 - 4.6.1.1 In 1980 the population was 28,44 million.
 - 4.6.1.2 In 2040 the population will be 138,9 million people at the current growth rate.
 - 4.6.1.3 Our natural resources can only support a population of 80 million people.

 - 4.6.2 Factors which assist the population growth
 - 4.6.2.1 Improved socio-economic conditions.
 - 4.6.2.2 Promotion of general health: better medical services.
 - 4.6.2.3 Decrease in infantile mortality: increased economic welfare and effective combating of contagious diseases.
 - 4.6.2.4 Increased life-expectancy.

 - 4.6.3 Reasons for the need for family planning
 - 4.6.3.1 Population growth will increase constantly and will even stabilise.
 - 4.6.3.2 Demographic objective: a population of 80 million people by the year 2100.
 - 4.6.3.3 Future project: 2 children per wife.
 - 4.6.3.4 Socio-economic conditions can improve and lead to more employment opportunities.
 - 4.6.3.5 Increase in living standards and quality of life.
 - 4.6.3.6 More living space: orderly spatial distribution.
 - 4.6.3.7 Parity in developmental levels for all population groups.

 - 4.6.4 Objections to family planning
 - 4.6.4.1 Religious objections.
 - 4.6.4.2 Objections of a political nature.
 - 4.6.4.3 Objections which are culturally based.
 - 4.6.5 Methods/...

4.6.5 Methods of overcoming objections

4.6.5.1 Indisputable statistics.

4.6.5.2 Communal objectives.

4.6.5.3 Effective family planning in overseas countries:
favourable consequences.

5. Communication and relationships

5.1 Communications

5.1.1 Systems of intellectual and emotional communication.

5.1.2 Communication problems.

5.1.3 The mass media and its effect on people.

5.2 Relationships

5.2.1 The cultivation of pleasant interpersonal relationships.

5.2.2 Relationships with parents, brothers, sisters and peers.

5.2.3 The influence of social limitations on sexual and personal
relationships.

5.3 Self-defence for boys and girls.

MODEL PROGRAMME 3

PRELIMINARY CONTENT FOR SECONDARY SCHOOL SEXUALITY EDUCATION PROGRAMME

CONCEPTS OR FOCUS OF ATTENTION

TEACHING STRATEGIES OR PUPIL ACTIVITIES

Personal value systems with particular reference

Values are intimately tied up with sexuality and are a recurring central theme. There are many different ways of exploring them.

Challenges to personal value systems.

1. Discuss, analyse, role play latest soap opera. Focus in particular on the value systems which it portrays and on how these often contradict on's own. What are the implications for young viewers in particular?
2. Discuss magazine articles which deal with the same sort of issues.
3. Role play various situations in which peer pressure, a fact of life for adolescents, can have serious consequences for an individual. Try to get the pupils themselves to suggest ways in which peer pressure can be counteracted, i.e. what skills are needed?

Changing sexual values.

1. Group discussion; Values of different cultures - a particularly useful way of challenging adolescents about the relativity of value systems with a view to clarifying their own - for deciding where they stand.
2. Debate: "Values don't change, times do."

Commitment as an element of sexuality.

1. Discussion on commitment in general, e.g. to sports team through to relating to girl/boy friend.
2. Discuss marriage vows as a commitment.
3. Discuss the role of sex in marriage with particular reference to the cementing of a relationship and of the commitment between two people.

Note: The perceived need for sexuality education has part of its origin in a desire to see sex given its rightful and respectful place within committed marriage relationships. Sexuality within marriage should be a mutual celebration of this commitment. So much of sex is the antithesis of this. Its exploitation for selfish and financial means usually destroys rather than builds.

Violation of commitment.

1. Discuss some of the effects of a violation of commitment. Focus in particular on the personal effects, the effect on self esteem, on trust, on family relationships.
2. While divorce is dealt with elsewhere, it will inevitably surface as an issue here. Because it is so real for many adolescents, a very sensitive approach must be adopted. Hard moralising can be particularly hurtful to adolescents who are prone to blaming themselves for their parents' divorce. The heartaches, realities, consequences need to be discussed and aired.

Growth, development and puberty.

Review the changes which occur at the onset of puberty. Chapters 4-6 of "Talking about sex" by Tomaszewski are a good starting point. Do not assume that all pupils have necessarily had sexuality education classes before, or that those who have had them are at the same level of knowledge. Use diagrams where necessary.

The human reproductive system - terminology.

It is essential that reproductive terminology be reviewed. This is best done by reference to diagrams, preferably presented on an O.N.P. (See "Talking about sex".) A good text is a prerequisite.

The reproduction process.

This section should have been dealt with at primary school level but as mentioned earlier, this cannot be assumed. The issues to be dealt with will include: ovulation, menstruation, fertilisation, sex determination, gestation and delivery.

Note: Pupils at this stage will often want to know specifics about sexual intercourse. The best way to deal with this is to point out that people engage in sexual intercourse in different ways. They decide what is best for them based on religious, social and familial values. A loving relationship, based on serious commitment is the first necessary ingredient. A discussion of the details of different forms of sexual practice will not normally form part of the sexuality education programme.

Hormones and me.

Pupils need to be introduced to the effects of hormones - in particular their tendency to effect dramatic mood changes for no apparent reason at various stages of our lives e.g. adolescence and menopause. Discuss these changes. Have they been aware of any of them?

Hormones and physical development.

Discuss the role of hormones in normal growth and in particular with respect of the development of primary sexual characteristics - transformation from foal to stallion, boy to man, girl to woman, etc.

Hormones and the human sex drive.

1. Relate the effects of the physical and personality changes to a similar awakening of the sex drive which is often most powerful in adolescence. What challenges does this present to the adolescent?
2. How does one deal with them?

Feelings associated with puberty.

As a period most noted for the individual's search for identity, adolescence is characterised by mood changes, a search for independence, feelings of being in and out of the group, romantic and sexual feelings, and an ambivalence between the need to be part of the crowd vs. the need for privacy.

1. All these issues can be dealt with in depth through class discussion and debate. They should be noted as normal development trends albeit very 'loaded' ones.
2. Stories and poetry which focus on adolescence feelings provide valuable catalysts for discussion and growth.
3. Having a parent or teacher talking about life at home with an adolescent or having an adolescent talking about life at home as an adolescent, can be both humorous and enlightening.

Adolescence and social interaction.

Adolescence brings major changes in social interaction. The primary changes are changing relationships with parents and friends, the need to cope with peer pressure and a growing interest in the opposite sex. All have important implications for normal development and are issues which require little prompting for discussion!

1. Discuss relevant, topical TV programmes.
2. Use magazine articles depicting the different ways in which young people relate to others.
3. Ask pupils to do some research into the topic and to report back to the class, e.g. talk to their parents about the way their own relationships and dependency needs have changed, and then to relate these to their own perceptions of the same.
4. A project designed to identify different adolescent behaviour patterns in different cultures.
5. A historical look at adolescents through the ages.
6. Role play peer pressure and focus in particular on handling it.
7. Role play interactions with parents.

Readiness for sexual activity.

Discuss the implications of physical maturity and consequent sexual maturity at a stage of life when emotional immaturity is still a fact of life, and when social, ethical and moral restraints on sexual activity are strongest.

Same sex friends and idols.

During adolescence same sex crushes in adolescence are normal, but can be misinterpreted. The issue needs to be aired with particular reference to the phenomenon of labelling and the inherent damage that it causes. The issues of homosexuality and lesbianism will arise as a natural consequence of discussion on this topic and must be particularly sensitively handled. It is essential to be well prepared when broaching the topic.

Types of relationships.

Discuss this concept in relation to the following: platonic friendships, same-sex friendships, infatuation, lust vs love, attraction, liking, love.

Note: This is essentially a topic that can be discussed at almost any level - and if well handled will naturally raise relevant and related issues which can be dealt with as they arise.

Sexuality values and peer pressure.

Discuss the following:
 "We need to be tolerant of the views of others without feeling that we have to agree with them or that we are being pressured into imitating them. Many young people who are sexually active - who "do it" often think the ones who "don't do it" are boring. The ones who "don't", consider the ones who "do" to be cheap. Usually neither group knows what the other really does - only what they say they do."

Sex manners - dating.

1. Discuss consideration and care for one's date.
2. Raise issues such as who should pay when going out? (This question is one that leads on naturally to often lively discussion of the question of males who exploit payment during a date by trying to collect dues later.)
3. "Who's Who in the Dating Zoo" provides a humorous method of dealing with the subject:

Fox	-	underhand, deceitful
Hyena	-	scavenges other peoples' prey and then laughs loudly
Lion	-	proud, boasts openly of conquests
Elephant	-	tramples on others' feelings
Giraffe	-	looks down on others
Ape	-	all hands and no finesse
Gazelle	-	scampers away nervously at any advances
Parrot	-	copies what everyone else does and says
Swan	-	graceful, serene, self-confident and faithful to one partner for life

Standing up for what you believe.

Discuss: "No assault on one's value system can be more blatant and immoral than an attempt by another to force sexual favours from one."

1. Role play practical situations, for example, date rape. Endeavour to focus, in particular, on strategies to combat this.
2. Teaching practical self defence strategies for girls can be introduced as one such strategy.

Deceptive sexual perception and myths.

Myths about sex abound. Sometimes these have a grain of truth in them and need therefore to be discussed and clarified. Choosing misconceptions and myths for discussion will depend on the group. Many of these will be raised spontaneously during sexuality education lessons and will include the following:

- * all men want a lot of sexual partners; all women want one true love
- * the only proper use for sex is to make babies - using it for pleasure is lust
- * you can't get pregnant if you have sex standing up
- * having sex with all and sundry is a way of proving you're attractive.

Note: When dealing with particular sexual myths and misconceptions it is best that the teacher be in charge of any discussion. Discussions in small groups can perpetuate myths if not monitored. However, small group discussions can usually be used to identify possible myths for discussion and clarification.

Contraception - methods.

1. Present different methods of contraception or invite a guest speaker from a local family planning agency to address pupils on the topic. Teachers are referred to Chapter 10 of Tomaszewski's "Talking about Sex", and also to figures 14-18 at the back of her book - illustrations that carry very important messages.

Note: It is not permissible to ask pupils about their possible sexual activities and/or use of contraceptives.

Detailed information about actual use of contraceptives may be less important than general information about options, but it will be necessary also to discuss such issues as:

- * contraception methods requiring prescriptions (and reasons for this)
- * the relative effectiveness of different types of contraceptives
- * the advantages/disadvantages of oral contraceptives
- * contraceptives and family planning
- * ethics and contraception

2. Some topics for group discussion and feed-back are:

- * What are some of the reasons that people don't use birth control?
- * It's women who get pregnant so contraception is their responsibility.
- * What are some of the health risks linked to sexual activities during the teenage years?
- * What are some of the short and long term implications for school girls of unplanned pregnancy?
- * What are the most effective/least effective methods of contraception?

Note: Written assignments on these and similar topics can be handled most effectively in conjunction with main language instruction.

Some related ethical issues.

Contraception and ethics is an issue for some, but modern science has created other more complex issues which do not always provide moral and ethical challenges at first sight. Senior pupils, in particular, will enjoy debating the following:

1. "In Vitro Fertilisation - meddling with nature or hope for the childless?"
2. "Surrogate motherhood - hope for the childless or exploitation for financial gain?"
3. "Artificial insemination is a justifiable choice in the case of childless couples desperate for their own children - even if they're only half their own."
4. "Abortion should be available on demand." (This question cannot be seriously discussed or debated without a thorough airing of the complex, and often horrifying, issues involved.)

The costs of irresponsible or premature sexual activity.

1. Refer to Tomaszewski's "Talking about sex" figs. 22-32.
2. Try to introduce real situations for either role play and feedback from the groups:
 - * psychological and emotional consequences for the girl and boy
 - * consequences for families
 - * economic consequences
 - * consequences for schooling
 - * etc.

Involuntary sexual activity.

Note: While this section does not fall strictly inside the scope of a sexuality education programme, it cannot be side-stepped, because it will confront realities of contemporary living and is bound to be raised anyway. Pupils need to understand from the outset that the issues involved here are concerned with abuse and violence rather than sexuality - sex is merely a motive, or means to an end.

Child sexual abuse is not sex; it, like rape, is violence. Its victims are not sought out for mutually satisfying experiences, rather it is criminal behaviour perpetrated upon powerless, innocent people to dominate, control and oppress them. It is a pathological expression of rage and aggression, never to be confused with the emotions involved with sexual expression.

The fact that most victims of child sexual abuse are abused by an adult family member or close family friend highlights the power-abuse dynamic.

It is inevitable that there will be pupils in many groups who have been victims of sexual abuse of one kind or another and for that reason alone, it is imperative that the teacher conducting this session should not only be extra-sensitive, but also extra-aware of children who may signal a need to talk privately about their experiences.

Sexual abuse of young children.

1. Discuss the nature and extent of the problem. The prevalence of sexual abuse of children has been underestimated over the years. Grant Robertson's book *Sexual Abuse of Children in South Africa*, understanding and dealing with the problem is the first of its kind in this country, but there are many others dealing with the same theme. Newspaper articles will provide very topical points for class discussion and debate.
2. A primary focus should be on developing preventative strategies - alerting young people to the kind of dangers that their own children can face and of providing them with approaches to deal with them. A number of educational programmes have been developed for young children in an attempt to "street proof" them - one of these could be presented to pupils for discussion and possible improvement.
3. In conjunction with main language and/or the Drama department, pupils could be given the task to develop and present appropriate material, etc.
4. What is the legal position on abuse and what should be done if one becomes aware of it? Discuss available avenues of help and encourage pupils to use them.
5. What is Child Line? How can it help?

Sexual abuse and assault of teenagers.

Focus on preventative strategies or skills.

1. Discuss the dangers of hitch-hiking, being alone in unfamiliar places, being plied with alcohol, drugs, etc.
2. Discuss, or have group discussions which focus on dealing with such situations should they arise.

Deliberate seduction or date rape.

1. Role play a scene in which a "conquest" is being planned. What are the issues involved for both boys and girls?
2. Refer to the earlier section entitled "Who's Who in the Dating Zoo" and discuss.
3. Teach self-defence skills.

Incest

Incest involving members of the family - parents, siblings, grand parents, uncles, aunts, nieces, nephews, step-kin and cousins - is more common than generally assumed and is unacceptable in most cultures.

Some facts for discussion:

- * sibling incest is most common
- * father-daughter incest is second and most frequently reported
- * mother-son incest is least commonly reported but probably more prevalent than reports suggest
- * father-son and mother-daughter incestuous relationships exist but least is known about them
- * emotional and psychological rather than physical coercion is most commonly used to establish these relationships
- * the majority of cases appear to leave a harmful psychological residue
- * most incestuous relationships occur over a period of time and are more likely to be initiated by parents than children.

Some causes:

- + a symptom of personal and/or family conflict
- + improper, confused and disorganised family role development
- + father-daughter incest frequently occurs at peak points of marital stress
- + alcoholism and overcrowding are secondary factors.

Homosexuality (and Lesbianism).

Whatever we might believe and feel personally about it, homosexuality is a complex problem and extremely value laden, and must therefore be dealt with very sensitively.

Theories of the aetiology of homosexuality vary greatly and range from over protective parenting (usually by the mother) to insufficient parental attention and many others. Reactions to homosexuality vary from those who consider it to be a sin to others who consider it to be a lifestyle choice. For this reason there is always the distinct possibility that discussions/debates on this topic can become circular and even counter-productive. Because the question of homosexuality will arise spontaneously at almost any stage of a sexuality education programme all teachers offering components of the programme should be well prepared to deal with it, and must be prepared to present differing points of view without compromising their own value systems. Mere moralising is usually counter-productive and does not appeal to the older adolescent.

Pornography.

While the average adolescent is unlikely at present to come into direct contact with pornography, there is evidence that material which could be categorised as such is becoming more easily available. While research findings on the effects of pornographic material are still contradictory, it is important that young people should know of the potential dangers. Discussing a topic which to most is purely theoretical presents its own problems, but reality dictates that it can't be avoided.

Sexually transmitted diseases.

For this section it is essential that the teacher has reliable sources of information as a guide. Conventional knowledge about sexually transmitted diseases is a minefield of myths and misconceptions and it is essential that these be corrected where they surface.

1. An introduction to sexually transmitted diseases in which basic facts are provided could be followed up with an essay topic dealing with the following:
 - Syphilis
 - Herpes
 - Gonorrhoea
 - Venereal warts, lice and crabs
 - Scabies
 - other STD's

Sub-headings for the various topics could be:

- Symptoms
- Treatment
- Dangers
- Prevention.

AIDS

In view of the projected magnitude of AIDS; the implications it has for mankind; and the relatively high profile that it enjoys in the media, it is essential that the topic is thoroughly dealt with. Of all the topics in the sexuality programme the question of AIDS probably offers the most scope for input across the curriculum.

- * the attempts of science to find a cure
- * the implications for the economics of countries where there is already large-scale infection
- * declination and depopulation of certain areas in Africa - Zaire in particular
- * moral and ethical questions.

The scope is seemingly limitless, but if the topic is to be approached from a cross-curricular perspective, co-ordination is essential and at some stage all the information will need to be brought together to illustrate the integration. Perhaps in a media department display.

Note: In view of continual developments in this area it is essential that accurate, up-to-date sources be used.

THE DEPARTMENT OF NATIONAL HEALTH AND POPULATION
DEVELOPMENT: ADOLESCENT SERVICES

COURSE IN : ADOLESCENT SEXUALITY EDUCATION

1. The Department of National Health and Population Development offers a training programme in adolescent sexuality as well as a course in systematic training for effective parenting for professionals, parents and teenagers in the RSA.

This training programme is now available to the independent and self-governing states.

2. The main long-term objectives of the programme are:-
 - 2.1 To equip adolescents with knowledge and skills to enable them to make responsible and informed decisions and choices regarding their own sexuality and social lives. When education is provided pregnancy is delayed and this enables the adolescent to assume responsibility towards a future career and quality life.
 - 2.2 To equip parents with the necessary knowledge and skills to improve communication with their adolescent children through the course in systematic training for effective parenting.
3. The adolescent sexuality education programme is offered to teenagers according to their stages of psychobiological development.
 - PREADOLESCENCE - EARLY ADOLESCENCE 10 - 14 yrs
 - MIDDLE ADOLESCENCE 15 - 17 yrs
 - LATE ADOLESCENCE 18 - 21+ yrs

It is suggested that during training the sexes are separated for the early adolescent phase and mixed for the middle and late adolescent phases.

4. The basic outline of the programme is set out as follows:
 - Column A lists the topics which form the subject content of the course. It becomes possible therefore to adjust and adapt the programme to meet the training needs of the different areas and situations in the country as identified by respondents.
 - Column B serves as a guide to indicate the approximate time required for each topic.
 - Column C - respondents are requested to indicate their specific training needs in this column.
5. Any additional problems or needs not included in the list can be indicated at the end of each programme in the space marked "ADDITIONAL PROBLEMS/NEEDS".
6. The training team decides on films which are relevant to the course content.
7. The adolescent sexuality education programme and the systematic training for effective parenting courses are run concurrently by different teams. It is cost-effective for this Department to present the training to an adolescent/professional as well as a parent group on similar dates.

It would therefore be appreciated if the two teams are invited together wherever possible.
8. Should a group of professionals require a course in sexuality education, it is possible to adapt the content to meet that need.

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

ADOLESCENT SERVICES

COURSE IN: SYSTEMATIC TRAINING FOR EFFECTIVE PARENTING
(S.T.E.P. programme)

This course can be very useful to parents, professionals like teachers, nurses, social workers and any other people who work with children. It runs over two days and is limited to fifty persons per group.

The STEP programme deals with the following topics:-

1. A simplified analysis of behaviour, explaining that the key to understanding it, lies within the family's interaction.
2. Strategies in expressing encouragement and appreciation to a child.
3. The importance and nature of positive communication between parent/adult and child.
4. Strategies to improve communication styles.
5. Natural and logical consequences are outlined.

The essential nature of permitting inter-play of social order in discipline of children is explained.

6. The family meeting as a strategy to promote quality and depth of parent/child interaction.

The great value of STEP lies in making people who work with, or who parent children aware of both the responsibility they carry but also the means to discharge that responsibility with greater success. The child who emerges will be better disciplined, more responsible and a happier person.

- EARLY ADOLESCENT PACKAGE
APPROXIMATE TIME FOR TRAINING : 9 HOURS

PREADOLESCENCE - EARLY ADOLESCENCE 10 - 14 YRS

CONTENT	TIME REQUIRED PER TOPIC	INDICATE BY A ✓ TOPICS REQUIRED
1. Onset and Progress of Puberty	30/60	
2. Menstruation	1 hr.	
3. Ejaculation/Nocturnal Emissions	30/60	
4. Physical Changes in:		
4.1 Girls	1 hr.	
4.2 Boys	1 hr.	
5. Conception, Pregnancy and Child-birth	1 hr.	
6. Emotional changes and coping mechanisms		
1) Mood swings)		
2) Feelings of Invulnerability)		
3) Feelings of independence)	1 hr.	
4) Intense self-centering)		
7. Same sex friendships	30/60	
8. Shift to non-parental adults as models	30/60	
9. Basic Communication skills and values in the family	1 hr.	
10. Sexual abuse - To create an awareness and thus become less vulnerable	45/60	

MIDDLE ADOLESCENT PACKAGE

APPROXIMATE TIME FOR TRAINING: 16 HOURS

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MIDDLE ADOLESCENT 15 - 17 YRS

CONTENT	TIME REQUIRED PER TOPIC	INDICATE BY A TOPICS REQUIRED
1. Completion of Puberty	30/60	
2. Adult-like Physical Sexual Drives	45/60	
3. Psycho-social and Physical Behaviour		
1) Demonstration of Physical Skills (exhibitionism))		
2) Experimentation, Risk-taking and Consequences)		
3) Sexual attractions forming, concern with sex appeal)	2½ hrs	
4) Independence/Dependence conflicts)		
5) Unwilling to admit to ignorance)		
4. Fertility, Pregnancy and Abortion	1 hr	
5. Teenage pregnancy and it's consequences	1 hr	
6. Responsible sexual behaviour	1 hr	
6.1 Abstinence		
6.2 Contraceptive		
7. Sexually transmitted diseases	1 hr	
8. Intelligent choice of a sexual life style	1 hr	
9. Complete Awareness of Media Messages, Inconsistencies (society's double standards) and the effects of this on the behaviour of the adolescent	1 hr	

CONTENT	TIME REQUIRED PER TOPIC	INDICATE BY A TOPICS REQUIRED
10. Conflict Management	1 hr.	
11. Communication skills	1 hr.	
12. Self-image and Assertiveness	1 hr.	
13. Relationship skills and Etiquette	1 hr.	
14. Values and value clarification	1 hr.	
15. Decision-making and Problem-solving skills	1 hr.	
16. Psycho-social Pathologies - (Alcohol, Daggga, Suicide, Prostitution, Delinquency)	1 hr.	
17. Physical abuse - Rape	45/60	
18. Information on Homosexuality	30/60	
19. Sex Stereotyping	1 hr.	

ADDITIONAL PROBLEMS/NEEDS

LATE ADOLESCENT PACKAGE

APPROXIMATE TIME FOR TRAINING : 12 HOURS

LATE ADOLESCENCE 18 - 21 YRS

CONTENT	TIME REQUIRED PER TOPIC	PLEASE INDICATE BY A ✓ TOPICS REQUIRED
1. Establishment of adult self-identity, Independence, Career choice	1 hour	
2. Establishment of firm Sexual Identity	1 hour	
3. Relationship to family as an adult	1 hour	
4. Establishment of a value system incorporated from parents, peers, life experiences (hopefully) consistent with societal expectations	1 hour	
5. Marriage choice	1 hour	
6. Sexual response cycle	1 hour	
7. Family spacing for quality of life	1 hour	
8. Preparation for Parenthood	1 hour	
9. Cultural Differences	30/60	
10. Sexual disorders	1 hour	
11. Demography	45/60	
12. Psycho-social Pathologies (Alcohol, Dagg, Truancy, Delinquency, Prostitution, Suicide)	1 hour	

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ADDITIONAL PROBLEMS

ANNEXURE B

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MIDDLE ADOLESCENT PROGRAMME:-
TRAINING OBJECTIVES, METHODS AND TRAINING AIDS

SUBJECT	OBJECTIVES	TRAINING METHOD	TRAINING AID
1. <u>Puberty</u>	<ul style="list-style-type: none"> - To give Information on puherty. - To give basic Information on the physical and physiological changes that occur during the early and middle adolescent phase. - To create an appreciation of these changes as a natural dimension of human development. - To explain the Individuality and uniqueness of each person, hence the changes occur at different ages and rates in different people and sexes. 	<ul style="list-style-type: none"> - Information giving - Charts " " 	<ul style="list-style-type: none"> CHART BOARD/ BLACKBOARD OVERHEAD PROJECTOR
2. <u>Human Reproductive System</u>	<ul style="list-style-type: none"> - To give basic information about the anatomy and physiology of the human reproductive system. - To discuss the changes which occur to the external and internal organs of this system during the early and middle adolescent phase. 	<ul style="list-style-type: none"> - Give Information - class Discussions - Charts 	<ul style="list-style-type: none"> BLACKBOARD CHART BOARD - FILM PROJECTOR
2.1 <u>Menstruation</u>	<ul style="list-style-type: none"> - To give information on menstruation, the menstrual cycle and menstrual hygiene. 	<ul style="list-style-type: none"> " 	<ul style="list-style-type: none"> FILM GIRL TO WOMAN

SUBJECT	OBJECTIVES	TRAINING METHOD	TRAINING AID
2.1 Menstruation (continued)	<ul style="list-style-type: none"> - To discuss ovulation and relate it to conception and pregnancy. - To create an awareness that the adolescent is now (or just before the first period) capable of falling pregnant should she engage in sexual intercourse. - To discuss and dispel myths about menstruation. - To discuss socio-cultural factors associated with menstruation. - To discuss common problems related to menstruation. 	<ul style="list-style-type: none"> - Information giving - Class discussion " - Class discussion 	<ul style="list-style-type: none"> - BLACKBOARD - CHARTBOARD - FILM
2.2 <u>Erections</u>)	<ul style="list-style-type: none"> - To define. - To relate these experiences to the maturation of the male internal sex organs and the general changes occurring in the body during this phase of development. - To explain that this is a normal part of development. 	<ul style="list-style-type: none"> - Give Information - Class discussions " 	<ul style="list-style-type: none"> <u>FILM</u>
2.3 <u>Ejaculations</u>)			<ul style="list-style-type: none"> BOY TO MAN
2.4 <u>Wet-Dreams</u>)			<ul style="list-style-type: none"> - OVERHEAD PROJECTOR - FILM PROJECTOR

SUBJECT	OBJECTIVES	TRAINING METHOD	TRAINING AID
	- To discuss sudden erections and how to cope with them.	"	"
3. <u>Conception and Pregnancy</u>	- To revise ovulation and conception.	- Class discussion	CHARTS
	- To discuss confirmation of a pregnancy, signs and symptoms and the duration of a pregnancy.	- Give Information	"
	- To discuss the concept of a happy, healthy and planned pregnancy.	- Class discussion	
	- To discuss the roles and responsibilities of parents and link this discussion to the adolescent's present stage of development.	- Class discussion	
3.1 <u>Outcomes of a Pregnancy</u>	- To discuss the possible outcomes of a pregnancy.	- Give Information	Transparency
3.2 <u>Child-Birth</u>	- To give information on child-birth.	- Charts	OVERHEAD PROJECTOR
	- To impress on the adolescent that her body at this stage has not matured enough to carry a pregnancy without possible health consequences to both mother and child.	- Information - Class discussion	"

SUBJECT	OBJECTIVES	TRAINING METHOD	TRAINING AID
3.2.1 <u>Abortion</u>	<ul style="list-style-type: none"> - To give information on spontaneous and induced (therapeutic and criminal) abortions. - To give information on the provisions/conditions for a legal abortion. - To relate a criminal abortion to an unplanned/unwanted pregnancy. - To give information on the possible consequences of a criminal abortion. 	<ul style="list-style-type: none"> - Information - Class discussion 	"
4. <u>Emotional changes/needs</u>	<ul style="list-style-type: none"> - To discuss the common emotional changes/needs related to this stage of development e.g. mood swings, feelings of anxiety, guilt, fears etc. - To discuss feelings of:- invulnerability/vulnerability, dependence/independence. - To discuss peer influence. - To relate this discussion to child/parent and family relationships. 	<ul style="list-style-type: none"> - Class discussion - Information - Information - Information 	

SUBJECT	OBJECTIVES	TRAINING METHOD	TRAINING AID
5. <u>Cognitive changes</u>	<ul style="list-style-type: none"> - To discuss parent/child communication as a strategy in handling the changing emotional needs of the adolescent. - To discuss the Intellectual development that is also taking place during this phase and the effect this has on the adolescent's self-concept and decisions. - To discuss the Idealistic views of the adolescents and the tendency to over-value Intellectual theories to the exclusion of reality. - To discuss the tendency to refuse to admit to Ignorance. - To relate this discussion to the need to demonstrate Individuality and independence from parents and society. 	<ul style="list-style-type: none"> - Class discussion <li style="text-align: center;">" Information. - Class discussions - Class discussions - Class discussion - Class discussion 	
6. <u>Social Behaviour</u>	<ul style="list-style-type: none"> - To discuss same sex friendships and relations with the other sex. - To discuss relations with adults outside the family and "crushes". 	<ul style="list-style-type: none"> - Information - Class discussion - Information - Class discussion 	

SUBJECT	OBJECTIVES	TRAINING METHOD	TRAINING AID
	- To discuss self-centredness (narcissism).	"	
	- to discuss the search for a self-identity.	Information - Class discussions	
	- To discuss experimentation and risk-taking and the consequences of this behaviour.	"	
	- To link above behaviour to feelings of vulnerability and invulnerability.	"	
	- To discuss alcohol/drug misuse as part of this experimentation.	"	

7. Gender Identity
and
Sex stereotyping

- | | |
|--|-------------------------------------|
| - To give information on the development of a gender identity and relate this discussion to the development of a self-concept. | - Information
- Class discussion |
| - To discuss role models and their influence on sex-stereotyping. | Class discussion |

SUBJECT	OBJECTIVES	TRAINING METHOD	TRAINING AID
	<ul style="list-style-type: none"> - To discuss the influence of attitudes and socio-cultural aspects in gender identity and sex-stereotyping. 	Class discussion	
8. <u>Sexual Feelings and The Sexual Drive</u>	<ul style="list-style-type: none"> - To define sexual feelings and give information on the sexual drive. - To explain the normality of these feelings and to discuss sensible and responsible ways of coping with these feelings. 	<ul style="list-style-type: none"> - Information - Class discussion 	
8.1 <u>Sexual Fantasy</u>	<ul style="list-style-type: none"> - To define fantasy - To discuss sexual fantasy as a normal aspect of the lives of people of all ages. 		
8.2 <u>Sexual Choices</u>	<ul style="list-style-type: none"> - To give information on factors influencing sexual choices. - To list sexual choices. 	<ul style="list-style-type: none"> Information Class discussion 	<ul style="list-style-type: none"> Transparent Chart board

SUBJECT	OBJECTIVES	TRAINING METHOD	TRAINING AID
	- To discuss the advantages and disadvantages of each choice listed.	Small Group discussion	Chartboard
	- To discuss the importance of making decisions about one's sexuality and taking responsibility for decisions taken.	- Class discussion	<u>FILM</u> Are you ready for sex
	- To reinforce the fact that adolescents should not be swept or pressurised into sexual activity.	Class discussion	
	- To discuss responsible sexual behaviour and sexual etiquette.	- Information - Class discussion	- Overhead Projector - Chartboard
	- To relate the concept of a positive sexual self-image to a healthy self-concept	- Information - Class discussion	<u>FILM</u> It's okay to say No
	- To impress on the young person that whatever choice is made, he/she will have to live with it for the rest of his/her life.	Class discussion	
9. <u>Homosexuality</u>	- To define homosexuality.	Information	Overhead Projector

SUBJECT	OBJECTIVES	TRAINING METHOD	TRAINING AID
9. Homosexuality (continued)	- To discuss the importance of respecting other people's sexual choices.	Class discussion	
	- To discuss the consequences of promiscuity among homosexuals.	Information	
10. <u>Teenage pregnancy</u>	- To give information on contributing factors.	Information	
	- To give information on the physical and socio-economic consequences of teenage pregnancy.	"	
	- To discuss the effects on the family.	Class discussion	
	- To discuss preventive factors.	Class discussion	
11. <u>Sexually Transmitted Diseases</u>	- To define the term STD.	Information	
	- To give information on the transmission and spread of these diseases.	Class discussion	
	- To give information on the general signs and symptoms.		- Slide Programme

SUBJECT	OBJECTIVES	TRAINING METHOD	TRAINING AID
	<ul style="list-style-type: none"> - To list and briefly discuss 4 sexually transmitted diseases which are common amongst the population. - To give information on the diagnosis, treatment and consequences of STD's. - To relate prevention to responsible sexual behaviour. 		- Video on Aids
17. <u>Relationship and Life Skills</u>	<ul style="list-style-type: none"> - To develop an awareness and understanding of relationships. - To discuss factors affecting relationships e.g. physical, social factors etc. - To do an exercise on the qualities of a good relationship. - To develop an awareness and respect for the different attitudes and values held by various people but that one has to decide on his/her own values, ideals and interests. 	<ul style="list-style-type: none"> Class discussion Class discussion Small group discussions Class discussion Small groups 	<ul style="list-style-type: none"> BLACKBOARD CHARTBOARD " "

SUBJECT	OBJECTIVES	TRAINING METHOD	TRAINING AID
	<ul style="list-style-type: none"> - To discuss exploitation in relationships within the context of the self eg. self-image. - To give information on the self-image and relate this concept to assertiveness. - To discuss the pressures facing this age group and how life skills can enable them to cope. - To discuss and do exercises on the following relationship and life skills:- <ul style="list-style-type: none"> - Communication - Values and Values Clarification - Decision - making - Problem - solving - Handling confrontation 	<ul style="list-style-type: none"> Class discussion Information and Class discussion Class discussion Role plays 	
13. <u>Psycho-Social Pathology</u>	<ul style="list-style-type: none"> - To discuss:- <ul style="list-style-type: none"> - delinquency/truancy - promiscuity - prostitution - depression/suicide 	<ul style="list-style-type: none"> - Information - Class discussion 	

SUBJECT	OBJECTIVES	TRAINING METHOD	TRAINING AID
	<ul style="list-style-type: none"> - alcohol/drug misuse and abuse - eating disorders - To discuss factors which could be cited in causation. - To discuss prevention. 		
14. <u>Sexual Abuse</u>	<ul style="list-style-type: none"> - To give an overview of sexual abuse. - To create an awareness about sexual abuse especially by the immediate family members, relatives and family friends. - To discuss the importance of a positive, healthy self-esteem in minimising the risk of being a victim of sexual abuse. - To discuss the effects of sexual abuse. - To discuss assistance available to victims of sexual abuse. 	<ul style="list-style-type: none"> Information - Information - Class discussion - Information " " 	
15. <u>Sexual Dysfunction in Adolescence</u>	<ul style="list-style-type: none"> - To define sexual dysfunction. 		

SUBJECT	OBJECTIVES	TRAINING METHOD	TRAINING AID
	<ul style="list-style-type: none"> - To list the major sexual dysfunctions that may affect adolescents. - To outline the possible causes of these dysfunctions. - To trace the linkages between negative sexual experiences in youth and future sexual dysfunctions. 	<p>Information</p> <p>Class discussions</p>	Chart Paper
16. <u>Future Choices</u>	<ul style="list-style-type: none"> - To reinforce the concept of postponing gratification. - To reinforce the concept of managing their sexuality in a responsible and self-elevating manner. 	Small group discussions	Chart Paper

THE LATE ADOLESCENT

Young people in this age group are on the threshold of adulthood.

Arrival at adulthood is not marked by any specific rituals or ceremonies. There is no exact criterion to mark the end of adolescence.

The yardstick which measures adulthood is erratic and inconsistent. In all societies a teenager of eighteen has individual responsibility for a crime and can be put in an adult jail if convicted. He can be hanged for committing murder. Legally he can drive a car. They can't sign contracts until the age of twenty-one.

Against this background of conflict there is the additional problem for young people in this group, that they are viewed by most parents, teachers and other adults in the community as children.

Some young people grab the reins of adulthood by availing themselves of measures which force the issue, eg by leaving school.

Before it is necessary; by becoming pregnant, by moving out of the parental home, by establishing households with a partner of the opposite sex, by getting married, etc.

There are variations, of course, among the norms of different communities, sub-groups, etc. Some parents/guardians force adulthood on teenagers who are not ready for it, by requiring them to leave school and get a job or even forcing the girls to "get a man" and have his children. For some young people then adolescence comes to an abrupt end.

Young people who are still in this age are usually expected to conform to "school-child" norms. Needless to say they are not expected to be leading sexual lives, but many of them are ready for sex.

The adolescent in this age-group then is really a young adult, who occupies a stage of life that falls somewhere between the relative attainment of emotional and physical maturity and entry into the adult world.

Our young adults then are coming of age in a society which is exemplifying the highly westernised norms and on the one hand our society still has traditional values which, for example, place emphasis on the submission of young people to the authority and will of parents and other "elders".

On the other hand, modern values exist in that we expect young men and women to develop qualities of independence, self-direction and emotional maturity, so that they can learn so that individuals in a rapidly changing society, detached from their families of origin.

The late adolescent is therefore torn between two extreme systems which result in the incongruent fact that responsibility is handed to them or taken away from them at the convenience of adults.

They will however still strive to develop a personal, ethical and moral code of behaviour amidst conflicting norms.

Content	Objectives
1. Human reprod. system	- Comprehensive review of the female and male human reproductive system.
2. Conception and pregnancy	- Revise conception - Discuss the RH factor. - Explain the functions of chromosomes and genes. - Explain how the gender of a baby is determined. - Revise signs of pregnancy.
3. Problems of conception, pregnancy and child-birth	- Explain the conditions in the male and female which may result in infertility. - State the usual medical treatment used for detecting and treating infertility. - State problems usually associated with pregnancy and child-birth. - State the consequences of the use of drugs and alcohol during pregnancy.
4. Disorders of the reproductive system	- Identify some disorders of the male and female reproductive system and define these disorders. - Discuss the medical treatment for correcting these disorders. - Outline the symptoms which signify the presence of a problem.
5. Details of contraceptive method	- Discuss child spacing, family planning and contraception. - Outline the advantages of family planning and child-spacing.

Content	Objectives
5. Details of contraceptive method (Continued)	<ul style="list-style-type: none"> - Describe the types of methods used for contraception and how they achieve contraceptive effect. - State the contra-indications in the use of the individual method. - Explain the advantages/disadvantages of all methods. - Discuss "Natural methods" and evaluate their effectiveness.
6. Sexual maturation	<ul style="list-style-type: none"> - Explain the importance of physical, mental and social readiness for sexual intercourse. - Discuss how these elements of readiness contribute to a satisfying sexual experience.
7. Understanding sexual disfunction	<ul style="list-style-type: none"> - Define sexual disfunction. - List the major sexual disfunctions that may men and women and define these disfunctions. - Outline the possible causes of these disfunctions. - Outline the recommended treatment for these disfunctions, differentiating between self-help treatment and medical RX.

Foremost in the adolescent's thoughts at this time are the questions "Who am I?", "Where am I going?", "Am I ready to face the world out there?".

The need for an ego-identity would have manifested itself in the teenager during mid-adolescence resulting in efforts to separate "Self" from parents. These adolescents would also have identified with the role and expectations of gender, carving out themselves and identity as individual human beings and as males or females in the society.

These struggles would be carried over from mid-adolescence to later adolescence, since answers would hardly have been found, particularly for the teenagers who are still in school.

The teenager still at school realises that answers should be found soon. This search for identity, which includes the teenagers' struggle for independence and self-esteem, now combines with the full force of other needs - for autonomy, status, achievement; and the sexually oriented need for intimacy.

The goal of this unit is to help the students understand these needs, find positive methods of fulfilling them, avoid frustration and its attendant feelings of rebellion and alienation.

EMOTIONAL DEVELOPMENT

Content	Objectives
1. Emotional needs	<ul style="list-style-type: none"> - Revise the concept of self-esteem. - Discuss ways in which young people can attain a high level of self-esteem. - Discuss the emotional needs that manifest themselves during later - adolescence. - Discuss between negative and positive ways of meeting these needs.
2. Challenges facing the later-adolescent	<ul style="list-style-type: none"> - Discuss their individual feelings about moving into adulthood. - Examine the emotional problems that may be caused by involvement in pre-marital sex. - Discuss the hallmarks of adulthood that can be applied locally. - Identify the social and parental expectations of later adolescents and compare these expectations with the real possibilities. - Discuss ways to iron out conflicts between personal expectations and social expectations. - Discuss the ability to make effective decisions. - Identify community services which may provide assistance for individuals needing counselling.
3. Love, sex and marriage	<ul style="list-style-type: none"> - Discuss love in the context of male/female relationships.

Content	Objectives
3. Love, sex and marriage (Continued)	<ul style="list-style-type: none"> - Examine the link between love and sex. - Explore the possibilities of the existence of physical attraction without <u>LOVE</u>. - Identify types of "Unions" existing in the society. - Discuss the Adv./Disadv. of these unions/relationships. - Outline the requirements for a stable relationships. - Examine the place of children in these relationships/unions. - Discuss the marriage relationship. - Outline the ways in which parents can demonstrate responsibility for their children. - Define for themselves what they would like marriage to be, as opposed to what exists in the community. - Discuss the qualities desirable in a mate. - Examine themselves in terms of personal assets and liabilities and compare traits against desirable in a mate/spouse. - Examine female/male contribution to a stable relationship. - Discuss the effects of divorce.

Content	Objectives
1. Taking care of the body	<ul style="list-style-type: none">- Discuss preventive health care.- Outline all aspects of preventive health care.- Discuss sexually transmitted diseases and the effects of the individual diseases.- Outline preventive measures against STD's.- Identify community agencies which can provide services to the individual for maintenance of health or treatment of diseases.- Specify the services offered by these agencies.

APPENDIX G

CONTENTS

Press Reports, pp.264-271

APPENDIX G
PRESS REPORTS
G1 - G7

G1

EKSTRA-RAPPORT, 3 MAART 1985 — 5

Dis darem erg!

TIENERSWANGERSKAPPE, veral onder ons melsies is 'n nasionale ramp en die Regering gaan geïra word om in te gryp. So sê 'n Paarlse dokter wat pas skokkend syfers bekend gemaak het.

Daar word beweer dat 50 000 melsies van onder 16 jaar verlede jaar landwyd ongeplande geboortes gegee het. Die dokter het ook bekend gemaak dat die Paarl die hoogste tienergeboortesyfer te wêreld het met 'n syfer van 30,51 persent teenoor die 25 persent van die Karibiese Eilande, 20 persent van die VSA en 3,5 persent van Egipte. In Japan en China is dit maar 1 persent. In die Paarl was die syfer in 1979 so hoog soos 35 persent.

Die ergste van alles is dat die babas dikwels misvorm is met min hoop om lewers in die lewe te kom. Die skrywer van die verslag sê ook dat in die meeste gevalle daar tussen die jong moeder en die kindjie 'n swak verhouding is. Sy is nie toegerus om die jong kindjie te stimuleer of te inspireer nie. Sy het self aanpassingsprobleme tuis, en word dikwels verdryf.

Dit is 'n ramp, want baie min van die jong moeders of die kinders kan tot die land se vooruitgang bydra. Die meeste van hulle word 'n ekonomiese las en dit moet nou 'n groot nasionale doelwit wees om hierdie swangerskappe te vermy. Ons moet terugkeer na 'n stabiele gemeenskap met duidelike waardes en dissipline, waarheid en gemeenskapstrots. Die oogmerke van kuisheid voor die huwelik en trou aan jou lewensmaat moet bevorder word.

Die dokter sê ons moet ook realisties wees en aanpas by die wêreld waarin ons woon. Baie van

hierdie jong melsies kom uit huise met geen geslidsdissipline nie.

In 'n hoofartikel van die Jongste SA Mediese Tydskrif skryf die redakteur dat die vraag nou ontstaan of tienerswangerskappe wenslik is. Uit 'n mediese oogpunt is dit miskien 'n goeie ding, want tienermoeders het minder komplikasies, maar sulke bevallings is beslis nie wenslik nie.

Vingervysing

Die artikel beklemtoon die probleem dat sulke tienermoeders met siekundige probleme te kamp het. Wat kan gedoen word? Om die sedes en 'n gemeenskap oor die kort termyn te verander is omtrent 'n onbegonne saak. Beter voorbehoedmiddels-advies, met ander woorde voorligting en 'n meer liberale abortiebeleid, word genoem as antwoorde op die probleem.

Ander genesheer met wie ons gesels het, sê uitdruklik dat die skoksyfers uit die Paarl 'n vingervysing na ons gemeenskap is wat veral in die laer inkomstegroepe afgesny is van gesondheidsvoorzorg.

Die SA Mediese Tydskrif het vroeër vandeesmaand gewaarsku dat die grootste enkele probleem van seksvoorzorg juis by ouers lê want daar is teenkanting van ouers se kant af. In die Paarlse gemeenskap is die tienermoeders klaarblyklik in 'n kategorie buite hierdie groep, sê een genesheer. Dit is voor die hand liggend dat die probleem van tienerswangerskappe net opgelos kan word deur 'n beter opvoeding te verskaf.

By RUTH GOLEMMO

SHOCKING new disclosures about schoolgirl pregnancies and backstreet abortions in South Africa have come to light — and the lack of sex education at schools is being blamed.

More than 200 000 illegal abortions are carried out in South Africa every year and the number of unwanted babies has rocketed to more than 500 000. Many of the pregnancies occur among young teenagers.

Saving the lives of young victims of bungled backstreet abortions costs thousands of rands in medical fees and valuable man hours, according to Dr J H O Pretorius, director of the Family Planning Association.

Family planning experts have hit out at the education departments' strict closed door policy which prohibits them from addressing schools on matters of contraception.

The Transvaal Education Department only allows teachers officially appointed to educate pupils to address them during school hours.

The other education departments only allow outside speakers to address pupils on charity or cultural matters.

"We cannot possibly allow people to address our pupils on social or moral issues," a spokesman for the Cape Education Department said.

Mrs Non Trollip, national president of the Family Planning Association in South Africa, said educators could no longer ignore the problem.

Responsibility

"An increasing number of teenagers are sexually active and they have a right to information on how to control their fertility," she said.

"Information of this kind does not spread promiscuously, but allows young people to foster a responsibility for their sexual activities. Schools have a duty to educate pupils about sex."

Mrs Trollip said erotic literature was available to youngsters and sex symbols emerged from popular films and novels — but these only stressed the one side of the issue.

Lack of sex guidance in schools blamed

"The sad part of the story — the unwanted child, the battered child or the lonely distraught teenager who falls pregnant — is not always shown.

"And it seems that, as times get harder and life becomes more stressful, many teenagers are turning to one another for love and comfort and becoming sexually active.

"In the Johannesburg clinic a large number of young girls whose boyfriends were serving in the defence force have recently come for pregnancy tests.

"In Cape Town, four times more teenagers have come to the clinic this year than last," she said.

According to Dr Pretorius, the estimated figure for abortions was based on those which caused complications and resulted in the women coming to the hospital for aid.

More than 200 000 illegal abortions in South Africa every year

More than 500 000 babies are unwanted

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More than 500 000 babies are unwanted

"From the very nature of the illegal act it is very difficult to calculate figures, but there is no doubt that the numbers have increased in recent months," he said.

Dr Pretorius said the risk of being struck off the medical roll was too high for doctors to get involved, so the abortions were done by untrained people.

Support

Last year a report by the Human Sciences Research Council, commissioned by the Government, came out in support of abortion on demand.

Last month the report, entitled "Abortion and Family Planning: a Literature Study", by senior researcher Monica Bezela, was released to the public.

The report said the Government had recognised the need for "deceleration of population growth and supports national efforts at family planning.

"In most African countries use of modern methods is virtually non-existent.

"No population has ever been able to control fertility by reversible methods of contraception alone. That is without making wide use of sterilisation and abortion.

Principles

"The decision to have an abortion is an individual one. An abortion policy should be sensitive and humane towards the needs of individuals, and should be based on ethical principles acceptable to all sectors of a society", the report says.

Dr Wille van Heek, Minister of Health and Population Development, said this week that they were still studying the report.

According to a report released by the Department of Health and Welfare in May this year, nearly 30 000 operations for the removal of the residue of pregnancies were performed from December, 1983, to October last year.

The department recorded 474 legal abortions in 1983. Official British Government statistics show that in 1981, 511 South African women obtained legal abortions in Britain.

Call for sex education at primary school level

All Government education departments should investigate and set up a balanced, responsible, co-ordinated programme of sex education, commencing in primary school, Mrs A C Routier, said yesterday.

Speaking in the debate on the report of the Committee for Social Affairs on the youth of South Africa, she said she considered it a national priority to prepare suitable staff and curricula to undertake this task.

Statistics showed that more than 500 000 black children entering school in a particular year would not go beyond Standard 5.

They did not have the economic resources to bring up and educate children.

"So if these children are to be reached, authorities must en-

lighten them before that time."

In recent surveys by two women's magazines, the South African teenagers showed a crying need for more information.

"And these are children whose parents are in a class which can afford glossy magazines."

HORRIFIED

A well-known Afrikaans editor visited a leading high school in Cape Town in the past few weeks and was horrified at the total ignorance of some 15-year-olds.

"To those children the 'birds and the bees' were things that flutter around flowers and trees. One 14-year-old wrote asking if she could become pregnant by kissing," Mrs Routier said.

Among black leaders who spoke to her certain of these

pleaded that suitable instruction be given to their children.

They felt that in traditional extended families, children conceived out of wedlock were more easily accommodated. But in an urbanised shifting society no grandmother or older relative was available to care for illegitimate offspring.

"Thus they are often abandoned.

"This can have extremely dangerous political consequences because such children roaming free, are the easiest possible prey for political agitators.

"Here are children for whom 'the system' has offered nothing and who believe that any other system could only bring an improvement." — Sapa.

STAR L.R.
18/6/87

Study shows need for sex education

Medical Reporter

A STUDY conducted among 1 000 high school pupils has highlighted the need for marriage and sex education — and the problem that schools have neither the motivation nor people qualified to provide it.

This was the finding of Dr G Cilliers of the University of Port Elizabeth, who delivered a paper during an adolescent and child psychiatry congress at Unisa.

Dr Cilliers' study, taken at 21 high schools in the Port Elizabeth/Uitenhage area, revealed that young people were not adequately prepared for

marriage and family life.

Many of the children lacked knowledge about sex and their own physical and emotional development.

Dr Cilliers said poor communication between parents and adolescents often hampered the youngsters' preparation for later life.

"Since parents often don't provide proper family guidance and many children are not privileged to live in homes with strong marital bonds, it is unfortunately the task of the school to provide education programmes."

The main reason schools were not sufficiently motivated to give attention to the matter was that they were often ignorant of the practical applications of such a programme.

"Finally there is the very real problem that there are not enough trained people to present family and marital education programmes at all the schools in the city."

Dr Cilliers stressed that schools and parents had an important task in presenting marital programmes and sex guidance to adolescents.

PRETORIA NEWS
7/10/87

by DAVE MARRS

EAST LONDON — The Cape Department of Education has banned the Family and Marriage Society of South Africa (Famsa) from delivering lectures to children at schools under its control.

Although a spokesman for the department had failed to comment on the reason for the banning by the time of going to press, Famsa officials believe the action was in response to complaints from a minority of parents.

In a letter to the local Famsa office, dated December 15, 1987, the chief superintendent of education, Mr W. M. Diepeveen, said he had been instructed by the Cape director of education, Dr S. W. Walters, to inform Famsa of the decision "following a number of complaints".

"Your organisation may under no circumstances conduct lectures or courses at any schools of the Cape Education Department.

"Please note that this instruction applies to all schools in the province and is not a specific reflection on your branch," the letter stated.

Famsa has already been barred from working in Transvaal schools.

Famsa banned in schools: education department fails to give reasons

although the organisation works closely with the Free State and Natal education departments.

The education trainer for the East London branch of Famsa, Mrs Sue Matthis, said the Famsa's education councillors had been working in almost all the high schools and many of the primary schools in the area for more than eight years.

She said one East London high school had conducted a survey of parental opinion that revealed a 95 per cent positive attitude to Famsa continuing with its programmes.

Another school had reported a drop in the average number of pregnancies per year from eight to four, and had attributed the result directly to Famsa's counselling.

"On further investigation it turned out that Mr Diepeveen had received only four com-

plaints about our Education for Living programmes and that the substance of the complaints had been similar — that our programmes are not presented as absolute biblical truths," Mrs Matthis said.

Although a list of questions relating to the issue was teleaxed by prior arrangement to the Department of Education before noon yesterday, no response had been received by the time of going to press.

The department was asked why Famsa had been barred from Cape schools and if this action had been in response to only four letters of complaint.

Among other questions, the department was asked to reveal what alternative programme would be instituted to replace Famsa's guidance lectures.

In a letter to Mr Die-

peveen after hearing of the decision, Mrs Matthis stressed that Famsa's aim was "to work from a more global approach to encompass the experience of as many children as possible".

"We believe that for the type of work that we do, this is more valuable than a narrower denominational approach.

"What we work towards is to help young people to integrate a value system of morals as a core part of their personalities, rather than imposing such a moral system on them.

"In this way, in a situation where there is no adult present to help make a decision that will not harm the child emotionally, intellectually, physically or spiritually, he will be able to resist peer pressure as a natural part of his own internalised value system," she said.

Mrs Matthis, who is holder of a degree, majoring in psychology,

said Famsa believed that successful marriages were the "foundation of happy family life and are vital to the well-being of the community".

"It is to this end that we have worked in the schools, helping equip pupils to form healthy relationships by improving their self-image and their feelings of self-worth.

"We deal with issues such as conflict management, human sexuality, decision making, family roles and expectations.

"Famsa does not work from an overtly Christian base as this is not our mandate. However, we do work from a firm moral foundation which derives its deepest insights from the Christian tradition and not from any other source," Mrs Matthis added.

She said although the Famsa preferred to work without a teacher present because of the different roles and ex-

pectations in the teacher/pupil relationship, when a directive from the Department of Education had asked to have a teacher in the classroom, they had been willing to comply.

"The work we have done with younger children is very different from work with older children.

"In other words, we talk to them about relationships relevant to them at their age and maturity level — their friendships, their relationships within the family circle, their bodily changes and decision-making procedures."

Mrs Matthis said Famsa stressed, when discussing contraception, that knowledge did not mean permission.

The organisation emphasised concepts such as reverence for their own bodies, respect for other people's bodies and responsibility for their actions.

"We talk about the fallibility of contraception and the fact that sexual activity is only appropriate for people who are ready for the responsibilities of parenthood.

"We point out that the only place for really wholesome parenting is within the marriage," she said.

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G5

47 out of 1 000 infants die

Coloured illegitimate births highest in SA

Staff Reporter

ALMOST 38 out of every 100 first born coloured children are illegitimate. This is the highest rate in the country, Mr Chris April, Minister of Health Services and Welfare in the House of Representatives, said in Mitchell's Plain at the launching of the programme, "Give the Child a Chance".

"It is very disturbing that, characterised by the highest illegitimacy rate in the country, the coloured population are cha-

children who die young, children who are undernourished, children who do not progress at school and young girls who have children," Mr April said.

world, parents have to accept the responsibility of giving them all that is rightfully theirs," said Mr April.

Immature

"Many of the mothers of illegitimate children are children themselves and are far too young and immature to handle the responsibilities of a child. The number of coloured children who die within the first year of birth are the second highest amongst the people in this country. Almost 47 out of every 1 000 children born, die before they are one year old," he said.

These statistics can be ascribed to poor social conditions and the weak health of mothers during pregnancy, which influences that of the babies.

As a result of these poor social conditions, we find that almost 50% of our children do not progress any further than standard two," said Mr April.

Fiefa

Quoting "Fiefa", the lead character in Dalene Mather's book "Fiefa's Child", he said: "God forgives us for many things, but God does not forgive us for the wrong we do to our children."

"I wish to remind you that children also have rights. When children are brought into the

Precious gifts

He reprimanded parents who irresponsibly conceive children without thinking of how the children would survive their future.

"If we look at these grave statistics, it appears as if we do not value our children. People do not realise that children are precious gifts from God - we will have to give account on what we have done with this privilege. Are we really worthy of this great responsibility?" he asked.

A peek into teenager sexuality

Studies show one in five SA schoolgirls falls pregnant

A TORCH was shoved into the bedroom of teen sex this week following a report that schoolgirls at a Cape school had been expelled after they were found with the possession of the pill and condoms.

And a Sunday Tribune investigation has found that while teenage sexuality is rampant and "far higher than the man in the street thinks", school pupils are still abysmally ignorant about AIDS.

A Medical Sciences Research Council survey has found that most high school pupils interviewed had indulged in sex, yet they did not think they were at risk of getting AIDS.

Another study showed that most teenagers do not use contraceptives for about a year after they start having sex. As a result, one in five schoolgirls in South Africa falls pregnant. This is one of the highest rates in the world.

Experts this week called for the schools to be swept aside and for sex education programmes to be instituted in schools with the backing of parents to inform pupils and help them make choices.

The principal of the co-ed De Villiers Graaff High School in Villiersdorp in the Cape, Abert Uys, confirmed that schoolgirls were asked to leave the hostel after they were found in the possession of the pill and condoms, but stressed that this was not the only reason. There had been other long-term disciplinary problems with the girls, he said.

In the past, pupils found with contraceptives were sent to a guidance teacher, he said.

Erica Greathead, of the Planned Parenthood Association, has, however, backed schoolgirls who have a condom in their possession and said

search programme of the MSRC said many schoolgirls were scared out of it because of fear.

He called for a school programme, possibly part of the curriculum, to inform pupils.

Giving pupils information was not the same as giving them the go-ahead to have sex, he said. It was like warning children about the dangers of smoking before their first cigarette.

He also suggested schools needed to look at the question of providing condoms.

Dr Angelo Grazioli, director of the Sex Education and Dysfunction Unit of South Africa called for a programme for youth, but said it should be one which offered practical life skills for teenagers to learn to express love without using their genitalia.

"I'm not saying that they should not hug or kiss."

He also warned that the condom was not completely reliable in protecting against the spread of AIDS as there was a failure rate of more than 10 percent.

Teenagers were under pressure to start becoming sexually active, he said.

"Every time they look at a movie, they see boy and girl, they get into bed and live happily ever after."

"Life is not like that. What happens is that 70 percent of children born at Tygerberg are born to teenage mothers."

"The best thing that could happen on television would be for JR to get V.D.," he said.

APPENDIX H

CONTENTS

Research Questionnaire administered
in 1988 and 1989, pp.272-286

APPENDIX H
RESEARCH QUESTIONNAIRE ADMINISTERED
IN 1988 AND 1989

QUESTIONNAIRE

AN EXPLORATORY FIELD STUDY INTO SCHOOLGIRL PREGNANCIES

CONFIDENTIAL NATURE OF THE QUESTIONNAIRE:

All information obtained by means of this questionnaire is strictly confidential and will be used for research purposes only.

THE PURPOSE OF THE QUESTIONNAIRE:

- to determine attitudes towards the description of the problem of schoolgirl pregnancies;
- to identify causes of the problem;
- to gain insight into the overall problem;
- to obtain views on what the school can do in its prevention.

INSTRUCTIONS:

1. Please read the instructions carefully before answering the questions.
2. You are not required to write your name(s) as this questionnaire is anonymous.
3. How to complete the questionnaire:

3.1 Where appropriate, questions must be answered by placing a cross in the blocks.

Example:

My home language is:

English	1
Afrikaans	2
Other	3

3.2 Some questions require answers by means of sentences.

3.3 This questionnaire may be completed in English or Afrikaans.

QUESTIONNAIRE

Assessment No.:

Date of Assessment:

SECTION A: BIOGRAPHICAL INFORMATION

1. My sex

Male	1
Female	2

2. My date of birth

	day	month	year
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

3. My age in years

	<input style="width: 100%;" type="text"/>
--	---

4. My home language

English	1
Afrikaans	2
Other	3

5. My present occupational status

Pupil	Std. <input style="width: 30px;" type="text"/>	1
Parent		2
Ex-pupil (pregnancy case)	Std. <input style="width: 30px;" type="text"/>	3
Parent of ex-pupil (pregnancy case)		4
Teacher		5
Member of Clergy		6
Community worker/leader/professional person		7

6. My religious group

Catholic	1
Protestant (Anglican, Methodist, Presbyterian, Baptist, etc.)	2
Dutch Reformed	3
Other	4

SECTION B: DESCRIPTION OF THE PROBLEM

7. Are schoolgirl pregnancies a problem at school?

Yes	1
No	2
Don't know	3

8. Is the number of schoolgirl pregnancies increasing?

Yes	1
No	2
Don't know	3

9. Are those schoolgirls falling pregnant nowadays younger than they used to be?

Yes	1
No	2
Don't know	3

10. Will the problem become worse if it is left to sort itself out?

Yes	1
No	2
Don't know	3

11. Does the pregnancy problem need urgent attention?

Yes	1
No	2
Don't know	3

12. Should the school and the community show greater interest in the problem?

Yes	1
No	2
Don't know	3

SECTION C: SEXUAL ACTIVITY AND KNOWLEDGE OF CONCEPTION

13. Schoolgirls begin dating boys -

before the age of 11	1
between 11 - 13	2
between 14 - 16	3
between 17 - 19	4
between 19 and more	5

14. Adolescent schoolgirls think they know more about sex than they really do.

True	1
False	2
Not sure	3

15. Adolescent girls think that a girl is physically capable of becoming pregnant before her first menstrual (monthly) period.

True	1
False	2
Not sure	3

16. Adolescent girls think that a girl can become pregnant during her menstrual (monthly) period.

True	1
False	2
Not sure	3

17. Adolescent girls think that a girl can become pregnant without full intercourse taking place (without going all the way).

True	1
False	2
Not sure	3

18. Most adolescent schoolgirls know when it is the "safe period" for having sex.

True	1
False	2
Not sure	3

19. Most adolescent girls are aware of the dangers of having sex at an early age.

True	1
False	2
Not sure	3

20. Schoolgirls know everything about becoming pregnant and how a baby is conceived/made.

before the age of 11	1
between 11 - 13	2
between 14 - 16	3

SECTION D: EDUCATION, ATTITUDES TO PRE-MARITAL SEX AND SEXUAL EXPERIENCE

21. Do most young girls have an adequate understanding of the reproductive system in the female body?

Yes	1
No	2
Unsure	3

22. The age at which most girls first find out about sex and love-making is -

10 years and younger	1
11 - 13 years	2
14-16 years	3
17 years and older	4

23. Teenage girls usually first find out about sex and love-making -

from mother / father	1
from a brother / sister / relative	2
from friends at school	3
from a sex education programme at school	4
from magazines/books	5
Other	6

24. Is sex talked about freely by teenagers today?

Yes	1
No	2
Don't know	3

25. Do most girls talk openly about sex with their mother / father?

Yes	1
No	2
Don't know	3

26. Do most parents talk openly about sex with their children?

Yes	1
No	2
Don't know	3

27. Do you think teenagers have enough opportunity to acquire sex information for themselves?

Yes	1
No	2
Don't know	3

28. Do those young girls who engage in sex do so because everyone is "doing it" today - (i.e. it is the "in thing")?

Yes	1
No	2
Don't know	3

29. Do you think the fear of pregnancy would stop a girl from having sex?

Yes	1
No	2
Don't know	3

30. At which age do most schoolgirls begin to engage in sexual intercourse?

12 - 13 years	1
14 - 16 years	2
17 - 18 years	3
19 years and older	4
cannot say	5

31. Do girls often engage in sex because they feel embarrassed about being a virgin?

Yes	1
No	2
Don't know	3

32. Do girls think that it is often "old fashioned" not to have sex before marriage?

No	1
Yes	2
Don't know	3

33. Do you think boys today put pressure on girls to have sexual intercourse with them?

No	1
Yes	2
Don't know	3

34. Would most parents approve of an adolescent indulging in pre-marital sex?

No	1
Yes	2
Don't know	3

35. Which of the following girls would most likely engage in sex?

a girl coming from a poor home	1
a girl who lacks love from her parents / because of broken family	2
a girl who does badly at school - therefore sex is an escape	3
a girl whose friends influence her into having sex	4
Increased opportunity in home / outside for sexual contacts	5
another reason (explain)	6

36. Having sex before marriage nowadays is:

all right if one is in love	1
immoral, sinful and therefore wrong	2
a normal part of a youth's growing up	3
a personal matter	4
another reason (explain)	5

37. Boys believe that the responsibility for contraception rests with a girl?

Agree	1
Disagree	2
Unsure	3

38. Which of the following do you think is the main reason for young boys and girls engaging in sex?

too much sexual freedom	1
tolerant attitude on the part of the Church	2
Increased opportunities for meeting the opposite sex	3
approval by parents	4
boredom with school	5
the mass media (T.V., films, magazines, literature)	6
poor quality of life in the Township	7
another reason (explain)	8

SECTION E: KNOWLEDGE, ATTITUDES AND PRACTICE WITH RESPECT TO CONTRACEPTION

39. Are young girls adequately informed about contraception?

Yes	1
No	2
Don't know	3

40. Do you think adolescent girls know about most of the following birth control methods?

- 40.1 Condom
 40.2 Pill
 40.3 Withdrawal
 40.4 Cream/Jelly
 40.5 Foam
 40.6 Rhythm
 40.7 Diaphragm
 40.8 IUD/Coll
 40.9 Other

Yes	1
No	2
cannot answer	3

41. How frequently do sexually active schoolgirls use birth control?

not at all	1
sometimes	2
most times	3
every time	4
don't know	5
other reason (state)	6

42. Who do you think should be responsible for contraception?

the girl	1
the boy	2
both girl and boy	3
don't know	4

43. Many sexually active teenagers prefer not to use contraceptives.

True	1
False	2
Not sure	3

44. They don't use contraceptives because of -

Religious beliefs	1
Falling to accept that they are indeed having intercourse	2
Inability to get hold of any	3
Bad planning	4
The belief that parents would disapprove of sex	5
The fear that it is dangerous	6
A lack of factual knowledge about using them	7

45. Many schoolgirls do not know how and where to obtain contraceptives.

Agree	1
Disagree	2
Unsure	3

46. A girl not using birth control is most likely to get pregnant if she has sex frequently.

Agree	1
Disagree	2
Unsure	3

47. Many schoolgirls fall pregnant because they believe that sex relationships are a sign of maturity.

Agree	1
Disagree	2
Unsure	3

48. Many young girls think that sexual intercourse is the best way to show someone you love them.

Agree	1
Disagree	2
Unsure	3

49. Teenagers are misinformed about the "facts of life".

Agree	1
Disagree	2
Unsure	3

50. Sexually active girls are not adequately protected against the possibility of falling pregnant.

Agree	1
Disagree	2
Unsure	3

51. Young boys and girls think sex is fun - you don't have to take it seriously.

Agree	1
Disagree	2
Unsure	3

52. These days it is O.K. for a girl to have sex with a steady boyfriend.

Agree	1
Disagree	2
Unsure	3

53. Think of schoolgirls who have recently had a baby. Close your eyes for a brief moment and try to focus attention on them. Now kindly read the following statements and place a Y for Yes or N for No in the block to describe them.

53.1 The girls were pleased to have the babies	
53.2 Their boyfriends were pleased about the baby	
53.3 The girls' parents were pleased about their babies	
53.4 Most people were upset/disappointed about them	
53.5 The girls did not know about birth control	
53.6 They blamed the boys for not using contraceptives	
53.7 They planned to go back to school after they had the babies	
53.8 They got married because they were pregnant	

SECTION F: SCHOOLGIRL PREGNANCIES - WHAT CAN BE DONE

54. Do you think there is an urgent need on the part of the School, Parents and the Community to look seriously into the problem of pregnancies?

Yes	1
No	2
Don't know	3

55. Who should be the source of information about sex for school children?

The Church	1
The School	2
The Parents	3
Community Organisations	4
The School in co-operation with Parents	5

56. Should boys and girls be told about contraception?

Yes	1
No	2
Don't know	3

57. When should sex education begin?

before puberty begins	1
between 10 - 12 years	2
between 13 - 14 years	3
between 15 - 16 years	4
between 17 - 18 years	5
18 years and after	6

58. Do you think providing school-based sex education programmes could help in reducing the number of unwanted pregnancies?

Yes	1
No	2
Don't know	3

59. As the school is the only social institution that reaches all youths, should it see the teaching of family life and sex education programmes as being its responsibility?

Yes	1
No	2
Don't know	3

60. Should parents and outside community organisations be consulted in setting up sex education programmes jointly?

Yes	1
No	2
Don't know	3

61. Should schools be allowed to present parents with course outlines on sex education to urge them to follow up with their children at home?

Yes	1
No	2
Don't know	3

62. Which of the following do you consider to be the most important factors for discussion in a sex education programme?
Fill in the blocks as follows:

1. (VI) Very Important
2. (I) Important
3. (NI) Not Important

62.1 The Reproductive System in the Male and Female, and how it works, Pregnancy and Childbirth	
62.2 Contraceptive methods - who is to use them and where they can be obtained	
62.3 Intelligent choice of a Sexual Life-Style	
62.4 Help available for pregnant girls	
62.5 Sexually Transmitted Diseases (STD)	
62.6 The Advantages of Delaying the First Pregnancy	
62.7 The Dangers of Having Sex too early	
62.8 Strategies for reducing unwanted/unintended pregnancies in schoolgirls	
62.9 Abortion	
62.10 How to use leisure time activities	
62.11 The Risks of falling pregnant and Consequences of Teenage Pregnancies	
62.12 Improving communication between Children and Parents	

APPENDIX I

CONTENTS

Specimen Copy of Covering Letter, pp.287-288

APPENDIX I
SPECIMEN COPY OF COVERING LETTER

Dear

RESEARCH QUESTIONNAIRE

It will be highly appreciated if you would kindly complete the enclosed questionnaire which is voluntary, strictly confidential and duly authorised by the Principal, John Bisseker Secondary, East London.

I trust that your completed questionnaire will be either handed personally to me or posted to my address below. If however, you would like me to collect the questionnaire, please telephone me at the number listed below. Please do not hesitate to contact me should you have any queries regarding the questionnaire.

Thank you

Yours sincerely

I.M. KOOVERJEE

P.O. Box 7182
EAST LONDON
E20 0
Telephone: 28340

Dated:

APPENDIX J

CONTENTS

Full Responses to the Final Open-Ended Question (Question 64)
of the Research Questionnaire, pp.289—333

APPENDIX J

FULL RESPONSES TO THE FINAL OPEN-ENDED QUESTION

CATEGORIES/TOPICS

In this Appendix are recorded the actual comments/ideas as generated by the Final Open-Ended Essay. The full responses for each of the seven groups of subjects in the total sample are presented respectively under the following seven broad categories/topics:

1. SUPPORT FOR SCHOOL-BASED SEX EDUCATION.
2. PARENT-CHILD COMMUNICATION.
3. PARENT-SCHOOL PARTNERSHIP.
4. CURRICULAR CONTENT.
5. CONTRACEPTION AND CONTRACEPTIVE INFORMATION.
6. COMMUNITY INTERVENTION.
7. MORAL EDUCATION.

G1 : SENIOR SCHOOLGIRLS

1. SUPPORT FOR SCHOOL-BASED SEX EDUCATION.

RUTH:

1. Schools should have sex education programmes to bring about an awareness of the dangers of pre-marital sex and its consequences.

MARY:

2. Sex education at school.

ANNE:

3. Books published for the youth on contraceptives and abortions and teenage pregnancies.
4. Teenagers taught about sex education.

RONELLE:

5. Sex education programme for girls at school.
6. The girls should be told about sex, when puberty begins.

TRISH:

7. Teachers being involved in the programme as many of them are parents of teenagers and in this way they can relate their opinions and come to conclusions.
8. As different opinions will arise there will definitely be solutions to the high pregnancy rate at schools and also in our townships.

PATTY:

9. Pay attention to and be interested in the welfare of schoolgirls.

BETH:

10. School should devote more time to their pupils as individuals and sex programmes and guidance counselling.

JOSEY:

11. Schoolgirl pregnancies can be reduced if parents, teachers etc. speak openly to girls about sex, what a sexual relationship is about and the dangers involving a sexual relationship.

CATHY:

12. Important for teachers to talk about sex.
13. They should be open because most pupils don't have conversations with their parents, therefore the teachers can help them.

ANITA:

14. Schools have sex education programmes so that youngsters would be aware of the consequences of falling pregnant.

ROSE:

15. School must ask the adolescent and youth counsellors to come to school and share their views.

PINKY:

16. Children and teachers should be able to communicate openly.

COLLEEN:

17. School should introduce sex education.
18. The community, church and school should organise more educational campaigns at schools.

SONIA:

19. Schoolgirls should be told about sex and pregnancy before they start indulging in sex.
20. Boys should be told how bad it is to have sex before time.

JO-ANNE:

21. The school should have special classes.

LIZ:

22. Open discussions on sex, condoms etc. between boys and girls at school.

SUN:

23. School itself should take more interest in the child as an individual.
24. Sex education should be an open discussion.
25. Guidance counsellors should be enlisted in communities and schools.

SUNITA:

26. Sex education classes included at school.

TOSH:

27. School teachers should also speak about sex and the discussion should be spoken openly.

LEE:

28. They must teach sex education at school.
29. So my point of view is that SEX EDUCATION MUST BE TAUGHT IN EVERY SCHOOL.

PENNY:

30. Introduce a programme for boys and girls at school.
31. Schoolgirls bring disgrace to the community.
32. I think they should do something about this.
33. The community, churches and schools should launch sex education programmes in schools and in the community.

2. PARENT-CHILD COMMUNICATION.

RUTH:

1. Parents should spend more quality time with their children so that they can understand their children's emotional and psychological problems.

MARY:

2. Improving communication between children and parents.

ANNE:

3. Parents should also play their role in teaching their own children about sex education.
4. Parents are negligent towards their children, therefore they don't do well in school and think that it is not worth schooling.

5. The girl becomes pregnant just to spite the parent.
6. Parents ignorant attitudes towards their children is also responsible for teenagers to become pregnant.

JOAN:

7. Parents must show more interest in their children, especially their daughters.

RONELLE:

8. Parents should talk to girls about sex and the embarrassment it brings to the family.
9. There should be a love for children to enable them not to think of sex.

RHONA:

10. The parents have to tell their children about pre-marital sex.

TRISH:

11. Happens in broken homes where parents are divorced or children of illiterate parents.
12. Where people have a low income and the strife to live from what they earn.

LYNN:

13. Parents should talk to their children and try and show them the right paths in life.

ERICA:

14. I think Parents must talk openly about sex with their children.
15. Responsibility of the parent to tell the child about sex.

PATTY:

16. Parents should inform their children about the dangers of early pregnancies.
17. Make them aware of the risks that go with pregnancies.

BETH:

18. Sex education should be discussed openly.
19. Parents should pay more attention to their children's welfare.
20. Sex should be a broad-minded and open discussion between children and parents.

JOSEY:

21. If parents are open to children then they can feel free to speak to their parents about sex.

CATHY:

22. Most of the parents don't communicate with their teenagers.
23. Should not be shy to talk to their children, they should feel free.
24. They should explain everything clearly.

ANITA:

25. Parents should be very open towards their children, especially where sex is concerned.

ROSE:

26. Parents must talk to their children at a young age and tell them about sex.

27. Pupils must feel free to ask their parents or the school about anything concerning sex.

PINKY:

28. Parents should communicate openly with their children from the time that they are able to understand.

CLEO:

29. Parents should be more broad-minded and have serious conversations with their children.

30. Does not pay for parents to keep adolescents in the dark.

SONIA:

31. Parents should talk freely to their children about sex - this can be a family discussion.

JO-ANNE:

32. Parents should be more open with their teenagers.

LIZ:

33. Parents can take time to talk to children i.e. understand adolescents' problems regarding inferiority complexes and uncertainties.

SUN:

34. A better relationship between parents and children.

35. Parents should pay more attention to their children.

36. Parents should participate in their children's activities.

RON:

37. Parents should make their children aware of the dangers of pre-marital sex and the consequences thereof.

38. Communicate with their children and allow them the freedom of speaking [about] their own thoughts and fears.

39. Not dictate to their children, but speak to them on an equal basis.

40. More understanding of their children's emotional as well as psychological problems.

41. Spend more time with their children and in the process will be able to understand them better.

SUNITA:

42. Greater communication between parents and pupils.

MEL:

43. Speak openly to children and not be shy to tell them about the facts of life.

TOSH:

44. Speak openly with their teenagers about sex and what danger it can be.

SAM:

45. Communication between parent and child should improve.

46. Parents should talk very openly with their children.

47. Teach the children about the consequences of sexual relationships.

48. Not allow the teenagers too much freedom.

LEE:

49. Parents do not know how to tell their children.

PENNY:

50. Parents should give their children advice about sex.

MARIE:

51. Talk more openly about sex to their children, because some of the children are very scared to discuss their problems with them.

52. Never chase away children with problems saying you're still a child to know about sex, otherwise he or she will go to her friends for help and they will mislead her.

3. PARENT-SCHOOL PARTNERSHIP.

JOAN:

1. Speaking to boys and girls and explain all the problems which could arise.

2. Mostly speaking to girls and by asking them questions e.g. what will the people say and think about their pregnancy? Who will mostly be blamed for her pregnancy? Will it be him/her who gets most of the blame?

RHONA:

3. Parents and teachers have to have meetings and discuss the children's behaviour.

TRISH:

4. Teachers and parents should get together and discuss training programmes for teenagers on using contraceptives and the dangers of having pre-marital sex.

LYNN:

5. Firstly the Parent and Teacher should have meetings with nurses telling them how to go about the problem.

ANITA:

6. Adult support is necessary to assist teenagers in matters concerning sex.

CLEO:

7. Schoolgirl pregnancies would reduce if parents, school, community and church did something about it.

JO-ANNE:

8. Community should have special programmes showing the importance of not indulging in sex before marriage.

LIZ:

9. Parents and youth advisers should discuss the matter with adolescents.

RON:

10. Community can help by imparting more knowledge concerning the dangers of teenage pregnancies.

MARIE:

11. Community and parents should provide advice for teenagers.

4. CURRICULAR CONTENT.

MARY:

1. Tell them about all Sexually Transmitted Diseases; Dangers of having sex too early; Strategies for reducing unwanted pregnancies.
2. Risks of falling pregnant and the Consequences of Teenage Pregnancies.

ANNE:

3. Schoolgirls get pregnant because of peer pressure.

JOAN:

4. Books containing risks etc. of engaging in sex be given to students to help them understand the dangers of sex before marriage or too early could lead to illnesses and unwanted pregnancies.

RONELLE:

5. Understanding between boyfriend and girlfriend that sex is out of the question before marriage.

RHONA:

6. Get it across to children about how important sex after marriage is.
7. Explain the lost opportunities in life by falling pregnant, and the fact that the boyfriend might not wish to get married and therefore she will have no child support.

LYNN:

8. Advise pupils how dangerous sex is before marriage.

JOSEY:

9. The reasons why teenagers indulge in sex are also very important.
10. Young girls should know not to indulge in a sexual relationship.

CATHY:

11. Should know not to have sex before marriage.
12. Feel free to speak to parents or teachers to help solve problems.

ROSE:

13. Pupils feel shy to ask questions. Films should be shown on different topics and methods of contraception. By seeing a film you learn about the facts of life very quickly.
14. Boys and girls should ask each other questions and more information would be gained.

PINKY:

15. Girls should not allow themselves to be influenced/intimidated by boys, as they have a mind of their own.

CLEO:

16. Pupils can help friends by giving them literature about sex, how to use contraceptives and not to indulge in sex

- if they don't have any knowledge about it.
17. Parents should understand that adolescent girls and boys like to explore and it is their duty to teach these youngsters about "the facts of life."
 18. Some teenagers don't know about sex yet they indulge in it.

COLLEEN:

19. Pupils should be educated about their bodies and the changes taking place in them, firstly by their parents then at school.

JO-ANNE:

20. Parents are too shy to discuss the facts of life with their children, therefore there are many early schoolgirl pregnancies.
21. Books about sex should be read and discussed with friends.

SUNITA:

22. Information about birth control, abortion, sex etc. should be made available to pupils.

MEL:

23. Explain the dangers of sex at an early age.

TOSH:

24. Should be told they are not yet ready to take [on] the responsibilities of a baby.

LEE:

25. Teenagers are not able to talk to their parents about the facts of life.

PENNY:

26. Boys and girls should be made aware that pregnancy endangers their education.
27. Boys and girls should both take the blame for pregnancy.

5. CONTRACEPTION AND CONTRACEPTIVE INFORMATION.

RUTH:

1. Pupils should curb unwanted pregnancies by obtaining more information about contraception and the dangers of early pregnancies.

MARY:

2. Told about birth control and where to get it.

ERICA:

3. Contraception is the responsibility of both the boy and the girl.

JOSEY:

4. I think that sexually active pupils should be made aware of the contraceptives available.
5. Teenagers do not know about the dangers of sex or contraceptive methods and are not yet able to accept responsibility of bringing up a child.

LIZ:

6. Discussions concerning correct use of all birth control methods, including their side effects.

MEL:

7. Parents should inform daughters on the use of contraceptives.
8. Should wait until they are married before having sex.

TOSH:

9. Teenage girls should be informed about contraceptives.
10. Parents and the community should teach teenagers how contraceptives are used.

SAM:

11. Children should be told about birth control at school.

PENNY:

12. There are many contraceptives but they are not used.

6. COMMUNITY INTERVENTION.

LYNN:

1. Nurses should explain the prevention of early pregnancies and family planning which will be their security in life.
2. Should be told today to plan for a better life tomorrow.

CATHY:

3. Clinics should be made available for teenagers.

ROSE:

4. The health caring community should make the pupils feel free to talk to them.

PINKY:

5. Pupils should get frequent talks from Health Agencies about family planning, abortion, pregnancy and birth control methods and allow pupils to air their views.

CLEO:

6. Family life education to enlighten young boys and girls on pre-marital sex and family planning.
7. Form youth clubs.

SUNITA:

8. There should be more recreational activities and facilities for young people to indulge in.

7. MORAL EDUCATION.

RONELLE:

1. Churches must be very strict on this.

RHONA:

2. A child's life starts at home - parents should give their children a Christian upbringing and tell them what's right and wrong.

CATHY:

3. The church youth should have conversations and discuss their problems with the elderly people.

CLEO:

4. Church communities should be more open-minded about teenage sex and have programmes to inform them of the dangers of sex without using contraceptives.

SONIA:

5. The Sunday school teachers should talk about sex and contraceptives.

JO-ANNE:

6. The church should have special films and youth group discussions about sex.

LIZ:

7. Church places too much emphasis on the Bible.
8. Sex should be treated with openness and not as 'some dark evil'.

SUNITA:

9. Immoral, sinful or not, information concerning biblical beliefs about sex before marriage, etc, should be made known, this is of utmost importance.

G2 : EX-SCHOOLGIRL PREGNANCY CASES.

1. SUPPORT FOR SCHOOL-BASED SEX EDUCATION.

TARA:

1. The socio-economic factor is the greatest contributor to teenage pregnancies.
2. Accepted as a way of life.

PEARL:

3. Youth should be taught sex education at an early age to fully understand the risks of pre-marital sex.

JILL:

4. Sex education programmes at school.

PENINA:

5. Discuss and encourage teenagers to attend sex education programmes.

ERICA:

6. Discourage pre-marital sex.
7. Sex for unmarried girls and school children should be discouraged.

CHARMAINE:

8. Children should be taught more about sex.

FLORENCE:

9. The school, because most of the pupil's time is spent there, should play a major role as pupils spend most of their time there, more school psychologists, guidance programmes and sex education should be introduced as part of the school syllabus.

FATIMA:

10. Explain pregnancies and the dangers to girls.

DEIDRE:

11. Teachers should play a bigger role and discuss sex and risks of early pregnancies.

LITHA:

12. Teachers can play an important role in counselling pupils on sex.

MIRIAM:

13. Parents, teachers, church leaders and health agencies should have discussions at least once a term to make boys and girls aware and encourage them to keep their bodies pure.

ISA:

14. Teachers should be the source of sex education.

YVETTE:

15. Teachers play a major role as they know their students and can get the message across thoroughly.

CARLA:

16. Sex education programmes at school.

HARRIET:

17. Pregnancy can destroy a young girl's life.

18. Girls should be made aware of that.

KATIE:

19. Schools should have sex education to assist girls.

WENDY:

20. Sex education classes from Std 2 to matric.

SARAH:

21. Sex education programmes to inform the children.

GWEN:

22. Educational programmes offered to teach about sex.

TAY:

23. Pregnant schoolgirls should warn other schoolgirls.

JON:

24. Teachers do not set an example.

DORA:

25. Specialist nurses sent to schools.

26. Teachers should discuss the problem with schoolgirls.

27. Access to sex information.

LOLA:

28. Girls from the age of when they menstruate must have the necessary knowledge that they can become pregnant very easily.

29. Sex guidance classes for boys and girls.

TEMBI:

30. Talk to girls during guidance periods.

2. PARENT-CHILD COMMUNICATION.

STELLA:

1. Parents should discuss sex from the age of 14.

2. Child should ask parent for advice.

3. Parents should communicate with children.

TARA:

4. Parents should take a greater interest in the supervision of free time.

JILL:

5. Better communication between parent and child.

ERICA:

6. Parents should talk to boys and girls together about sex when they start dating.

FLORENCE:

7. Parents and children should communicate freely.

DIEDRE:

8. Parents should discuss sex with their children.

9. Most parents are too shy.

LITHA:

10. Uncontrolled student relationships and pregnancies are overlooked.

ISA:

11. Parents should teach themselves how to communicate with youngsters about sex education.

CARLA:

12. Parents should speak openly.

KATIE:

13. Parents should be there for their children.

14. The parents' love enables the pupils to follow their pattern and do as the parent desires.

SARAH:

15. More love and concern from teachers and parents.

16. Parents should inform their children about sex and the risks.

ROWENA:

17. Parents should inform children.

18. Parents should be more strict.

19. Adolescent girls do not get love at home and seek it elsewhere.

GWEN:

20. Parents must supply information before puberty.

TAY:

21. It is the parents and daughters who are most affected as it is normally the girls who takes responsibility for the baby.

JON:

22. It would be appreciated if pupils and parents talk about the problem.

GAIL:

23. Schoolgirl pregnancies have to be reduced.

24. Parents must share the blame for the problem because they never speak openly with their children about sex.

DORA:

25. Daughters must be home early in the evening.

LOLA:

26. Parents should talk openly about sex and the consequences.

3. PARENT-SCHOOL PARTNERSHIP.

FATIMA:

1. Have meetings with parents and the community to discuss ways of solving the problem of schoolgirl pregnancies.

WENDY:

2. Parents who are shy could get together with teachers, clergymen and organisations and have a monthly get together and discussions with youth groups.

3. Girls who have fallen pregnant can talk to pupils about their mistakes and feelings.

GWEN:

4. Pupils must pay more attention.

TAY:

5. The school should arrange to talk with parents whose daughters are affected by pregnancies.

GAIL:

6. Community should arrange meetings with parents to help them talk seriously with their children.

TEMBI:

7. Teachers and parents should talk about sex to the pupils and give appropriate advice.

4. CURRICULAR CONTENT.

SANDRA:

1. Discuss and teach the facts of life.

CHARMAINE:

2. Teenagers should learn about sex and that it is a sin.

3. Teenagers are subjected to peer-pressure and become pregnant.

DEIDRE:

4. Children find out about sex from their friends and are easily influenced by them, which results in pregnancies, abortions and a ruined school career and future.

ISA:

5. Schoolgirls can get thorough knowledge of sex instead of seeking back-door information.

YVETTE:

6. Mothers should talk to their daughters before they get their first menstruation.

7. Now that they are young ladies they can fall pregnant.

CARLA:

8. Pupils should talk to and help each other.

HARRIET:

9. Pupils should be reminded how important their education is.

10. To make something of their lives, so they and their parents can be proud.

11. They must strive towards something in life.

12. They must look after themselves for their own sakes.

KATIE:

13. Pupils must tell each other how important it is to be a virgin until the right time.

LOLA:

14. Parents are responsible and must tell their children the facts of life.

5. CONTRACEPTION AND CONTRACEPTIVE INFORMATION.

PEARL:

1. Give the necessary training and education about various methods of contraception available from family planning clinics.

ERICA:

2. Children should not be taught how and where to obtain prevention measures.

CHARMAINE:

3. If a parent gives the child contraception they are giving them permission to have sex.

ISA:

4. Boys should take responsibility for the prevention of conception along with the girls.

YVETTE:

5. The mother should explain about birth control, and also take the child to a clinic and let a professional nurse tell her about sex.
6. Boys should also be informed about the use of contraception.

HARRIET:

7. I do not think it is wise to encourage them to use contraceptives as it is like encouraging them to have sex.

DAISY:

8. Make contraception available to every schoolgirl from the age of 12 or her first menstruation.

DORA:

9. Parents must allow their daughters to have injections if they are sexually active.

LOLA:

10. The necessary information should be available on where to obtain contraceptive methods.

6. COMMUNITY INTERVENTION.

TAY:

1. The community, school, church and parents must aim to create more recreational functions and facilities for the pupils and youth.

CHRISTIE:

2. Family Planning Clinics should be consulted.

7. MORAL EDUCATION.

FLORENCE:

1. The church should not criticise but advise young people on sexual matters.

ISA:

2. Churches can help by broaching the subject openly.

WENDY:

3. Priests or nuns should give talks to teenagers once a month.

GWEN:

4. Church must emphasise that sex before marriage is wrong.

G3 : PARENTS OF SENIOR SCHOOLGIRLS

1. SUPPORT FOR SCHOOL-BASED SEX EDUCATION.

SHARON:

1. Sex education should be taught in school.

SHEILA:

2. The right time to give sex education to the child is when they start asking questions about the subject.
3. Schoolgirls should be told about the dangers of early sexual activity.

DEE:

4. Teenagers must be told that sex doesn't prove anything and brings unhappiness to those involved.

JUDY:

5. Talk about prevention and the dangers of having sex too early.
6. Discuss sex freely and without fear.
7. Make the shortcomings of falling pregnant clear.

ANGEL:

8. As an ex-pupil, there was a sex education programme given.
9. With lectures and pictures.
10. It opened and broadened my mind about life and my surroundings.
11. Today having such [sex education] programmes at school are of utmost importance.
12. Such programmes help some and not others. The school must have the co-operation of the boys and girls.
13. This will help stop early pregnancies and prevent school drop-outs.

MAGGIE:

14. Pregnancies must be freely spoken about.
15. Discussions should be held.

LEONIE:

16. Arrange periods at school for discussions.

TANYA:

17. Guidance teachers must talk about sex and inform the pupils of what sex entails and the consequences.

VERA:

18. Sex guidance, family planning and contraceptive methods should be given.
19. Give all girls and boys contraceptives.

BONNIE:

20. Regular sex guidance classes.

DEBBIE:

21. Should receive information about sex as soon as an interest in the opposite sex is shown.

22. Special sex guidance so children do not feel shy to talk.
23. Hold open discussions.
24. A good idea to fill in questionnaires like this one.

JEAN:

25. As far as information about sex and the dangers thereof are concerned, this must be emphasised at the schools.

SANDY:

26. Have guidance periods for such discussions.
27. Schoolgirls should be told about sex by the above-mentioned personnel [see Question 63]; including pupils and parents.

JULIE:

28. Talks should be held about sex with boys and girls.
29. They ought to know what it is all about.

MARLENE:

30. School to make time for a period to talk about pregnancies.

CONNIE:

31. Pupils should be informed about sex not jokingly but seriously.
32. Teachers should talk openly and the pupils should feel free to talk about their problems.

KAY:

33. Sex education programmes must be implemented by the above mentioned institutions [see Question 63].
34. More open talks on sex with minors.
35. Early sexual relationships must be talked about.
36. Guidance periods must be used to inform pupils about relationships and sexual activities.

CAROL:

37. In-depth discussions held to promote sex education and create awareness of the advantages and disadvantages of early sex.

VERNA:

38. Pregnancy in schoolgirls is a big problem.
39. Youth and adolescent advisers, teachers and parents must do something urgently otherwise the problem will become worse.
40. Demands urgent attention.
41. Teachers must discuss "sex before marriage" carefully with their pupils.

2. PARENT-CHILD COMMUNICATION.

MARTHA:

1. Parent and child should have an open relationship.
2. Adolescents should feel free to speak about sex and its consequences.

3. Parents should know if their children are sexually active.

SHEILA:

4. Children should be granted less freedom with the opposite sex.

5. Parents should speak openly about sex and answer all questions.

DEE:

6. Parents should be more open about sex and its consequences.

DOREEN:

7. Explain to children about sex and pupil pregnancies.

UNA:

8. Parents should tell children about sex and its consequences from the age of 14 years.

9. Most teenagers become pregnant from the age of 13 years.

DEBBIE:

10. Parents play an important role as they know and understand their children.

11. They should talk about sex if their children ask them questions.

KATE:

12. Parents should discard their conservative attitudes and speak about contraceptive methods.

MARLENE:

13. Parents must devote time to talk about the facts of life frankly and keep nothing back.

CONNIE:

14. It is the parents' duty to inform their children about sex before the puberty years.

KAY:

15. Parents must talk openly about everyday problems with relationships at school and irresponsibility with schoolwork.

3. PARENT-SCHOOL PARTNERSHIP.

LEONI:

1. Arrange meetings with parents and pupils.

CYNDY:

2. Less afraid to discuss the dangers of sex.

3. If a pupil falls pregnant [in the case of a matriculant] she must be supported by parents and teachers so she is able to complete the final examinations and not turned away, which does happen in some cases.

CAROL:

4. The crux of the whole prevention strategy is getting the involvement of the parents.

4. CURRICULAR CONTENT.

MARTHA:

1. If adolescents indulge in pre-marital sex it is a personal matter between the individuals.
2. Prevent unwanted pregnancies rather than bring unwanted children into the world.
3. The babies will face the hardship of being unwanted and uncared for.

DEE:

4. Girls must be told that being a virgin is healthy and something to be proud of.
5. Teenagers should become more involved in activities.
6. The community should apply for recreation buildings.
7. Prevent too much leisure time on youngsters' hands.
8. In the beginning when I discovered I was pregnant, I contemplated an abortion. A black cloud of depression befell me. It felt as if God had deserted me. During my pregnancy I was very pleasant in front of people. Everybody marvelled at the way I was handling the situation. What they did not know, and still don't know is that I felt like dying; because I had failed myself and also all my wonderful plans for becoming a career women were dashed.
9. They must realise they are individuals and have the right to abstain from sex and not to follow their friends or because it is the "in thing".

JULIE:

10. Girls should learn to say NO to boys.

CONNIE:

11. When a child has received enough sex education and is aware then the choice is up to them. They must decide what to do with their lives.

5. CONTRACEPTION AND CONTRACEPTIVE INFORMATION.

MARTHA:

1. More knowledge should be brought to their attention.

SHEILA:

2. Schoolgirls should be encouraged to contracept.

JUDY:

3. Introducing contraceptives to be [made] available at school as early as Std 7.

DOREEN:

4. The only way to prevent pregnancy is to discuss sex with the pupils and explain birth control methods to them and their importance.

ANGEL:

5. Girls should be shown how the various contraceptives work and then ask their parents' permission to use them.
6. The parents are embarrassed therefore the girls are afraid of using any methods.

MAGGIE:

7. Teenagers should use contraceptives.

BONNIE:

8. Make them aware of contraceptive methods.

JEAN:

9. When a couple decides they are ready for sex they should consult a clinic and receive information about sex and contraception.

DOT:

10. Schoolgirls must know more about pregnancies and the results and contraceptive methods.

JULIE:

11. Contraception should not be encouraged for unmarried girls.

TANYA:

12. They should be told about contraceptive methods and how to use them.

KATE:

13. Most teenagers are aware of the dangers of sexual intercourse but many still fall pregnant.
14. Teenagers can be protected by encouraging them to use contraceptives, and the community should not regard contraception as a "sin".

VERNA:

15. Schoolgirls should not refuse to take injections or pills.

6. COMMUNITY INTERVENTION.

SHARON:

1. Family Planning Clinics should be enforced at schools under the strictest confidence.
2. The girls should not be looked down on as they are only protecting their future.
3. Teachers tend to look down on pupils.
4. A more caring role should be played in relation to children's needs.

DEE:

5. The community must protest about so many bottle stores and shebeens being opened.

JUDY:

6. Introduce "Sex Education" at school, with a doctor, nurse or social worker.

MAGGIE:

7. Community should show greater interest.

LEONI:

8. Hold talks with every individual in the community.

CYNTHIA:

9. The community must not look down on pregnancy cases, but something should be done about the problem.

TANYA:

10. Nurses should talk to the girls and tell them about the dangers of early sex.

VERA:

11. Nurses, parents and teachers must communicate with the students.

UNA:

12. If the parents do not talk about sex then they should be taught from Youth and Adolescent Counsellors or school nurses about the right time and the dangers.

MARLENE:

13. Meetings must be arranged between parents and pupils with health organisation members.

CONNIE:

14. The community, church and schools must organise tours, outings and concerts to keep the youth busy.

CAROL:

15. The whole-hearted support and co-operation of the total community is essential.

VERNA:

16. Teacher and the community must convince the pupils that "sex before marriage" is very wrong.

7. MORAL EDUCATION.

MARLENE:

1. Churches to introduce a sex education programme for teenagers.

CONNIE:

2. The church must organise more youth activities for young people: "An idle mind is the devil's workshop."

CAROL:

3. Active participation and guidance by the school, church and education authorities is of utmost importance.

G4 : PARENTS OF EX-SCHOOLGIRL PREGNANCY CASES

1. SUPPORT FOR SCHOOL-BASED SEX EDUCATION.

ZOLA:

1. I hope attempts on the part of the school will curb schoolgirl pregnancies.

MANDY:

2. Hold talks once a week about sex.

LUCY:

3. This step is the best way of preventing schoolgirl pregnancies.

DEENA:

4. Girls forget about the dangers of sex and indulge blindly in it.

LESLIE:

5. Children should be told about the dangers of early sex such as cancer of the cervix and sexually transmitted diseases.

6. Parents and teachers should encourage the girls to say NO.

MONA:

7. I would like to request that a programme on pre-marital sex be considered at the school.

GLORIA:

8. Teenagers spend most of their youth at school and that is where they should receive sex education.

GERTY:

9. The formulation of sex education programmes and their implementation are important.

JEANE:

10. Schoolgirls should be informed through sex education early in their school life.

RAY:

11. School nurses, teachers and parents must communicate with the youth - sex guidance, family planning and contraceptive methods should be freely available.

BONITA:

12. The best solution is to speak openly with the girls.
13. Show and teach the advantages and disadvantages of sex.
14. Use simple language so they understand.
15. Point out examples and their serious consequences.

MONICA:

16. Teachers must alert schoolgirls about the dangers of early pregnancy.
17. Attention must be paid to girls who do not show a keen interest in their schoolwork.
18. Pregnant schoolgirls must be given the opportunity to complete their studies.

19. The pregnant schoolgirl is neglected but the boy is able to complete his studies.

20. The school nurse should speak to both boys and girls about sex from Std 6.

ANTHEA:

21. Regular visits and discussions from the school nurse should be given to boys and girls.

2. PARENT-CHILD COMMUNICATION.

LUCY:

1. As a parent of an ex-pupil pregnancy case I feel that parents should talk about sex, birth control measures and how to plan for a better future.

BERRY:

2. I am a mother of seven children and therefore I would not be able to supply an appropriate answer.

DEENA:

3. I have no idea what to suggest as most girls do not take heed.

LESLIE:

4. Parents should show less approval of their children going out late at night.

5. Teenagers should be granted less sexual freedom.

6. Parents should answer questions and give advice openly.

MONA:

7. Parents and pupils do not communicate about sexual matters.

8. Parents and pupils should have a close understanding about pre-marital sex.

9. If parents spoke more openly about sexual intercourse the rate of pregnancies could be reduced to a certain extent.

GLORIA:

10. Parents must learn to talk openly about sex before marriage. 'Prevention is better than cure.'

11. The problem is that the youth are shy to come out with their problems

SYLVIA:

12. The parents should discuss the issue and outside help can be received.

13. The children can become aware of the problem and ask questions.

VANESSA:

14. Girls and boys discuss sexual experiences with their friends - as a parent I find this wrong.

MONICA:

15. Parents should talk about sexual matters at home.

ANTHEA:

16. Guidance and discussions for parents should be the responsibility of the church.

3. PARENT-SCHOOL PARTNERSHIP.

SYLVIA:

1. Parents in the community should play a greater role in drawing up Sex Education Programmes with school nurses and the pupils.
2. The problem must be discussed between parents, teachers and children.

YVE:

3. The parents and teachers must get together and talk about how they can jointly take action at home and at school to expose the problem and find out the causes.

HETTIE:

4. Children must be informed at home and at school about pre-marital sex and contraceptive methods.

VANESSA:

5. Should all get together and discuss the problem in totality.

MONICA:

6. Schoolgirl pregnancy is very sad for those who wish to attain some goal in life.
7. Teachers must show a keener interest in the children and their parents not only in the school situation - where are the days when school teachers visited the homes of parents?

4. CURRICULAR CONTENT.

ZOLA:

1. All of the above [refer to Question 63] can play an important role to curb the problem.

MANDY:

2. Parents should talk about the facts of life including sex.

5. CONTRACEPTION AND CONTRACEPTIVE INFORMATION.

BERRY:

1. I have never used contraceptives due to my religious beliefs.
2. I also firmly believe that if contraceptives are introduced at an early stage, then adolescents will have sex without the parents being aware of it.

PAULA:

3. Pupils should be told about birth control.

DEENA:

4. Young girls who engage in sexual activities should use contraceptives.

LESLIE:

5. Teenagers should use contraceptives if they engage in sex.
6. Parents should watch the sexual behaviour and activities of their children and then decide whether the child should contracept or not.

THANDI:

7. More effective knowledge about contraceptive methods and must also be informed about sex.

GERTRUDE:

8. Receiving information about contraceptive methods—to my mind there is no other solution.

RAY:

9. Place all girls on contraceptives and give the boys condoms even though they might not acknowledge that they are sexually active.
10. This might encourage them to become sexually active, but will prevent unwanted pregnancies; if you don't give them this protection, unwanted pregnancies will result.

VANESSA:

11. Contraceptive methods should be encouraged among sexually active youth.

6. COMMUNITY INTERVENTION.

ZOLA:

1. The community should establish more recreational centres as unsupervised time leads to pregnancies.

MANDY:

2. Meetings should be arranged with parents and children.

BERRY:

3. Adolescents must be motivated to have other interests like sports, art, music and so on.

GLORIA:

4. The community must be made aware of the problem and how to prevent it.

GERTRUDE:

5. All concerned must realise that schoolgirl pregnancies is now a common problem.
6. Schoolgirls should go to Family Planning Clinics for advice.

BONITA:

7. The above-mentioned bodies are not in a position to solve the problem.

8. The clinics also have no solution.

ANTHEA:

9. Schoolgirl pregnancy is a community problem; schools, churches, parents, pupils, the whole community and the health organisations can all make their contribution towards solving the problem.

10. Preachers should have regular consultations and joint discussions with parents, children and teachers on a quarterly basis to discuss pre-marital sex.
11. It should be monitored to determine if the problem is growing.

RUNA:

12. All interested parties must come together and have discussions on the problem and possible solutions.

7. MORAL EDUCATION.

MANDY:

1. Meetings should be held with the youth to discuss sexual matters openly.

BERRY:

2. Pre-marital sex is wrong and sinful.

MONA:

3. The church should speak openly to help curb the problem.
4. Lack of interest in religious instruction results in the problem being overlooked.

GLORIA:

5. The church can play an important role in guiding the youth in becoming fully-fledged loyal members of the church and its teachings.

G5 : SCHOOL TEACHERS

1. SUPPORT FOR SCHOOL-BASED SEX EDUCATION.

ALLIE:

1. The youth's knowledge of sex comes mainly from their peers or from what they read and see on T.V. or films, therefore they are not being educated about sex.
2. Sex education should start from a young age before they are educated by their 'experienced' friends.

FOZIA:

3. Sex education programmes.
4. Sex should be taught in school.

GLENDIA:

5. Sex education programmes in school curricula as well as youth groups in the churches.
6. Discuss more frequently problems surrounding teenage pregnancies.

PATRICK:

7. Introduce sex education in schools.

LORETTA:

8. Should be part of school programmes.

JESSICA:

9. Introduce sex education as a non-exam subject.

PETER:

10. Imperative that they be educated.
11. Sex education will be ineffective unless sound moral sense and principles can be instilled in everyone concerned in the programmes.

MERCY:

12. Teach the meaning of "love."
13. A relationship does not have to include sexual intercourse.

NATALIE:

14. Be made aware of the dangers of falling pregnant.
15. Most teenagers think: "It cannot happen to me."
16. Should be made wise of this fallacy.
17. Specialised person who is readily available to explain.

NORMA:

18. Separate sex education classes for boys and girls.

NONO:

19. Sex education into the curricula in all secondary schools.

JONELLE:

20. Sex education given to boys and girls separately.
21. Be firm, straight-forward and to the point.

FAITH:

22. We need a more "open" attitude towards sex education and teachers must confront these issues in a confident manner

emanating from personal knowledge and attitudes towards sex; openness would encourage children to feel confident.

23. Questions must never be evaded - openness would encourage the children to have an enquiring mind.

ALVERA:

24. I foresee no decline in pregnancy rates at present although sex education has been introduced in some communities.

MELANIE:

25. Provide family life education and sex education programmes in the schools.

JOHN:

26. In many cases early knowledge of sex could have prevented pregnancy.

DAVID:

27. Admitting that there is a problem and discussing strategies and methods for a responsible, serious and mature image towards sexual intercourse is extremely positive.

DENISE:

28. Schools can tell pupils about the dangers of pre-marital sex and consequences of teenage pregnancies.

SUSAN:

29. Girls must be enlightened about sex.

SHEREEN:

30. School nurses must visit on a regular basis.
31. Teachers can contribute by giving guidance on how to utilise free time.

JOHANNA:

32. Pupils must not be shy to ask questions.

ANGELO:

33. The school can play a complementary role.
34. Sex education at school must be implemented with proper objectives.

NADINE:

35. Early information about the risks of pre-marital sex.

2. PARENT-CHILD COMMUNICATION.

ALLIE:

1. Parents must be made aware that they must communicate with their children about sex education from an early age.

FOZIA:

2. There must be communication between parent and child.

GLENDIA:

3. Parents must be more open with their children.

MERCY:

4. Teach them to be more open, especially the parents.

NATALIE:

5. Parents should be more open.

NORMA:

6. Parents should be given courses on how to instruct their children.

ALVERA:

7. Parents should communicate with their children.

8. Neglecting the duty to talk to the child leads to his learning "from the street."

9. Schoolgirls engage in pre-marital sex because they are curious.

10. Parents should not think it taboo to discuss sex.

11. Parents must also play a part in sex education.

MELANIE:

12. Parents should be encouraged to spend more time with their children - to gain their confidence and show them more affection.

JOHN:

13. Communication to be increased between parent and child and child and teacher.

DENISE:

14. Sex education must begin at home.

15. Parents must talk openly with their children.

16. Children should not hear about sex from friends.

17. It is the parents' duty to inform their children.

SUSAN:

18. If parents spoke more openly about sex the problem would not be so huge.

SHEREEN:

19. Communication between parent and child must improve.

JOHANNA:

20. Parents must hold open discussions with their children.

21. They must attempt to establish better relationships with their children.

ANGELO:

22. The school cannot do as much as the parents can do at home.

NADINE:

23. Parents must inform their children about the reproduction system of the human body.

24. Parents must talk about sex so the children do not hear it from their friends.

25. Parents can attend sex education courses so that they in turn can educate their children at home.

3. PARENT-SCHOOL PARTNERSHIP.

PATRICK:

1. Sex education programmes should be implemented in conjunction with the support of parents and other community organisations.

LORETTA:

2. Parents and teachers should contribute towards sex education in both the home and classroom.

LIESLE:

3. Church, community, school, parents and pupils must discuss sex openly and freely, without guilty feelings.

PETER:

4. Parents should be reached so that there can be a concerted effort on the part of both parent and teacher.

FAITH:

5. Parent and teacher must educate the children.
6. A concerted effort must be made by both parents and teachers to educate children about the physical changes that occur during puberty, so this period is not fraught with fears which could result in psychological scars later on.

ALVERA:

7. Parents should make sex education part of family guidance.

MELANIE:

8. Consult with parents in setting up education programmes at school.

SUSAN:

9. The responsibility lies with the parents and guidance teacher.

SHEREEN:

10. Parents and teachers must work closely together.

NADINE:

11. There is a need for the school, parents and community to investigate the problem in depth.
12. Sex education must be provided in both the home and school.
13. Teacher and parents must point out the serious consequences.

4. CURRICULAR CONTENT.

LIESLE:

1. Workshops and discussions can be arranged on various topics.
2. Slides and films will help them understand the problem better.

JESSICA:

3. Arrange workshops with experts to discuss the facts.
4. Parents must be more open and discuss the facts of life.
5. Pupils must be encouraged to read about the fact of life.

NATALIE:

6. They should be taught the facts of life.
7. Should not tell the child the "baby comes from the stork", but explain truthfully.

FAITH:

8. All aspects [see Question 62] must be dealt with and issues surrounding the pregnancy such as relationships, responsible decision-making, maturity (mental and physical as there may be an imbalance).
9. Self-image is vitally important.

JOHANNA:

10. Schools must show films and disseminate literature on the problem.

ALVERA:

11. A whole programme not just isolated lessons must be devoted to sex education.
12. Youth must be taught responsibility and self-discipline.

NADINE:

13. Teach the children more about "the facts of life."; the use of contraceptives where and how to obtain them.

5. CONTRACEPTION AND CONTRACEPTIVE INFORMATION.

DALE:

1. Put them on the pill.
2. Their personalities will determine whether they have sex or not.

JOHN:

3. Introduce contraceptives to pupils after informing them about the dangers of early sexual intercourse i.e. before 18 years.
4. Contraception should be made available on demand.
5. Abortions should be made legal and easier to obtain in some instances.

NADINE:

6. Inform boys and girls completely about contraceptives - where and how to obtain them.

6. COMMUNITY INTERVENTION.

LORETTA:

1. Sex education programmes should be run by various health agencies in the community; teenagers feel more free to discuss this subject with someone with whom they do not have daily contact.

NORMA:

2. As there are no cultural activities to occupy them, children choose the lowest form of cultural activity.

MELANIE:

3. There is an urgent need for the community, school, church to look into the serious problem of schoolgirl pregnancies.

4. We need to improve the quality of life in townships as the conditions lead to sexual freedom.

JOHN:

5. The community must be made aware of the new programmes and its advantages.

SHEREEN:

6. Consult with various health organisations in the community.

7. Parents must play a greater role, show more interest and give constructive contributions.

JOHANNA:

8. Community must hold more discussions about the issue.

ANGELO:

9. Teenage pregnancy is a community problem.

10. Community must approach the problem on a family basis and attempt to solve it.

ALVERA:

11. Greater educational recreational facilities available for the community.

12. Young people must be encouraged to use these facilities.

NADINE:

13. Parents and community must share the responsibility of sex education.

7. MORAL EDUCATION.

JOHANNA:

1. The church must discuss the problem.

ANGELO:

2. The strengthening of the inner [spiritual] nature of the teenagers can lead to a more mature and responsible child.

3. The pupils must realise that they create the problem themselves and that they alone can solve it by following accepted norms in society.

G6 : CLERGY

1. SUPPORT FOR SCHOOL-BASED SEX EDUCATION.

COLLIN:

1. Sex education programmes introduced early in life.
2. School must teach self-knowledge, responsibility, good values as well as general problems facing adolescents.

ANDREW:

3. Reinforce biblical values and the problem will be ameliorated.

BRIAN:

4. Arrange for experts to address the problem at school.

MARTIN:

5. Teach sex education.
6. Make them aware of the consequences of pre-marital sex and pregnancies in formal sex education programmes.
7. School psychologists have an important role to play.

JOSEPH:

8. Biologically their bodies are ready for sex but their knowledge is limited, crude, adventurous and they are thus unable to cope with their bodily changes.
9. Introduce discussions, programmes and literature on the subject.

MATTHEW:

10. School psychologists should help.

BOB:

11. Information and dialogue must start NOW.

WILLIAM:

12. Sex education must be taught at school.

DOROTHY:

13. School must provide effective guidance educational programmes for parents and prevention programmes for teenagers.
14. Sex education must be part of guidance classes.

MARK:

15. Talk seriously with girls about pregnancies and the consequences.
16. Individual and open talks must be held with the girls by someone dedicated and serious about the problem.

MURIEL:

17. Pupils should be made aware of pregnancies and their implications.

JENNY:

18. Education must begin before puberty but in separate classes for boys and girls.

2. PARENT-CHILD COMMUNICATION.

COLLIN:

1. Parents should discuss sex with their children.

ANDREW:

2. The answer to reducing schoolgirl pregnancies lies mainly in the home.

NOLAN:

3. Parental caring concern, supervision and strong parental discipline is necessary.
4. Parents should receive sex guidance.

BRIAN:

5. Parental supervision.

MARTIN:

6. Children who are unsupervised resort to experimentation.

JOSEPH:

7. Encourage trust and openness.
8. Educate parents on how to impart knowledge and prepare teenagers.

MATTHEW:

9. Trust must be created and restored early.

DOROTHY:

10. Parents must create the opportunity to talk freely about sex before children begin experimentation.

SOLOMON:

11. It is first and foremost the parent's duty to communicate and provide information about sex to their children.

3. PARENT-SCHOOL PARTNERSHIP.

THEO:

1. The school and parents should become more involved with pregnancy prevention measures.
2. They must jointly decide which intervention projects to tackle.

4. CURRICULAR CONTENT.

NOLAN:

1. Teach responsibility in life.
2. Parents, teachers and community leaders should serve as role models and set examples.

BRIAN:

3. Use visual aids (videos and films) in sex education programmes.
4. The facts of life should be spelled out at home.

MATTHEW:

5. Films about girls who drop out of school because of pregnancy should be shown.

THEO:

6. Each instance mentioned [see Question 63] can make valuable and worthwhile contributions.

JENNY:

7. Decision-making skills must be taught.
8. Children must receive information and learn how to use it.
9. More emphasis must be made on the responsibility of the boy and girl to lead a pure life.

5. CONTRACEPTION AND CONTRACEPTIVE INFORMATION.

MATTHEW:

1. Contraception without sex education promotes promiscuity and the spread of disease.

WILLIAM:

2. Compulsory birth control measures must be adopted by all high school girls, using methods approved by doctors after a medical examination.

6. COMMUNITY INTERVENTION.

NOLAN:

1. Community involvement is vitally necessary.

MATTHEW:

2. Government must improve living standards in the townships.
3. Crowded areas are fertile grounds for sex adventure for both old and young scholars.

THEO:

4. Traditional indifferent 'don't care' attitude must be replaced by one of positive involvement.

BOB:

5. Involving the government authorities in these projects will be worthwhile.

WILLIAM:

6. Community workshops and seminars on the subject [awareness programmes] should be held.

MARK:

7. Irrespective of the increase or decrease in teenage pregnancies there is still a duty to fulfil with regards to prevention.

DOROTHY:

8. Community must become involved in the education of teenagers.
9. Living standards must improve.
10. Families in the lower socio-economic groups must be made more aware of family planning.

11. Because of a lack of facilities, teenagers resort to pre-marital sex as a form of escape.

SOLOMON:

12. Communication, education and morality together with counselling from health agencies functioning together could be the solution.

7. MORAL EDUCATION.

COLLIN:

1. The immorality of engaging in pre-marital sex should be discussed by preachers at youth meetings.

ANDREW:

2. Parents should have a clear understanding and commitment to biblical values - which they impart by sound teaching and example.

BRIAN:

3. A firm commitment should be made to the church.

MARTIN:

4. Community and church should introduce sex education programmes.

5. More contact with the church.

JOSEPH:

6. The community, church, school, parents and pupils can hold meetings to discuss the problem and create an awareness that sexuality is a gift and the ultimate way to share love in a very special way, thus reserving it for marriage.

PAUL:

7. Many girls leave school because of pregnancy.

8. This problem can be curbed through information programmes.

MATTHEW:

9. The church and school have a duty to educate the parents on how to communicate with their children.

MARK:

10. The role of the church is of supreme importance.

11. We must carry out the word of God and then we will succeed.

12. All efforts will fail if the church and the teachings of God are not respected.

DOROTHY:

13. Immorality and loose living go against the teachings of the Bible.

MURIEL:

14. The moral standards of the community must be improved.

15. Both church and school can play an important role.

SOLOMON:

16. The church must inform all members that pre-marital sex is SIN and unacceptable in God's sight.

JENNY:

17. Children should learn moral values from an early age.
18. A programme should be worked out and planned with a religious approach.

G7 : HEALTH CARE PROFESSIONALS.

1. SUPPORT FOR SCHOOL-BASED SEX EDUCATION.

YOLANDA:

1. Include sexuality education in guidance curricula.
2. Teachers and counsellors at high school should be trained in sexuality education.

PEARL:

3. Adolescents are hungry for accurate information - most are misinformed.
4. They get information from their peers, the T.V. and the media.
5. The school is the best source to reach lots of adolescents.
6. Adolescent and youth counsellors are doing a good job in the schools.
7. Youth counsellors are in a position to reach the vast majority of adolescents at a given time.

KAREN:

8. Youth advisers should offer sex education at school.
9. Tell them of the dangers of early sex.

TIM:

10. Sexual activity in its totality should be discussed frankly and honestly with both boys and girls by parents and teachers.

CHANTELLE:

11. Youth programmes should be made available daily.
12. Involve pupils in sex education programmes.
13. School nurses can educate pupils during health inspection.

ALAN:

14. Kids pick up their education from the streets.
15. Provide opportunities for discussion.
16. More openness about the topic of sex.

LISA:

17. The choice of facilitator, teacher or lecturer is all important - someone pupils can relate to.

VANETTE:

18. Providing school-based sex education programmes can help reduce the number of unwanted pregnancies.

HELEN:

19. Include both boys and girls in sexuality education and sexual responsibility programmes.

THOMAS:

20. Educator must be at ease with the subject and have the knowledge and ability to communicate to the audience.
21. Choose the correct educator, otherwise the whole project falls flat.

BEV:

22. Pupils must resist peer pressure.

JUANITA:

23. Sex education should start at school-going age.

24. The pupil is too immature to care for a child; loss of schooling and job availability are some of the consequences.

BRITT:

25. Youth groups, school and community based workers/agencies have a vital role to play.

26. Teens have to learn to cope with peer-group pressure.

LILLY:

27. Youth sex programmes.

INGRID:

28. Speak to children before puberty.

EVE:

29. Sexuality must not be regarded as a taboo subject.

30. Sex education must be introduced at school.

ALETTA:

31. Sex education should begin early.

32. The school should communicate about sexual matters as the parents do not.

ROSLYN:

33. Sex education is a must at school.

2. PARENT-CHILD COMMUNICATION.

PEARL:

1. Encourage open discussions between parent and child.

SALLY:

2. Communication is important.

3. Parents should start sexuality education from an early age.

KAREN:

4. Teenagers should be able to express their problem openly.

LISA:

5. Take ownership of informing children - even well educated parents duck the issue.

VANETTE:

6. Improve communication.

HELEN:

7. Strive to improve communication.

ERIC:

8. Parents should realise that sex is a normal instinct.

9. Talk constructively about sex to children.

BEV:

10. There should be increased supervision of pupils' activities [and leisure time] by parents - pupils are left to their own devices too often.

11. There should be frankness (in discussion) on the part of parents about sex and its sequelae.

JUANITA:

12. The facts of life must be explained when the child is in doubt.

BRITT:

13. Open communication and the freedom to discuss different issues.

14. Home is the first source of sex education.

INGRID:

15. Parents must communicate with children.

EVE:

16. Take more active interest in their children.

ALETTA:

17. Communication is important.

CHARLENE:

18. Speak openly about sex to children.

19. Teenagers should be able to speak openly about sex and contraception.

JANINE:

20. Be open-minded with children.

21. Sex education should start at home.

ROSLYN:

22. Teach sex education at home.

3. PARENT-SCHOOL PARTNERSHIP.

KAREN:

1. Parents should be educated, most are old fashioned in their thinking.

CHANTELLE:

2. Educate the parents to enable them to educate their children.

3. This can be done by holding PTA meetings making use of adolescent/youth counsellors or school nurses.

ALAN:

4. Adults should move away from their conservative views.

VANETTE:

5. Involve parents in sex education programmes.

6. Equip parents with communication skills.

THOMAS:

7. Educate the parents first.

JUANITA:

8. Teach parents sex education.

9. Sex talks should be given to parents so they can explain to their children in a clean, clear and simple manner.

LILLY:

10. Education of parents.

EVE:

11. Educate parents on how to communicate with their children.

4. CURRICULAR CONTENT.

YOLANDA:

1. Pupils need to be trained to think morally and responsibly about communication, expressing love, self-image, being lovable vs being loved, commitment, family life, being a parent, dating, self-discipline, peer group pressure and spiritual values.

PEARL:

2. The current youth counsellor's programme is enriching in that it entails learning about physical changes in their bodies, emotional changes, responsibilities and decision-making, peer pressure, communication and relationships, teenage pregnancies and abortions, sexual behaviour, and contraception and STD's.

ELIZE:

3. The programme should focus on self-awareness, physical development, self-esteem and decision-making.

KAREN:

4. Programmes should include, body development, contraceptive methods - where, when and how to obtain them.

TIM:

5. Video programmes should be made available - in this way those who are shy will have access to information.

CHANTELLE:

6. Physical training teachers should deal with human anatomy and the changes taking place.

LISA:

7. Regular sessions on parenting skills should be held.
8. Modules on sex education should be included in PT and Guidance periods.

ERIC:

9. Explain the dangers involved in sex, unwanted pregnancy and STD'S.

JUANITA:

10. Explain the facts of life to 10-11 year age-groups preferably girls and boys separately and later combined.
11. Films/slides should be shown on human anatomy.
12. Discuss the dangers of pregnancy from heavy "petting."
13. Psychiatric nurses can explain the psychological aspects of pregnancy and their consequences.

EVE:

14. Inform about the dangers of pre-marital sex.

JANINE:

15. Trauma of early pregnancy, rejection by peers and often by boyfriend, shame on girl and family, expense of pregnancy and rearing the child and possibility of battered babies.
16. Tell the facts of life at a young age.

5. CONTRACEPTION AND CONTRACEPTIVE INFORMATION.

ERIC:

1. Stress the use of contraceptives if sex takes place.

JUANITA:

2. Family planning nurse clinicians can give talks and explain and show contraceptive devices to increase child's knowledge.

ALETTA:

3. Health clinics can provide information on contraception.

JANINE:

4. Inform about the dangers of pre-marital sex and contraception.

6. COMMUNITY INTERVENTION.

YOLANDA:

1. Include social workers, FAMSA counsellors, local doctor or psychiatrist and youth counsellors.

SALLY:

2. Create recreational facilities to take their minds off their sexual urges.
3. School and community must make recreational facilities available.
4. Establish a youth centre for guidance in sexuality education.

ELIZE:

5. FAMSA Education for Living Programme would be most valuable.

CHANTELLE:

6. Use outside help for greater impact.
7. Pupil involvement is necessary - send group leaders for sex education which they in turn can pass on to others.

ALAN:

8. Establish youth clubs.

LISA:

9. Community and school should work closely together.
10. Involve and establish support groups to assist the community in dealing with the actual problem and prevention.
11. Attend courses on how to communicate.

VANETTE:

12. Confidentiality should be ensured.

BEV:

13. Improve recreational facilities.

BELLA:

14. Introduce the Education for Living Programme from FAMSA.

15. Get medical doctors or nurses or psychologists to address specific issues.

LILLY:

16. Recreational facilities.

17. Youth Centres.

18. Education camps.

ROSLYN:

19. Family planning should be taught by youth advisers and the church.

7. MORAL EDUCATION

MAVIS:

1. Children should apply the teachings of the Bible in their lives.

LISA:

2. Parents must encourage their children to be more morally responsible.

ALETTA:

3. Church can play an active role in teaching morality.

APPENDIX K

CONTENTS

Corresponding Full Statistical Tables

of the Research Questionnaire

(Tables : 20A; 27A; 29A; 30A;

37A; 42A; 43A; 45A; 48A; 49A;

51A; 60A; 62A; 64A; 69A.1; 69A.2; 69A.3; 70A), pp. 334 – 346

APPENDIX K

FULL STATISTICAL TABLES OF THE RESEARCH QUESTIONNAIRE

Schoolgirls begin dating boys - (013)

TABLE : 20A

	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	SAMPLE								
	Senior Schoolgirls	Ex-school girl pregnancy cases	Parents	Parents of ex-school girls	School Teachers	Clergy Members	Health Care Professionals	TOTAL								
	No	%	No	%	No	%	No	%								
before the age of 11	5	16.7	2	7.4	2	6.7	2	7.4	1	3.8	0	0.0	3	10.0	15	8.9
between 11-13	17	56.7	7	25.9	15	50.0	12	44.4	15	57.7	9	52.9	19	63.3	94	50.3
between 14-16	7	23.3	11	40.7	10	33.3	10	37.0	9	34.6	8	47.1	6	20.0	61	32.6
between 17-19	1	3.3	4	14.8	1	3.3	2	7.4	1	3.8	0	0.0	0	0.0	9	4.8
between 19 and more	0	0.0	1	3.7	1	3.3	0	0.0	0	0.0	0	0.0	0	0.0	2	1.1
Non-respondents	0	0.0	2	7.4	1	3.3	1	3.7	0	0.0	0	0.0	2	6.7	6	3.2

Schoolgirls know everything about becoming pregnant and how a baby is conceived/made - (029)

TABLE : 27A

	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	SAMPLE								
	Senior Schoolgirls	Ex-school girl pregnancy cases	Parents	Parents of ex-school girls	School Teachers	Clergy Members	Health Care Professionals	TOTAL								
	No	%	No	%	No	%	No	%								
before the age of 11	12	40.0	12	44.4	11	36.7	17	63.0	6	23.1	1	5.9	10	33.3	69	36.9
between 11-13	17	56.7	13	48.1	13	43.3	5	18.5	15	57.7	15	88.2	19	63.3	97	51.9
between 14-16	1	3.3	1	3.7	6	20.0	5	18.5	5	19.2	1	5.9	1	3.3	20	10.7
Non-respondents	0	0.0	1	3.7	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.5

The age at which most girls first find out about sex and love-making is - (Q22)

TABLE : 29A

	Group 1		Group 2		Group 3		Group 4		Group 5		Group 6		Group 7		SAMPLE TOTAL	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
10 years and younger	2	6.7	0	0.0	3	10.0	1	3.7	3	11.5	0	0.0	2	6.7	11	5.9
11-13 years	15	50.0	14	51.9	12	40.0	12	44.4	12	46.2	10	58.8	15	50.0	90	48.1
14-16 years	13	43.3	10	37.0	15	50.0	12	44.4	11	42.3	5	29.4	13	43.3	79	42.2
17 years and older	0	0.0	2	7.4	0	0.0	2	7.4	0	0.0	2	11.8	0	0.0	6	3.2
Non-respondents	0	0.0	1	3.7	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.5

Teenage girls usually first find out about sex and love-making - (Q23)

TABLE : 30A

	Group 1		Group 2		Group 3		Group 4		Group 5		Group 6		Group 7		SAMPLE TOTAL	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
from mother/father	3	10.0	3	11.1	4	13.3	3	11.1	0	0.0	0	0.0	0	0.0	13	7.0
from brother/sister/relative	0	0.0	0	0.0	2	6.7	0	0.0	0	0.0	0	0.0	0	0.0	2	1.1
from friends as school	18	60.0	12	44.4	23	76.7	17	63.0	23	89.5	17	100.0	25	83.3	135	72.2
from a sex education programme at school	4	13.3	5	18.5	4	13.3	3	11.1	0	0.0	2	11.8	1	3.3	19	10.2
from magazines/books	16	53.3	4	14.8	6	20.0	7	25.9	3	11.5	5	29.4	8	26.7	49	26.2
other	0	0.0	3	11.1	2	6.7	1	3.7	2	7.7	1	5.9	1	3.3	10	5.3
Non-respondents	0	0.0	1	3.7	0	0.0	0	0.0	0	0.0	0	0.0	1	3.3	2	1.1

At which age do most schoolgirls begin to engage in sexual intercourse? - (030)

TABLE : 37A

	Group 1		Group 2		Group 3		Group 4		Group 5		Group 6		Group 7		SAMPLE TOTAL	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
12-13 years	3	10.0	5	18.5	6	20.0	5	18.5	3	11.5	3	17.6	5	16.7	30	16.0
14-16 years	17	56.7	14	51.9	18	60.0	17	63.0	20	76.9	9	52.9	19	63.3	114	61.0
17-18 years	3	10.0	0	0.0	0	0.0	1	3.7	1	3.8	2	11.8	1	3.3	8	4.3
19 years and older	0	0.0	1	3.7	0	0.0	0	0.0	1	3.8	1	5.9	1	3.3	4	2.1
cannot say	7	23.3	7	25.9	6	20.0	3	11.1	1	3.8	2	11.8	4	13.3	30	16.0
Non-respondents	0	0.0	0	0.0	0	0.0	1	3.7	0	0.0	0	0.0	0	0.0	1	0.5

Which of the following girls would most likely engage in sex? - (035)

TABLE : 42A

	Group 1		Group 2		Group 3		Group 4		Group 5		Group 6		Group 7		SAMPLE TOTAL	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
1. a girl coming from a poor home	2	6.7	2	7.4	2	6.7	0	0.0	0	0.0	4	23.5	2	6.7	12	6.4
2. a girl who lacks love from her parents/because of broken family	14	46.7	13	48.1	13	43.3	13	48.1	15	57.7	7	41.2	19	63.3	94	50.3
3. a girl who does badly at school- therefore sex is an escape	4	13.3	4	14.8	0	0.0	0	0.0	1	3.8	1	5.9	3	10.0	13	7.0
4. a girl whose friends influence her into having sex	16	53.3	7	25.9	18	60.0	8	29.6	9	34.6	5	29.4	13	43.3	76	40.6
5. increased opportunity in home/outside for sexual contacts	4	13.3	1	3.7	3	10.0	2	7.4	7	26.9	7	41.2	6	20.0	30	16.0
6. another reason (explain)	3	10.0	7	25.9	2	6.7	3	11.1	0	0.0	0	0.0	3	10.0	18	9.6
Non-respondents	0	0.0	1	3.7	0	0.0	1	3.7	0	0.0	1	5.9	2	6.7	5	2.7

Having sex before marriage nowadays is - (Q36)

TABLE : 43A

	Group 1		Group 2		Group 3		Group 4		Group 5		Group 6		Group 7		SAMPLE							
	Senior School girls	Ex-school girls pregnancy cases	Parents	Parents of ex-school girls	School Teachers	Clergy Members	Health Care Professionals	TOTAL	No	%	No	%	No	%	No	%	No	%				
all right if one is in love	1	5	1	4	1	2	2	16	1	3.3	18.5	3.3	4	14.8	1	3.9	2	11.8	2	6.7	16	8.6
immoral, sinful and therefore wrong	16	10	24	14	9	10	13	96	16	53.3	37.0	80.0	14	51.9	9	34.6	10	58.8	13	43.3	96	51.3
normal part of a youth's growing up	4	1	2	3	1	2	3	16	4	13.3	3.7	6.7	3	11.1	1	3.9	2	11.8	3	10.0	16	8.6
a personal matter	9	7	3	6	15	1	10	51	9	30.0	25.9	10.0	6	22.2	15	57.7	1	5.9	10	33.3	51	27.3
another reason (explain)	0	4	0	0	0	1	6	2	0	0.0	14.8	0.0	0	0.0	0	0.0	1	5.9	1	3.3	6	3.2
Non-respondents	0	0	0	0	0	1	2	1	0	0.0	0.0	0.0	0	0.0	0	0.0	1	5.9	1	3.3	2	1.1

Which of the following do you think is the main reason for young boys and girls engaging in sex? - (Q39)

TABLE : 45A

	Group 1		Group 2		Group 3		Group 4		Group 5		Group 6		Group 7		SAMPLE						
	Senior School girls	Ex-school girls pregnancy cases	Parents	Parents of ex-school girls	School Teachers	Clergy Members	Health Care Professionals	TOTAL	No	%	No	%	No	%	No	%	No	%			
1. "too much" sexual freedom	13	9	12	5	9	3	7	58	13	43.3	33.3	40.0	18.5	9	34.6	3	17.6	7	23.3	58	31.0
2. "tolerant" attitude on part of church	0	1	0	0	0	2	0	3	0	0.0	3.7	0.0	0.0	0	0.0	2	11.8	0	0.0	3	1.6
3. increased opportunities for meeting the opposite sex	5	3	9	7	4	3	4	35	5	16.7	11.1	30.0	25.9	4	15.4	3	17.6	4	13.3	35	18.7
4. approval by parents	3	1	2	1	3	0	0	8	3	10.0	3.7	6.7	3.7	1	3.8	0	0.0	0	0.0	8	4.3
5. boredom with school	0	2	2	1	2	1	8	8	0	0.0	7.4	6.7	3.7	2	7.7	1	5.9	0	0.0	8	4.3
6. the mass media (T.V. films, magazines)	7	3	3	6	8	10	16	53	7	23.3	11.1	10.0	22.2	8	30.8	10	58.8	16	53.3	53	28.3
7. poor quality of life in the township	3	4	6	4	4	7	11	39	3	10.0	14.8	20.0	14.8	4	15.4	7	41.2	11	36.7	39	20.9
8. another reason (explain)	5	6	2	1	2	1	20	20	5	16.7	22.2	6.7	3.7	2	7.7	1	5.9	3	10.0	20	10.7
Non-respondents	0	3	1	3	0	1	9	1	0	0.0	11.1	3.3	11.1	0	0.0	1	5.9	1	3.3	9	4.8

How frequently do sexually active schoolgirls use birth control - (041)

TABLE : 48A

	Group 1		Group 2		Group 3		Group 4		Group 5		Group 6		Group 7		SAMPLE	
	Senior Schoolgirls		Ex-school girl pregnancy cases		Parents		Parents of ex-school girls		School Teachers		Clergy Members		Health Care Professionals		TOTAL	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
not at all	3	10.0	4	14.8	4	13.3	2	7.4	2	7.7	0	0.0	1	3.3	16	9.6
sometimes	9	30.0	6	22.2	7	23.3	12	44.4	4	15.4	1	5.9	15	50.0	54	28.9
most times	2	6.7	0	0.0	1	3.3	2	7.4	2	7.7	0	0.0	5	16.7	12	6.4
every time	0	0.0	0	0.0	0	0.0	1	3.7	1	3.8	0	0.0	0	0.0	1	0.5
don't know	16	53.3	16	59.3	16	53.3	10	37.0	17	65.4	16	94.1	8	26.7	99	52.9
other reason (state)	0	0.0	1	3.7	2	6.7	0	0.0	0	0.0	0	0.0	1	3.3	4	2.1
Non-respondents	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

Who do you think should be responsible for contraception? - (042)

TABLE : 49A

	Group 1		Group 2		Group 3		Group 4		Group 5		Group 6		Group 7		SAMPLE	
	Senior Schoolgirls		Ex-school girl pregnancy cases		Parents		Parents of ex-school girls		School Teachers		Clergy Members		Health Care Professionals		TOTAL	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
the girl	3	10.0	10	37.0	3	10.0	8	29.6	1	3.8	1	5.9	0	0.0	26	13.9
the boy	1	3.3	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.5
both girl and boy	22	73.3	14	51.9	20	66.7	16	59.3	23	88.5	11	64.7	29	96.7	135	72.2
don't know	4	13.3	2	7.4	7	23.3	3	11.1	2	7.7	3	17.6	0	0.0	21	11.2
Non-respondents	0	0.0	1	3.7	0	0.0	0	0.0	0	0.0	2	11.8	1	3.3	4	2.1

They don't use contraceptives because of - (Q44)

TABLE : 51A

	!Group 1		!Group 2		!Group 3		!Group 4		!Group 5		!Group 6		!Group 7		!SAMPLE	
	!Senior		!Ex-school		!Parents		!Parents of		!School		!Clergy		!Health		!	
	!Schoolgirls		!girl		!		!ex-school		!Teachers		!Members		!Care		!TOTAL	
	!		!pregnancy		!		!girls		!		!		!Professionals		!	
	!		!cases		!		!		!		!		!		!	
	!30		!27		!30		!27		!26		!17		!30		!187	
	!No		!%		!No		!%		!No		!%		!No		!%	
	!		!		!		!		!		!		!		!	
!1. Religious beliefs	!5	!16.7	!3	!11.1	!6	!20.0	!4	!14.8	!0	!0.0	!1	!5.9	!2	!6.7	!21	!11.2
!2. Failing to accept that they	!5	!16.7	!3	!11.1	!2	!6.7	!4	!14.8	!7	!26.9	!2	!11.9	!6	!20.0	!29	!15.5
! are indeed having intercourse	!	!	!	!	!	!	!	!	!	!	!	!	!	!	!	!
!3. Inability to get hold of any	!4	!13.3	!1	!3.7	!2	!6.7	!1	!3.7	!5	!19.2	!1	!5.9	!1	!3.3	!15	!8.0
!4. Bad planning	!6	!20.0	!3	!11.1	!6	!20.0	!3	!11.1	!4	!15.4	!3	!17.6	!2	!6.7	!27	!14.4
!5. The belief that parents would	!10	!33.3	!8	!29.6	!5	!16.7	!6	!22.2	!4	!15.4	!4	!23.5	!11	!36.7	!48	!25.7
! disapprove of sex	!	!	!	!	!	!	!	!	!	!	!	!	!	!	!	!
!6. The fear that it is dangerous	!3	!10.0	!12	!44.4	!7	!23.3	!3	!11.1	!0	!0.0	!2	!11.8	!3	!10.0	!30	!16.0
!7. A lack of factual knowledge	!7	!23.3	!5	!18.5	!10	!33.3	!7	!25.9	!13	!50.0	!6	!35.3	!14	!46.7	!62	!33.2
! about using them	!	!	!	!	!	!	!	!	!	!	!	!	!	!	!	!
!Non-respondents	!0	!0.0	!0	!0.0	!1	!3.3	!0	!0.0	!0	!0.0	!1	!5.9	!1	!3.3	!3	!1.6

Think of schoolgirls who have recently had a baby. Close your eyes for a brief moment and try to focus attention on them. Now kindly read the following statements and place a "Y" for YES or "N" for NO in the block to describe them - (Q53)

TABLE : 60A

	Group 1		Group 2		Group 3		Group 4		Group 5		Group 6		Group 7		SAMPLE TOTAL	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
The girls were pleased to have the babies	Y # 5	16.7	9	33.3	5	16.7	7	25.9	6	23.1	3	17.6	3	10.0	38	20.3
	N # 21	70.0	12	44.4	18	60.0	10	37.0	15	57.7	10	58.8	22	73.3	108	57.8
Their boyfriends were pleased about the baby	Y # 4	13.3	10	37.0	7	23.3	8	29.6	2	7.7	2	11.8	2	6.7	35	18.7
	N # 22	73.3	10	37.0	15	50.0	9	33.3	19	73.1	11	64.7	23	76.7	109	58.3
The girls' parents were pleased about their babies	Y # 0	0.0	6	22.2	1	3.3	3	11.1	2	7.7	1	5.9	3	10.0	16	8.6
	N # 27	90.0	14	51.9	21	70.0	14	51.9	19	73.1	12	70.6	22	73.3	129	69.0
Most people were upset/disappointed about them	Y # 28	93.3	23	85.2	26	86.7	21	77.8	20	76.9	14	82.4	24	80.0	156	83.4
	N # 1	3.3	0	0.0	3	10.0	0	0.0	2	7.7	1	5.9	3	10.0	10	5.3
The girls did not know about birth control	Y # 7	23.3	12	44.4	15	50.0	12	44.4	8	30.8	6	35.3	11	36.7	71	39.0
	N # 19	63.3	9	33.3	9	30.0	8	29.6	13	50.0	8	47.1	14	46.7	80	42.8
They blamed the boys for not using contraceptives	Y # 13	43.3	7	25.9	10	33.3	6	22.2	9	34.6	6	35.3	15	50.0	66	35.3
	N # 14	46.7	13	48.1	11	36.7	9	33.3	12	46.2	5	29.4	11	36.7	75	40.1
They planned to go back to school after they had the babies	Y # 13	43.3	16	59.3	11	36.7	9	33.3	11	42.3	11	64.7	13	43.3	94	44.9
	N # 12	40.0	6	22.2	14	46.7	8	29.6	11	42.3	3	17.6	12	40.0	66	35.3
They got married because they were pregnant	Y # 12	40.0	11	40.7	10	33.3	10	37.0	10	38.5	7	41.2	14	46.7	74	39.6
	N # 15	50.0	10	37.0	14	46.7	8	29.6	12	46.2	6	35.3	11	36.7	76	40.6
Non - respondents	# 0	0.0	0	0.0	0	0.0	3	11.1	2	7.7	1	5.9	2	6.7	8	4.3

Which of the following do you consider to be the most important factors for discussion in a sex education programme? - (1962)

TABLE : 69A.1

	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	SAMPLE	TOTAL							
	Senior School girls	Ex-school girls pregnancy cases	Parents of ex-school girls	Parents of ex-school girls	School Teachers	Clergy Members	Health Care Professionals									
Fill in the blocks as follows :																
(VI) Very Important	1 #30	127	130	127	126	117	130	1187								
(I) Important	2 #															
(NI) Not Important	3 #No	%	%	%	%	%	%	%	%							
The Reproductive System in the Male and Female , and how it works .	1 #20	165.7	117	163.0	121	170.0	113	148.1	119	173.1	112	170.6	123	176.7	125	166.8
Pregnancy and Childbirth .	1 #3	110.0	0	0.0	0	0.0	2	7.4	0	0.0	0	0.0	2	6.7	7	3.7
Contraceptive methods - who is to use them and where they can be obtained	1 #12	140.0	116	159.3	111	136.7	17	125.9	115	157.7	14	123.5	118	160.0	83	144.4
Intelligent choice of a Sexual Life - Style	1 #6	120.0	8	129.6	6	120.0	3	111.1	6	123.1	7	141.2	119	163.3	55	129.4
Help available for pregnant girls	1 #15	150.0	112	144.4	110	133.3	113	148.1	113	150.0	17	141.2	19	130.0	79	142.2

Which of the following do you consider to be the most important factors for discussion in a sex education programme? - (062)

TABLE : 69A.2

	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	SAMPLE								
	Senior School girls	Ex-schoolgirl pregnancy cases	Parents of ex-schoolgirls	Parents of ex-schoolgirls	School Teachers	Clergy Members	Health Care Professionals	TOTAL								
Fill in the blocks as follows :																
(VI) Very Important.	1	30	27	30	27	26	17	130	1187							
(I) Important.	2															
(NI) Not Important.	3	No	%	No	%	No	%	No	%							
Sexually Transmitted Diseases (STD)																
1	17	156.7	14	151.9	22	173.3	13	148.1	17	165.4	14	182.4	21	170.0	118	63.1
2	10	133.3	6	122.2	4	113.3	6	122.2	6	123.1	3	117.6	5	116.7	40	21.4
3	1	3.3	2	7.4	0	0.0	0	0.0	2	7.7	0	0.0	0	0.0	5	2.7
The Advantages of Delaying the First Pregnancy																
1	12	140.0	16	159.3	19	183.3	12	144.4	15	157.7	11	164.7	17	156.7	102	54.5
2	11	136.7	5	118.5	4	113.3	3	111.1	5	119.2	3	117.6	5	116.7	36	19.3
3	4	113.3	2	7.4	1	3.3	3	111.1	5	119.2	2	111.8	5	116.7	22	11.8
The Dangers of Having Sex too early																
1	26	186.7	19	170.4	24	180.0	14	151.9	15	157.7	16	194.1	25	183.3	139	74.3
2	2	6.7	5	118.5	4	113.3	3	111.1	9	134.6	1	5.9	4	113.3	29	15.0
3	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Strategies for reducing unwanted/unintended pregnancies in schoolgirls																
1	13	143.3	18	156.7	15	150.0	13	148.1	16	161.5	13	176.5	16	153.3	104	55.6
2	11	136.7	4	114.8	7	123.3	4	114.8	6	123.1	3	117.6	11	136.7	46	24.6
3	3	10.0	0	0.0	3	10.0	1	3.7	3	11.5	1	5.9	1	3.3	12	6.4

In building support for Family Life Education and Sex Education Programmes in the public schools, who do you think would play an important role? - (063)

TABLE : 70A

	Group 1		Group 2		Group 3		Group 4		Group 5		Group 6		Group 7		SAMPLE	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
School Teachers	6	20.0	8	29.6	7	23.3	4	14.8	6	23.1	4	23.5	13	43.3	49	25.7
Clergy in the Community	1	3.3	3	11.1	3	10.0	3	11.1	4	15.4	9	52.9	10	33.3	33	17.6
School Nurses	14	46.7	9	33.3	12	40.0	11	40.7	7	25.9	6	35.3	15	50.0	74	39.6
Parents in the Community	10	33.3	8	29.6	9	30.0	8	29.6	5	19.2	4	23.5	15	50.0	59	31.6
Parents and Teachers	19	63.3	21	77.8	19	63.3	15	55.6	16	61.5	10	58.8	24	80.0	124	66.3
Persons from various Health Agencies in the Community	13	43.3	6	22.2	10	33.3	9	29.6	8	30.8	8	47.1	16	53.3	69	36.9
Adolescent and Youth Counsellors	13	43.3	12	44.4	10	33.3	7	25.9	9	34.6	8	47.1	21	70.0	80	42.9
School Psychologists	7	23.3	6	22.2	9	30.0	4	14.8	8	30.8	9	47.1	10	33.3	52	27.9
Non-respondents	0	0.0	0	0.0	0	0.0	1	3.7	2	7.7	0	0.0	1	3.3	4	2.1

APPENDIX L

CONTENTS

A Selected Annotated Bibliography
for Updating Media Resource Centres for
Sex Education in Schools, pp. 347 — 351

APPENDIX L

A SELECTED ANNOTATED BIBLIOGRAPHY
FOR UPDATING MEDIA RESOURCE
CENTRES FOR SEX EDUCATION IN SCHOOLS

Ajo JJ and
Petas JW, 1978

Learning About Sex:
A Guide for Children and Their
Parents. Holt-Rinehart.

[A book for children about sex and family life.]

Bell R, 1980

Changing Bodies, Changing
Lives, Random House, New York.

[Comprehensive book for teens on all aspects of health and
sexuality issues including anatomy, physiology, relationships
nutrition, sexually-transmitted diseases, birth control,
pregnancy and parenting. Excellent photographs.]

Calderone MS, and
Johnson EW, 1990

The Family Book About
Sexuality, Perennial Library.

[The book covers topics such as the human response and the
reproductive system.]

Carrera M,
(undated)

Sex : The Acts, The Facts,
The Feelings, publisher
unknown.

[Excellent written and illustrated textbook on sex and
sexuality. Includes a great deal of technical information
but discusses and initiates thought on value-laden subjects
as well. Extremely useful for practitioners.]

Compton N, 1986

How Schools Can Help Combat
Student Pregnancy, National
Education Association,
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Gordon S, 1978 Facts About Sex for Today's Youth, Ed-U Press.

[A clearly and simply-written short book for teens. Conveys basic information about sexual anatomy, human reproduction, and love and sexual problems. It answers the ten most commonly asked questions about sex by young people.]

Gordon S, 1981 Teenage Survival Book, Times Books.

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Greenberg JS, 1989 Sexuality : Insights and Issues, William C. Brown.

[Deals with all aspects of sexuality : anatomy, physiology, sociology and psychology. It has interesting sections on sexual communication and the development of sexuality from childhood, through adolescence and beyond.]

Gruenberg SM, 1979 The Wonderful Story of How You Were Born, Doubleday.

[It is a book about sex and family life for children.]

Hubbard BM, 1989 Entering Adulthood : Living in Relationships, Network Publications.

[This book is organised as a series, which provides students with opportunities to examine their knowledge, feelings, beliefs and behaviour in regard to relationships.]

Phillips A and
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[This book includes a useful section on sexuality and relationships, albeit mainly from the woman's point of view.]

Uslander A, 1975

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[This handbook offers a "classroom tested" approach to presenting sex education in a relaxed, non-threatening manner. It also provides practical and very specific answers to questions about birth control asked by kindergarten children to junior high school. Contains detailed guides for discussion leadership of various topics.]

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[An excellent guide about sex and family life, designed for children.]

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