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DEPARTMENT OF SOCIAL WORK

RESEARCH TOPIC: Risk and Protective Factors for Adolescent pregnancy among Girls in Letlhakane Village.

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DECLARATION

I, Sizwile Dlamini, hereby declare that this dissertation is a presentation of my original research work, except where it is clearly indicated with correct references of other scholars. The dissertation has never been previously submitted by me for a degree at this or any other University.

Signed: _____ Date _____

DEDICATION

This dissertation is dedicated to my parents for their unwavering support and encouragement throughout my studies.

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This dissertation is an outcome of contributions, and support from different people who made the completion of this dissertation to be a success, and I would like to acknowledge them.

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ABSTRACT

Adolescent pregnancy is a global health issue, generating problems such as adolescent maternal deaths, school disruption, and limited job prospects for adolescent girls. This study examined the risk and protective factors for adolescent pregnancy among adolescent girls in Letlhakane village, using the social-ecological model. The model indicates that behavior is a result of multiple implicating factors. Adopting the major underlying notion of the social-ecological model, the issue of adolescent pregnancy was not interpreted as a result of individual behavior only, however, as an outcome of combined implications of individual, family, peer and dyad, community and institutional factors.

As a qualitative study, respondents were selected using purposive and snowball sampling techniques. In-depth interviews and focus group discussions were used as data gathering instruments. To analyze the data collected, thematic analysis was employed. Findings revealed that there is non-use of contraceptives; lack of knowledge about SRH issues and the use of contraceptives among individual adolescents. There is also lack of parental education and guidance on sexuality which resulted in adolescents being prone to peer pressure and intergenerational sex. Some cultures tolerate early childbearing and their living set-up led to early sexual debut of adolescents. Laws and policies were said to be ineffective because laws are not implemented and cases of sexual abuse are not reported.

To tackle this issue of adolescent pregnancy, respondents proposed that adolescents should use contraceptives; parents should be involved in the sexual lives of their adolescents so as to provide them with education on sexuality. Stakeholder collaboration was also emphasized and enforcement of the law. Based on these findings, practitioners, policy makers should design programs which simultaneously address multiple risk and protective factors, and to be inclusive of adolescents in the implementation of ASRH services.

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LIST OF ABBREVIATIONS

ASRH	Adolescent Sexual Reproductive Health
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
DHMT	District Health Management Team
VDC	Village Development Committee
KIs	Key Informants
FDG	Focus Group Discussion
GoB	Government of Botswana
WHO	World Health Organization
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund

CHAPTER ONE

Introduction

Adolescent pregnancy is a major public health challenge globally, with approximately 16 million female adolescents aged 15-19 years giving birth annually (Mphatswe, Maise, & Sebitloane, 2016; WHO, 2014; UNFPA, 2013; UNICEF, 2008). Adolescence is referred to as a developmental transition, often range from 10 and 19 years, between childhood and adulthood ‘‘that involves physical, cognitive, emotional, and social changes and takes varying forms in different social, cultural, and economic settings’’ (Papalia & Feldman, 2011, p.396). According to the Ministry of Health, (2003) as cited in Ntshwarang & Malinga-Musamba (2015), an adolescent in Botswana is defined as a person aged 10–19 years. However, this study focused on adolescent mothers aged 15-19 years.

Approximately 95% of adolescent pregnancies occur in developing countries with 36.4 million women becoming adolescent mothers before the age of 18 (United Nations Population Fund, 2013), implying that the other 5% of adolescent pregnancy occurs in developed countries. The vast difference of percentages of teen birth rates indicates the need for research towards minimizing the gap.

Adolescent pregnancy has affected the developed and developing communities, generating problems such as frequent absenteeism from school, and form repetition in schools, dropping out of schools and poor academic performance (Molosiwa & Moswela, 2012; WHO, 2013). Adolescent pregnancy has also been cited as a major constraint in the elimination of gender disparities between boys and girls in education (UNICEF, 2008).

There is a growing concern regarding the increasing rate of adolescent pregnancies in Botswana, leading to high school drop outs (UNFPA, 2013). However, the risk and protective factors of adolescent pregnancy have not been examined using a multiple level approach.

The prevention of adolescent pregnancy is an essential goal of Botswana. Although adolescent pregnancy and birth rates have been steadily decreasing, many adolescents still become pregnant. Efforts to prevent adolescent pregnancy have increased, and new studies and observations, technologies, and prevention intervention effectiveness data have emerged (Klein, 2005).

The Social-Ecological Model provides a comprehensive framework for understanding the effects of multiple levels of influence (such as individual, family, peer and dyad relationships) on health behavioral outcomes (Raneri & Constance, 2007; Baral et al., 2013; Kaufman et al., 2015; Svanemyr et al., 2015). A qualitative research study was, therefore, conducted among adolescent girls in Letlhakane village to assess the risk and protective factors of adolescent pregnancy using the social-ecological model.

Background of the Study

Factors contributing to adolescent pregnancy can be understood in the context of social, cultural, economic, and political dimensions. These structural factors mediate risk factors of adolescent pregnancy and as such, do not directly cause adolescent pregnancy (Baral et al., 2013). Therefore it is imperative to assess and discuss factors contributing to adolescent pregnancy in a multilevel approach. This chapter gives an overview of adolescent pregnancy in the global context, Sub-Saharan countries, Botswana, as well as Letlhakane village.

Global Perspective

Adolescent girls from marginalized groups often lack choices and opportunities in life. Also, they tend to have limited or no access to Sexual Reproductive Health (SRH), such as contraceptive information and services hence they are more likely to become pregnant (UNICEF, 2008). From the global perspective, the researcher will look at adolescent pregnancy in the United States of America, Eastern Europe, Central and South Asia, because it has been and is still a significant public health issue in these areas and these countries have also recorded the highest prevalence rate of adolescent pregnancy over the years.

United States of America (USA)

Globally, adolescent pregnancy is on a decline. However, it remains among the significant concern of the adolescent's health (Boonstra, 2014). Despite this overall decrease in adolescent pregnancy over the current decades, United States of America continues to have the highest prevalence rates of adolescent pregnancy in developed countries (Boonstra, 2014). In the USA more than 40 percent of girls become pregnant before they reach the age of 20 (Chen & Williams, 2013). The adolescent pregnancy rate in the United States is nearly twice that of Canada and Great Britain and approximately four times that of France and Sweden (Chen & Williams, 2013).

According to research, the level of adolescent pregnancy is highest amongst the minority populations in the USA, and these minority populations are faced with problems involving poverty, lack of education and quality health care (Akella & Jordan, 2015). Also, other factors have been found to be the elevating risk of adolescent pregnancy in the USA. These factors include residing in disorganized/dangerous neighbourhoods, living with a single parent, having older sexually active siblings or parenting adolescent sisters, inadequate parental supervision or regulation of children's activities (Dulitha et al., 2013).

Eastern Europe and Central Asia

Teen birth rates are also higher in many Eastern Europe and Central Asian countries. These rates have been attributed to some barriers in accessing contraceptives (Sedgh et al., 2015). Furthermore, socioeconomic disadvantage, disrupted family structure, limited education, risky sexual behaviours such as early sexual initiation, increasing number of partners and alcohol, drug or tobacco use were the factors associated with adolescent pregnancies in European Union countries (Dulitha et al., 2013).

South Asia

South Asian countries have high propositions of early pregnancy due to the common practice of early marriage and social expectation to have a child soon after the wedding (Sayem & Nury, 2011). The evidence further show that nearly 60% of all girls are married by the age of 18 years, and one-fourth are married by the age of 15 years in South Asia (Sayem & Nury, 2011). Moreover, within South Asia, the recorded adolescent pregnancy rate is highest in Bangladesh (35%), followed by Nepal (21%), and India (21%). The risk factors identified for adolescent pregnancy in South Asian countries of Bangladesh, India, and Nepal include low socio-economic background, low educational attainment, disrupted family structure, cultural factor and poor sexual health practices (Acharya et al., 2010).

Sub-Saharan Context

Sub-Saharan Africa had the highest prevalence of adolescent pregnancy in the world in 2013 (United Nations Population Fund, 2013). Births to adolescent mothers account for more than half of all the births in this region; an estimated 101 births per 1000 women aged 15 to 19 (United Nations Population Fund, 2013). These high rates of adolescent pregnancy have been associated with social risk factors such as early age at marriage and early start of childbearing (Akella & Jordan, 2015).

According to Mkwananzi & Odimegwu (2015), recent studies on adolescent pregnancy in the African subcontinent have looked at individual level demographic, socio-economic and reproductive health knowledge and behaviour parameters. Moreover, Mkwananzi & Odimegwu (2015), identified education and socio-economic status as consistent determinants of adolescent pregnancy in sub-Saharan African countries. Other studies have explored the effect of household variables on adolescent pregnancy in Nigeria, Kenya, and Lesotho, showing household size and parents' marital status as significant predictors of Adolescent pregnancy.

Jewkes et al., (2009), Lam, Marteleto, & Ranchhod (2008) and Macleod & Tracey, (2010), argue that the incidence and causes of adolescent pregnancy can be traced beyond the person. Jewkes et al., (2009) argue that there are several conditions that necessitate such a trend to be common in different societies. It has also been observed that societies with rampant cases of Adolescent pregnancy have some common societal features and are also associated with other social problems such as poverty, poor educational attainments and early marriages (Mkhwanazi, 2010). In 2013, birth rates ranged from 150 or higher to less than 50 births per 1000 women of ages 15 to 19 in the sub-continent, with Central Africa displaying the highest levels and Southern Africa having the lowest (Clifton & Hervish, 2013). However, these previous studies have not assessed the multiple level determinants of adolescent pregnancy simultaneously. Thus, they have not incorporated the Social-Ecological Model as a possible framework for understanding the risk and protective factors of adolescent pregnancy.

The Middle East and North Africa (MENA countries)

The average rate of adolescent birth rates in the Middle East and North Africa ranges at 56 births per 1000 adolescent females (Nguyen & Shiu, 2016). These adolescent birth rates

are attributed to social risk factors such as early marriage; adolescent girls are expected to have a child at the beginning of the marriage regardless of their socioeconomic background (Fahimi & Monem, 2010). There is also low contraceptive use among adolescent girls.

South Sudan is among the top ten countries with the highest prevalence of adolescent pregnancy, the others being Burkina Faso, Central African Republic, Chad, Guinea, Malawi, Mali, Mozambique, Niger, and Bangladesh. A third of South Sudanese girls start childbearing at the age of 15-19 years, and 3 percent have had a live birth before the age of 15 years. The high prevalence rate of adolescent pregnancy in South Sudan is associated with factors such as dowry payment, poverty, low educational status, poor quality and access to reproductive health services, peer pressure, tradition and culture (Vincent & Alemu, 2016).

Botswana

According to United Nations Population Fund's State of the World Population Report of 2013, Botswana in 2011 recorded 39 primary school students who dropped out due to pregnancy, while in the same year 453 dropped out of both junior and senior secondary schools. In the same year, the country had an average of about 52 per 1000 births attributed to women aged 15-19 years old (Botswana Central Statistics Office, 2012). According to the Central Statistics Office (2014), in 2012, a total of 757 female students who were enrolled in secondary schools became pregnant. As at September 2013, pregnancies in secondary schools had already exceeded 50, with 21 cases being reported in two secondary schools in Nata (UNFPA, 2013).

Although the country's average is way below the continental average, the growing pregnancy prevalence is noted to be on the rise reviewing the period since the turn of the millennium. Fertility levels in Botswana remain high, especially for less educated women. Botswana Central Statistics Office, (2012) reports that fertility among Batswana women with

no formal education is at 5.8 compared to 3.3 among women with secondary education and 2.6 for those with a university education. Thus, the level of education is cited as a major determinant of fertility levels in Botswana.

In essence, research done in Botswana shows that the statistics of adolescent pregnancy are high in different regions and they are growing over time. Therefore there was need for a study which assessed the risk and protective factors of adolescent pregnancy. Many female students have limited knowledge of their sexuality (Makwinja-Morara, 2009). Also, studies indicate that many parents are uncomfortable talking about sexuality with their children. Discussing sexual intercourse and sexuality issues are perceived as a taboo in most African cultures. Lack of sex education span across different levels of the social-ecological model.

Letlhakane Sub-district

Letlhakane sub-district is not highly populated, but the incidence of adolescent pregnancy is rampant (Central Statistics Office, 2012; UNICEF, 2008). The District Health Management Team in Letlhakane has recorded 320 cases of teenage pregnancy, accounting for 14 per cent of all pregnancies recorded under the financial year 2012/2013 (BOPA, 2014). However, little is known about the risk and protective factors of adolescent pregnancy in Letlhakane. Therefore there was a need for research addressing this matter.

Statement of the Problem

Adolescent pregnancy is a significant public health issue for both developed and developing countries. Adolescent pregnancy is viewed as a major setback, and it is associated with school disruption, economic strain, limited job prospects, emotional stress and even social stigma (Varga, 2003; Olufemi, Joel, & Ajibade, 2013; WHO, 2014). Adolescent pregnancy also signifies unprotected sexual intercourse. Therefore, there are often grave

consequences for the spread of HIV infection and other Sexually Transmitted Infections (STI) among adolescents (Makwinja-Morara, 2009).

About 70,000 maternal deaths of adolescents occur in developing countries annually due to complications related to pregnancy and childbirth (WHO, 2014). According to World Health Organization (2008), adolescent girls who give birth each year have a much higher risk of dying from maternal causes compared to women in the 20's and 30's. Adolescent mothers are likely to suffer from severe complications during delivery, which results in higher morbidity and mortality for them and their children (Philemon, 2007). These risks or complications at birth increase significantly as maternal age decreases, with adolescents under the age of 16 facing four times the risk of maternal death as women over 20 (WHO, 2008).

The Government of Botswana (GoB) has put in place several interventions to reduce adolescent pregnancy, such as Adolescent Sexual Reproductive Health (ASRH) Implementation Strategy, and incorporation of sexual education in guidance and counseling syllabus. ASRH services were introduced for the year 2012-2016 and are aimed at delaying first sexual intercourse, promote the use of family planning services, and prevent STI, to limit adolescent pregnancies and to ensure early treatment of STI (Mwinga, 2012). Despite the introduction of ASRH services, adolescent pregnancies are still occurring at an alarming rate in Botswana (UNFPA, 2013).

Over the past three decades, research has identified several factors that help differentiate individuals who are at risk of one problem or another (such as the use of drugs, pregnancy), from those who are less inclined to do so (Catalano et al., 2011; Hawkins et al., 1992). Risk factors are qualities of a person or his or her environment that tend to adversely affect their developmental trajectory and place them at risk for early pregnancy or other

behavioral problems. Protective factors are qualities that promote successful coping and adaptation to life situations and change. Protective factors do not mean the absence of risk factors, instead, their tendency to reduce or decrease the negative impact of risk factors (Cowen & Work, 1988; Garmezy, 1985; Hawkins et al., 1992; Rutter, 1985; Werner, 1989).

Moreover, studies conducted in the context of Botswana have yet to identify the potential risk factors for adolescent pregnancy. As a result, this raises questions of what could be the possible risk factors for adolescent pregnancy and their protective factors; how do those factors interact with each other and to what extent (magnitude) do they influence adolescent pregnancy. Therefore, this study explored the risks and protective factors of Adolescent pregnancy using the Social-ecological model.

Objectives of the Study

1. To explore the **individual-level risk and protective** factors associated with adolescent pregnancy in Letlhakane.

2. To explore the **peer and dyad-level risk and protective factors** associated with Adolescent pregnancy in Letlhakane.

3. To explore the **family-level risk and protective factors** associated with Adolescent pregnancy in Letlhakane.

4. To explore the **community-level risk and protective factors** associated with Adolescent pregnancy in Letlhakane.

5. To explore the **institutional- level risk and protective factors** associated with Adolescent pregnancy in Letlhakane

6. To examine the **relationship** between individual, family, peer and dyad, community and institutional level factors in Adolescent pregnancy

Research Questions

1. What are the **individual-level risk and protective factors** associated with Adolescent pregnancy in Letlhakane?

2. What are the **peer and dyad- level risk and protective factors** risk and protective associated with Adolescent pregnancy in Letlhakane?

3. What are the **family-level risk and protective factors** associated with Adolescent pregnancy in Letlhakane?

4. What are the **community-level risk and protective factors** associated with Adolescent pregnancy in Letlhakane?

5. What are the **institutional level-risk and protective factors** associated with Adolescent pregnancy in Letlhakane?

6. What is **the relationship** between individual, peer and dyad, family, community and institutional level factors about adolescent pregnancy?

Rationale of the Study

Little is known about the risk and protective factors for adolescent pregnancy in African continent generally and in Botswana, and particularly in Letlhakane when using multiple levels of influence. Moreover, most studies have been done in the USA, Europe, Australia, etc., with generalizations made to all contexts, under the label "developing countries." Other studies are conducted by development partners like World Health Organization which may increase the possibility of compromised methodology. Conducting this study could help to fill in existing knowledge gaps and inform the development of multi-

level context specific intervention strategies that prevent or curb the risk factors of unplanned pregnancies among adolescent girls in Letlhakane.

Significance of the Study

Policy level

This study raises awareness among decision-makers about the intensity of the risk factors associated with adolescent pregnancy. Thus, the policymakers are able to know the risk factors which span across all levels of influence. Therefore with the knowledge of risk factors associated with adolescent pregnancy, policymakers or the Ministry of Health could formulate and implement effective protective programs which modify risky health behaviours. As a result, reducing the numbers of adolescent pregnancies. The information that emerged from this study about the protective factors of adolescent pregnancy will guide policymakers on what needs to be improved or changed in the Adolescent youth-friendly services.

Practice

The findings from this study could help practitioners (such as nurses, social workers, and teachers) to have a comprehensive understanding of the multiple-level risk factors and protective factors for adolescent pregnancy, as well as determining the relationship between risk and protective factors. Therefore, as professionals, they will be able to develop intervention strategies that lessen the risk factors and promote protective factors associated with adolescent pregnancy.

Research

Most studies focus on the individual and family-level risk and protective factors for adolescent pregnancy. However, the growing concern of adolescent pregnancy calls for further research on multiple level risk factors (such as institutional factors). Therefore, this

study revealed the risk and protective factors of adolescent pregnancy across different levels of influence, hence it could motivate other scientists to engage in research to explore these factors further. This study contributes to the existing body of knowledge on adolescent pregnancy.

CHAPTER TWO

THEORETICAL FRAMEWORK

Introduction

The Social-Ecological Model was adopted to guide the conceptual framework of this study. The model helped the researcher to establish the interactive relationship existing between multiple level factors influencing adolescent pregnancy. As a result, the researcher was able to provide an evidence-based story that portrays a clear picture of the incidence of adolescent pregnancy in Letlhakane. The Social-ecological model recognises that individuals are responsible for instituting and maintaining lifestyle changes necessary to reduce risks and improve health, however, individual behaviour is also influenced by factors at different levels (Gombachika, et al., 2012). Therefore, the model helped the researcher to assess the risk and protective factors of adolescent pregnancy in a holistic manner.

The Social-Ecological Model

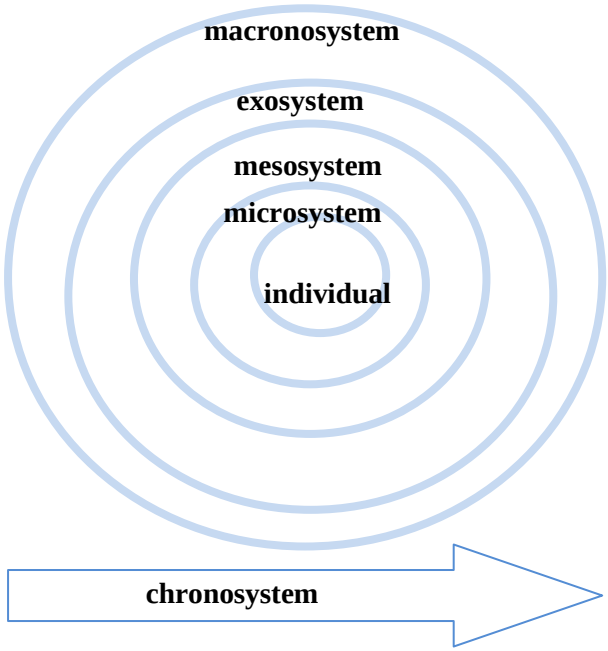
The Social-Ecological Model is a theory-based framework for understanding, exploring, and addressing the social determinants of health at various levels (Crosby, Salazar, & DiClemente, 2013). The Social-ecological model encourages us to move beyond a focus on individual behavior and towards an understanding of the wide range of factors that influence health outcomes (Crosby, Salazar, & DiClemente, 2013). The term ‘‘Ecological’’ means multiple levels beyond the individual. According to Golden et al., (2015), Social-ecological models are visual portrayals of dynamic relationships among individuals, groups, and their environments. Urie Bronfenbrenner (1992), as cited in Golden et al., (2015), explains that Social-ecological models originate from a systems orientation to human development, in which ‘‘individuals are understood to influence, and be influenced by people and organizations with whom they interact, available resources and institutions, and societal norms and rules.’’

Historical Background of the Social-Ecological Model

The ecological perspective emerged in the 1970's, and it was described as a form of general systems theory (O'Donoghue, et al., 2005). Ecological models were based on systems theories that built on the works of Ludwig Von Bertalanffy (1968) and Gregory Bateson (1972) and were used by social workers to explain the interactional processes between family members. The concept of ecological environment is attributed to Urie Bronfenbrenner. Von Bertalanffy's model assumed a single-dimension cause-and- effect relationship between social units within the environment (Brandell, 2010). However, Bronfenbrenner felt that systems theory did not fully address the complex dynamics that occur within social systems (Brandell, 2010). Therefore, through his early life experiences combined with his extensive study of the work of theorists like Kurt Lewin, Bronfenbrenner developed a strong belief that development is an interaction of the person and the environment (Ungar, 2002).

Urie Bronfenbrenner's Ecological Systems Theory (1979), focused on the interrelationship between individuals and their environment (Wendel, Garney, & Mc Leroy, 2015). Bronfenbrenner discussed different system levels in which human behavior occurs and these levels include the microsystem, mesosystem, exosystem, macrosystem and chronosystem.

Figure 1: Bronfenbrenner's Ecological Systems diagram



*The **microsystem** comprises of the immediate environment (such as family, peers), that influences an individual's development (Bronfenbrenner, 2005). The **mesosystem** is about the interaction of the micro-systems, for instance, the interaction between family and school (Bronfenbrenner, 2005). The **exosystem** entails the settings with which the individual does not interact directly but that nevertheless have an effect on the individual's development, for example, one's parent work experiences (Gombachika et al., 2012). The **macrosystem** comprises of the social ideologies, cultural values, and laws that affect individual's development and experiences (Gombachika et al., 2012). The **chronosystem** is about the changes that happen over time within systems that influence an individual (Bronfenbrenner, 2005).*

Adaptations/ Utility of the Social-Ecological Model

Mc Leroy et al. (1998) is often cited as one of the initial articles explicitly applying an ecological model to public health and health promotion. Kenneth Mc Leroy's Ecological Model of Health Behavior (1988), classified different levels of influence on health behavior: intrapersonal, interpersonal, organizational, community and public policy. The Ecological Model of Health Behavior is the perception that behavior affects and is affected by multiple levels of influence, and there is reciprocal causation. Thus individual behaviors shape, and is shaped by the social environment (Ungar, 2002). Baral et al. (2013) also adopted the social-ecological model to guide the collection of data to identify the multiple level risks and risk contexts for HIV infection. The model was classified into five level risk which included individual, social and sexual networks, community, and public policy as well as the HIV epidemic Stage (Baral et al., 2013).

Assumptions of the Social-Ecological Model

Individuals are understood to influence, and be influenced by various systems (Bronfenbrenner, 1992; Crosby, Salazar, & DiClemente, 2013). Multiple factors influence health behaviors. The social-ecological model stipulates that factors at multiple levels such as intrapersonal, interpersonal, organizational, community, and public policy, may affect health behaviors (Mc Leroy et al, 1998; Sallis & Owen, 2002; Baral et al, 2013). Therefore, the model encourages us to move beyond individual factors.

Multi-level interventions should be most effective in changing behavior. A direct implication of the ecological model is that single-level interventions are unlikely to have powerful or sustained population-wide effects (Sallis & Owen, 2002). Ecological model is more potent when it is behavior-specific. Ecological model appear most useful to guide research and intervention when it is tailored to specific health behaviors (Sallis & Owen,

2002). Environments are multidimensional and complex, hence the interrelationships between people and their environment are dynamic (Sallis & Owen, 2002).

Application of the Social-Ecological Model

A significant strength of the social-ecological model is the focus on various levels of influence that widens options for interventions (Sallis & Owen, 2002). The Social-ecological model uses a multilevel analysis to examine determinants of health behaviors. Therefore, it is possible to initiate intervention strategies of behavioral change and environmental enhancement on a multilevel approach. On the contrary, the social-ecological model lacks specificity about the most crucial determinant level of behavioral influence (Baral et al., 2013). This puts a higher burden on health promotion professionals to identify critical factors for each behavioral application (Sallis & Owen, 2002). The model also lacks information about how the broader levels of influence operate or how variables interact across levels (Sallis & Owen, 2002).

In the health promotion field, the ecological model has been used to understand and identify targets for both general and specific health behavior interventions (McLeroy, Bibeau, Steckler, & Glanz, 1988; Sallis, Owen, & Fisher, 2008; Stokols, 1996; Winett et al., 1989). The social-ecological models is used to explain the complex associations between social (e.g., social networks) and structural (e.g., access to care) factors, individual practices, the physical environment and health (Baral et al., 2013).

The social ecological model contextualizes individuals' behaviors using dimensions including intrapersonal (e.g., knowledge, attitudes, behavior), interpersonal/network (social networks, social support), community (e.g., relationships among organizations/ institutions), and public policy (e.g., local, state, national laws) to provide a framework for describing the interactions between these levels (Baral et al., 2013).

CHAPTER THREE

LITERATURE REVIEW

Introduction

This chapter focuses on the literature review of the research topic. A literature review is about collecting and analyzing readily available data which is documented by other scholars and data which is relevant to the study. Its purpose is to guide the study, critically analyze the researched data from other scientists, identify gaps in the study and suggest further research on the study. Research objectives guide the literature review of this study.

Individual-Level Risk Factors

General and common risk factors include biological development, lack of education, personal experience, behaviour and personal characteristics (attitude). These factors are understood to be playing a critical role in shaping how an adolescent girl may perceive the risk level of pregnancy. Moswela & Molosiwa (2012), cite lack of education as a significant risk factor among adolescents in the developing world. The authors describe education as a broader aspect that covers some factors that include general academic education that enables adolescents to sharpen their decision-making skills to specific knowledge-based education on the use of contraceptives and sexuality education. Concerning academic education, Botswana Central Statistics Office, (2012) reports that fertility among Batswana women with no formal education is at 5.8 compared to 3.3 among women with secondary education and 2.6 for those with a university education. These indicators reveal the implication of education level on the risk levels of adolescent pregnancy.

Biological development, especially the developments that take place during puberty stage contributes immensely to the incidence of adolescent pregnancy. WHO (2010), reports that at least 65 percent of the adolescents had their debut sexual experiences induced by

puberty developments. The report further states that the puberty stage dramatically affects the self-control of the majority of adolescents, and most of them are lured into sexual relationships. These biological developments constitute a significant risk factor for adolescent pregnancy because most of the boys and girls in the puberty stage do not have adequate knowledge about how to use contraceptives.

On the same subject of biological developments, World Health Organzation and other international health organizations attribute and anticipate a higher risk of adolescent pregnancy in developed countries because of the decreasing menarche age, ranging from about 12 years in contemporary Western countries to just more than 15 years in poor developing countries (WHO, 2013). Pierce & Hardy (2012) argue that;

> 'the mean age of puberty in girls in Western populations has been falling for the last 150 years. Slowing or cessation of this rate of decline in some of these countries since the 1960s suggests that the mean age at puberty is approaching the biological limit'(p. 300).

Individual Protective Factors

Winch (2012), urge that interventions aimed at influencing the behavior or cognitive mind of an adolescent girl may be taken to address these personal factors. Vulis (2015) further recommends that interventions and emphasis must be directed towards influencing teens' personal responsibility and discipline. Other key interventions suggested at the individual level include facilitating and increasing access to educational programmes that sharpens thinking skills as well a personalized counseling to influence personal experience. Remembered personal experience primarily on the negative consequences of adolescent pregnancy is regarded as a likely protective factor (UNFPA, 2013).

The main aim at this level is to cultivate a self-responsible adolescent who makes informed decisions and who has a positive attitude towards good health (UNICEF, 2014). The ISRN Public Health (2012), argues that individual-level interventions must seek to

emphasize the importance of personal health. Thus individuals must fight to protect their good health. Gombachika et al., (2012) also argues that successful interventions at individual level must yield self-regulatory behaviour. This is a form of behaviour that obliges adolescents to set goals for themselves.

Family/Relationship Level Risk Factors

CDC - Social Ecological Model - CRCCP (2017), refer to relationship factors as any social circumstances from immediate members of the family (parents, guardians or any other immediate relatives and closest social circles) that manipulate the decisions, beliefs, and values of any individual regarding their health. Commonly cited risk factors at family level include; paralyzed family relationship, poor parenting and family conflicts (CDC - Social Ecological Model - CRCCP, 2017). These three key factors may set adolescent girls for various health risks. Mkwananzi & Odimegwu (2015), discovered that most pregnant adolescents come from disorganized relational family. A disorganized family fails to set a proper structure that grooms children into caring and responsible adults. Children from such disorganized families are usually involved in main social ills such as sex work, robbery and substance use (UNFPA, 2013).

UNICEF (2014), reports that paralyzed families lack social support. A paralyzed family is described as a social family organization with members failing to discharge their responsible duties (Mkwananzi & Odimegwu, 2015). Such a family can be described by members who are not clear and familiar with their positions and who are ill-disciplined. Moreover, in such a family the parents or guardians may fail to control the children or discipline them in order to groom them into well-mannered adults. In fact adolescents living in such families may fail at all to receive appropriate family support that helps them to protect and be responsible for their health and future.

The aspect of poor family structure and relationships is addressed by Mkwananzi & Odimegwu (2015), as a menace and a disturbing trend in the modern society, where parents no longer have as much time with their children as they may need to. Given such a situation, children stand at a great loss of losing much required parental guide that helps them understand fundamental aspects of life. In such families, adolescent pregnancies are more common because there is more significant possibility that the adolescents may not have received any orientation on sexuality. Conflicting parents may suffer from the same challenge because they do not have time to discuss pertinent issues arising from their children.

Family Protective Interventions

Brindis, Sattley & Mami (2005), recommends among others the following protective interventions at relationship level; imparting skills-based knowledge, building relationships and communication and cultural competence. The interventions at this level seek to engage the relationship members into constructive stances that ensure that adolescents around are not vulnerable to pregnancy. Nsamenang & Tchombe, (2012), assert that family members play a critical role in shaping the values, beliefs, and attitudes of the children growing up in their custodian. It, therefore, translates that the close family members can make an enormous difference if they endeavor to cultivate a cautious mind against pregnancy to adolescents in their custodian.

Peer and dyad level risk factors

Adolescents both in the developing and developed countries are vulnerable to peer-pressure that usually ends up with them indulging in sexual relationships. Albert (2007), notes that many adolescents engage in unhealthy and risky activities just so that their peers will notice them or so that they may fit in. Raneri & Wiemann (2007), report that about 70-80 percent of the first adolescent sexual intimacy experiences, in the US, were indicated to be induced by peer-pressure. Blum & Mmari (2004), have also reported that adolescents who

perceive their friends or peers to be sexually active are more likely to engage in sex themselves hence they are more prone to adolescent pregnancies. Similarly, adolescents are more likely to have sex if they believe their friends have more positive attitudes towards childbearing and have permissive values about sex (Kirby & Lepore, 2007).

According to Carrera (2012), unrestricted interactions with the opposite sex ignite the sparks of lust in adolescents very quickly, especially when alcohol and drugs are involved. This shows that children learn a lot from their peers and as such, peer influence has a greater impact on the behaviour of children and this leads to early pregnancies which result in child marriages (Wang & Hsul, 2003). On the contrary, having a romantic partner increases the chances of sexual activity, however, having an older romantic partner increases them even further (Kirby & Lepore, 2007). Intergenerational sex also lowers the probabilities that contraception will be used hence the increase in the risk of adolescent pregnancy (Kirby & Lepore, 2007).

Peer and dyad protective factors

Blum & Mmari (2004), recommends the formulation and implementation of programmes that target peer norms and influences about sex. Having peers who have positive attitudes towards contraceptive use increases the probability of adolescents using contraceptives. For instance, if teens believe their friends support condom use or use condoms, higher the chances are that they will use condoms themselves (Kirby & Lepore, 2007). Similarly, partner support and approval for using condoms and contraception also appear to be a critical protective factor for adolescent pregnancies.

Community-Societal level Risk Factors

The CDC - Social Ecological Model - CRCCP, (2017) identifies the following factors to be significant influences of adolescent pregnancy; schools, neighborhood, religion, culture.

Several other authors refer to this as the society, which also deals with the national and international community. Culture is cited as a notable factor that induces adolescent pregnancy cases, especially in the African and Asian developing countries (Moswela & Molosiwa, 2012). According to Moswela & Molosiwa (2012), most cultures in developing countries accept adolescent pregnancy in their communities, and it is applauded as a sign of fertility. Some communities in sub-Saharan Africa, often condone or even predispose young people to engage in sexual activity by encouraging early childbearing and male promiscuity and failing to condemn sexual relationships between older men and younger girls (Ntshwarang & Malinga–Musamba, 2015). Evidence from a study conducted by Loaiza & Liang (2013), emphasizes this citing the Zulu culture in South Africa as a typical example.

In Botswana, sex is perceived as a means for reproduction, healing and cleansing, and as a conjugal right which is recognized by law and religion (Ntseane & Preece, 2005). It also enhances social interaction, and it may be used to control and oppress others (Ntseane & Preece, 2005). Related to culture, there are also religions mostly in the developing world that encourages early marriages. Moswela & Molosiwa (2012) and Mkhwanazi, (2010) support the argument referring to religions such as Muslim and Buddhism which are common in the Asian continent and the northern part of Africa (Muslim) as religions that are highly vulnerable to adolescent pregnancies because of their values and beliefs.

Recently, the new technology is believed to necessitating the occurrences of adolescent pregnancy because it exposes the adolescents to information that stimulates sexual appetite (Marteleto, Ranchhod, & Lam, 2008). It is estimated that more than half of the time the adolescents are online, they will be on a site that provides the indecent information such as pornography or so, which influences their sexual desires, thereby increasing the likely occurrence of pregnancies (WHO, 2014).

Community Protective Interventions

Communities should be made safe and supportive since adolescents who live in a safe, supportive communities are less likely to engage in risky sexual behaviours such as the use of drugs, commit crimes and early sexual initiation which may lead to adolescent pregnancy (Terzian et al., 2011). To foster a broad context in support of safe, stable, nurturing relationships and environments, it is helpful to increase positive norms within our communities, thus among individuals, families and peers; workplaces, schools, and community organizations (Linkenbach, 2014).

Institutional risk factors

Beyond the measures adopted and a few best practices identified, current indicators show that adolescent pregnancy and motherhood have not been adequately addressed by the public policies currently in place (Unicef, 2014). Even though there has been progressing with the elaboration of public policies aimed at the prevention of and attention to adolescent pregnancy, policies continue to be insufficient, fragmented, sector-specific rather than integral, and in general, poorly implemented (Unicef, 2014). Also, the social interpretations and cultural meanings of adolescence and sexuality held by families, peers, and social institutions remain attached in traditional structures that continue to reinforce gender inequality and the non-recognition and non-exercise of sexual and reproductive rights (Unicef, 2014).

Institutional protective factors

At the institutional level, the preventative measures are usually implemented through organizational institutions such as; schools, the state, and the international organizations. The major protection tools at this level are policies and curriculum. In schools, the curriculum may be used to influence the attitude of the adolescents to change their mentality towards unwanted health conditions. Macro-environmental institutions such as the nation and the

international organization may craft and enforce policies that promote and protect human rights. This involves advocacy for an age of consent to marriage and the distribution of contraceptives.

Programs and policies seeking to reduce the number of adolescent pregnancies need to take into account marital status and fertility preferences (Psaki, 2015). The majority of adolescent pregnancies occur within marriage; prevention is therefore mostly dependent on effective policies and programs to delay early marriage (Psaki, 2015). Countries with the highest prevalence and numbers of adolescent pregnancies are also those with the highest levels of child marriage, including Niger, Chad, Mali, Bangladesh, and India (Loaiza & Liang 2013).

CHAPTER FOUR

METHODOLOGY

Introduction

This chapter outlines a step-by-step approach to how the data required to satisfy the objectives of this study was collected. The chapter outlines the following: research method, research design, study site, sampling technique, data collection instrument, data quality/ trustworthiness, data analysis, and data management and storage.

Research Method

The researcher adopted a qualitative research design to examine in detail the risk and protective factors of adolescent pregnancy in Letlhakane. The qualitative research attempts to examine experiences and perceptions of people rather than imposing a framework that might distort the ideas of the participants. Thus, qualitative research discovers the meaning people give to their experiences and the way in which they interpret them (Holloway & Galvin, 2016). Therefore, using qualitative approach gave the researcher a comprehensive understanding of the risk and protective factors associated with adolescent pregnancy in Letlhakane according to the way participants described and interpreted them.

Qualitative research method can enable a researcher to gain rich and complex understanding of a specific social phenomenon (Mack, Woodsong, MacQueen, Guest, & Namey, 2005). Denzin and Lincoln (2000), notes that qualitative research involves an exploratory and realistic approach in which qualitative researchers study things in their natural settings, in an attempt to make sense of or to interpret phenomena regarding the meanings people bring to them.

According to Denzin & Lincoln (2000), qualitative research is especially useful in obtaining culturally accurate information about values, opinions, behaviours and social

contexts of a particular population. The advantages of qualitative research are that it allows one to use open-ended questions and probing which gives the participant the opportunity to respond in their words, rather than forcing them to choose from fixed responses (Patton, 2002). A qualitative design explores the study phenomenon and allows the researcher to learn a lot about the area of study. Thus the researcher may adjust the data collection tool if there is need to do so (Babbie, 2008).

Research Design

The research design is exploratory and descriptive. Exploratory research examines what has been studied before in an attempt to identify new information, new insights, and new meanings and to explore factors related to the topic (Brink, Walt, & Rensburg, 2006). An exploratory design allowed the researcher to develop new meanings and insights about the risk and protective factors of adolescent pregnancy. With the exploratory design, the researcher was able to use flexible, open-ended questions that yielded the rich and fully descriptive data that may be critical areas of focus for this study.

The study is also descriptive in the sense that the researcher collected detailed descriptions of the risk and protective factors of adolescent pregnancy. Descriptive studies do not manipulate variables or try to explain relationships between variables (Burns and Grove, 2005). They instead define and describe variables such as respondents' views, needs or other facts to provide a broader understanding of a phenomenon being studied in its natural setting (Brink, Walt, & Rensburg, 2006). Descriptive research provides a detailed representation of certain real-life situations for the purpose of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorizing information (Burns and Grove, 2005).

Study Site/Location

The study was conducted in Letlhakane village. Letlhakane is located in the Central district of Botswana and approximately 567 kilometers away from Gaborone, the capital city of Botswana. The population of the village is 20 841 from the 2011 population census (Botswana Population Census, 2011). A convenience sampling technique was used to select the village because the researcher can easily have access to some of the research participants and is familiar with area of study. Letlhakane was also selected because it is a semi-urban area surrounded by some remote areas of which the rates of adolescent pregnancies are high, and some of the adolescents have migrated to Letlhakane to enroll in junior and secondary schools in Letlhakane.

Study Population

The study focused on adolescent mothers in Letlhakane. However, various stakeholders were engaged and included in the sample. To obtain objectivity in the study, the sample size was biased towards adolescent mothers. Thus adolescent mothers contributed at least 68 percent of the total study sample.

Sampling Technique

The researcher used a non-random sampling technique. Non-random sampling is a sampling technique where the samples are gathered in a process that does not give all the individuals in the population equal chances of being selected (Bernard, 2000). Therefore purposive sampling and snowball sampling techniques were employed. The researcher carefully selected respondents who completed the information requirements for the study.

Purposive sampling technique, also called judgment sampling, is the deliberate choice of an informant due to the qualities the informant possesses (Tongco, 2007). The researcher opted for purposive sampling because participants were chosen on their anticipated ability to

provide meaningful and complete information that fulfilled the research objectives. Thus the researcher decided what needs to be known and sets out to find people who can and are willing to provide the information by knowledge or experience (Tongco, 2007).

Snowball sampling also referred to as chain-referral sampling or referral sampling involves requesting respondents for recommendations of acquaintances who might qualify for participation (Robinson, 2014). Snowball sampling method is particularly appropriate when the population of interest is hard to reach and compiling a list of the respondents poses a challenge for the researcher (Etikan, Alkassim & Abubakar, 2015). For example, snowball sampling is useful when the population being studied is unlikely to respond due to stigmatizing or the sensitive nature of the topic (Robinson, 2014). Snowball sampling was an ideal choice because the researcher was able to get access to adolescent mothers who were difficult to get, especially those who have dropped out of school.

Inclusion Criteria

The study included:

(a) Adolescent mothers aged between 15 and 19.

(b) Adolescents mothers who were willing to participate in the study.

(c) Those who dropped out from primary and secondary schools in Letlhakane due to pregnancy.

Exclusion Criteria

The study excluded:

a) Adolescent mothers below the age of 15 and those above the age of 19.

b) Those who declined to participate in the study.

c) Those who dropped out from primary and secondary schools in Letlhakane due to other reasons besides pregnancy.

Sample size

The qualitative sample must be big enough to assure that the researcher is likely to hear most or all of the perceptions that might be important. The researcher interviewed twenty-five (25) research participants because they provided the resercher with detailed information that fulfilled the research objectives of the study.The researcher purposively sampled eight (8) respondents based on their ability to provide information and because they interact with adolescent mothers. The Key Informants involved in the research were two midwives, a member of the Village Development Committee, Youth Officer, Social Welfare Officer, Guidance and Counselling teacher, Community Development Officer, as well as the Police officer. A sample of 17 adolescent mothers were selected; those who are still schooling and those out of school due to adolescent pregnancy. The researcher selected 17 adolescent mothers because they provided the researcher with meaningful and comprehensive information.

The researcher could not select more respondents since the data did not reveal any new information relating to the research questions. Initially, the researcher intended to interview twenty-two (22) adolescent mothers. However, the sample size was reduced to seventeen (17) after the researcher reached the data saturation point. Data saturation point occurs when the researcher is no longer hearing or seeing new information from the data collection (O'Reilly & Parker, 2012).

Recruitment Process

The recruitment process of adolescent mothers was done through the help of the Key Informants (such as midwives and guidance & counselling teachers). Firstly, the researcher required for permission to access adolescent mothers in schools from the Chief Education Officer at Boteti Sub-district council. Permission was granted and the researcher was given endorsement letters to give to the school principals of all primary, and all secondary schools

in Letlhakane. The researcher approached the school principals to assist with the recruitment of adolescent mothers and was referred to guidance and counselling teachers for assistance. However, there were no adolescent mothers in primary schools, the reseacher only managed to locate one adolescent mother from a junior school and five of them were located from a senior school with the help of guidance and counselling teachers.

The researcher also wanted to have access to out-of-school adolescent mothers and midwives at clinics in Letlhakane. Therefore, the reseacher requested for permission from the head of the District Head Management Team (DHMT) in Letlhakane. The reseacher was given a go ahead, and then approached midwives to help with the recruitment of adolescent mothers. The midwives assisted the researcher to compile a list of contacts for adolescent mothers using their records. From the list, some adolescent mothers were traced in their homes, who in turn, through snowball sampling, led me to other adolescent mothers. For each person listed and contacted, the researcher then explained to the adolescent mothers the nature of the study and requested for their voluntary participation in the study.

Data Collection Instrument

The researcher collected qualitative data, which was in the form of the respondents' tales of their situations. Thus, the data collected was in the form of people's lived experiences and their inner perceptions, attitudes, and feelings of reality. Data gathering process involved written records, visual observation, and interpretation of emotions and perceptions.

Semi-structured interviews with adolescent mothers

The researcher used semi-structured in the form of open-ended and close-ended questions to obtain information from out-of-school adolescent mothers. Semi-structured interviews are those in-depth interviews where the respondents have to answer preset open-ended questions (Jamshed, 2014). A semi structured approach with open ended questions was

preferred because it allowed the resercher to alter the sequence of the questions at any time hence more probing for information. In a semi-structured interview setting, the researcher develops a rapport with the respondents so that the respondents may feel comfortable to explain and express themselves comfortably, thus allowing the researcher to obtain detailed data from each one of the interviewees (Alshenqueeti, 2014).

Semi-structured interviews with the Key informants

The researcher also conducted semi-structured interviews to collect data from the Key Informants. Semi-structured interviews allow in-depth information to be achieved by giving the researcher an opportunity to probe and expand the interviewee's responses (Rubin & Rubin, 2005). When undertaking such interviews, it is recommended that the researcher use a basic checklist that would help in covering all relevant areas (Alshenqeeti, 2014).

Focus Group Discussions

The researcher used a focus group discussion with the aid of a focus group discussion guide to collect data from adolescent mothers in school. A focus group is a group comprised of about 5-10 individuals with shared characteristics whose focus is to discuss a given issue or topic (Dilshad & Latif, 2013). The researcher formulated a focus group discussion comprising of six (6) adolescent mothers from Letlhakane secondary schools with ages ranging from 15-19 years. According to Casey and Krueger (2000), a focus group provides a more natural environment than that of the individual interview because participants are influencing and influenced by one another, just as they are in their everyday lives. Focus group also yields rich and detailed data as it stimulates discussions and respondents influence one another through commenting or contributing to the discussion (Dilshad & Latif, 2013).

Document Reviews

A literature review is a way of collecting data by examining existing documents (Evaluation briefs, 2009). According to Payne and Payne (2004), as cited in (Mogalakwe, 2006), a documentary method is described as the techniques used to categorize, investigate, interpret and identify the limitations of natural sources, most commonly written documents whether in the private or public domain. The researcher sought permission to access documents related to adolescent pregnancy such as official reports, and publication reports from the Key Informants (like the Police officer, and midwives), as well as statistical reports from clinics and schools about students who dropped out of school due to pregnancy.

Recording of Data

The researcher used digital voice recording gadget to record interviews after obtaining the consent to use such a device from the participants. Nonetheless, the researcher also used a notebook for recording the main points during discussions with the participants as a backup to the audio files of the interviews. Informed consent was obtained through written consent forms that were read and signed by participants before recording interviews.

Data Management and Storage

The written scripts and tapes that contain the findings of the study were stored in a lockable cabinet which was only accessible to authorized personnel. A password was used to protect information stored on the computers. The research data collected was destroyed after the research report has been completed and submitted.

Pre-Testing the Research Instrument

A pre-test or pilot study is a small-scale trial of the data collection instrument to determine the clarity of questions and whether the instrument elicits the desired information (Polit & Beck, 2004). To ensure credibility of the study, the researcher conducted a pre-test

interview with a sample of 8 Adolescent mothers with similar attributes in Rakops Village. The pilot study assisted the researcher to refine the research tool and to determine the suitability and credibility of the whole research methodology. The pilot study also helped the researcher to check the clarity of questions and identify ambiguous questions.

Data Analysis

Thematic analysis was used to analyze data. Using thematic anlysis method helped the researcher to discover and describe new themes on the risk and protective factors for adolescent pregnancy.

Historical background of Thematic Analysis

Thematic analysis was first introduced by the physicist, philosopher, and historian of science, Gerald Holton in the 1970s (Boyatzis, 1998). It was often changeable and inconsistently used. However, Boyatzis (1998) proposed an excellent specification and guidelines which focused on coding and theme development that moved away from the embrace of grounded theory. In 2006, Braun and Clarke proposed a theoretically flexible approach to thematic analysis which increased its popularity and usage.

Ethical Considerations

Permission for the study/ Ethical clearance

The research proposal was submitted to the University of Botswana Office of Research and Development which gave the researcher an ethical approval. After permission was granted, the researcher went further to seek for a research permit from the Ministry of Local Government and Rural Development. Before undertaking the study, the researcher ensured that the proposal has been reviewed at the Ministry by the board and endorsed accordingly.

Voluntary participation

The principle of voluntary participation requires that people shall not be coerced into participating in research (Dodd, 2003; Fouka & Marianna, 2011).The research participants of this study were given an opportunity to freely agree to participate in the study without force/coercion. Research participants were also given full disclosure of the nature of the study to enable them make informed choices of whether to participate in the study or not. The researcher explained to the participants what the study is all about in a language they understand, afterwards the participants were asked if they are willing to participate and their decision was respected. In addition, research participants were made aware of their right to refuse participation at any time, including withdrawal from the research study at any stage and they were not given impression that they are obligated to participate.

Informed consent

Informed consent means that a person knowingly, voluntarily and intelligently, and in a clear and manifest way gives his/her consent (Fouka and Marianna, 2011). The researcher issued an informed consent form that each research participant read and signed before the beginning of the interview, and by doing so participants indicated that they have understood the form and agreed to participate.

Logically some of the adolescent participants were below the age of 18 years which is the legal age of consent. For these participants the researcher sought for the consent of the guardians on behalf of the participant. The interview only commenced when the consent form had been signed by both the respondent and the researcher.

Beneficence/ Freedom from harm

The ethical principle of beneficence refers to the Hippocratic "be of benefit, do no harm'' (Fouka & Marianna, 2011). A researcher conducting research should ensure that any

risk of harm to study subjects is reduced to a minimum and that there is a balance between risks and benefits (Polit and Beck, 2008). Since the study is about adolescent pregnancy which is a sensitive topic surrounded by social stigma, and for some of the participants it could arouse some emotional issues or psychological discomfort. The researcher organised counseling sessions in case whereby a research participant experiences psychological discomfort during or after the interview. However, there were no such cases.

Respect for anonymity and confidentiality

The anonymity and privacy of research participants should be respected, and personal information relating to participants should be kept confidential and secure. Where possible, threats to the confidentiality and anonymity of research data should be anticipated by researchers and normally the identities and research records of participants should be kept confidential, whether or not an explicit pledge of confidentiality has been given (Polit and Beck, 2008). The researcher kept the written scripts and tapes that contained research records of participants in a lockable cabinet which was only be accessible to researcher. The names of the respondents remained anonymous as they were not written in the research findings.

Limitations of the Study

The study is cross-sectional in nature. This means that data was only collected at a single time period on a selected sample therefore predictions cannot be made about the incidence (frequency/ occurrence) of the risk and protective factors associated with adolescent pregnancy in Letlhakane.

The study was only limited to government primary and secondary schools in Letlhakane village due to time and financial constraints. The researcher was not be able to go beyond Letlhakane village. Therefore the results and conclusions of the findings are localized, they cannot apply to other adolescent girls in other areas in Botswana.

The study lacks objectivity, in the sense that it is based on subjective experiences. Participants were sharing their knowledge and experiences; however since adolescent pregnancy is a sensitive topic and it is associated with social stigma, some adolescents were uncomfortable with opening up about their experiences, they gave answers that are seen as culturally or socially accepted.

Dissemination of Data/ Research Findings

The research findings or data from the study will be disseminated through the following;

Publication of the research study: The researcher plans on publishing the research paper on one of the international journals to add value to the existing body of knowledge. Copies of the dissertation will also be printed and submitted at the department of Social Work, the DHMT at Letlhakane as well as the Ministry of Local Government and Rural Development.

Community forum: The researcher plans to disseminate data through local Kgotla meetings at Letlhakane targeting members of the community.

Seminar: The researcher plans to host a seminar at Letlhakane, whereby it will be a discussion of the research findings among various stakeholders such as social workers, nurses, midwives, and teachers.

CHAPTER FIVE

PRESENTATION AND DISCUSSION OF FINDINGS

Introduction

This chapter aims to present and discuss the findings of the study on the risk and protective factors for adolescent pregnancy among adolescents girls in Letlhakane village. The study explored these factors at individual, family, peer and dyad, community as well as institutional levels. The research findings have been organised to highlight the objectives of the study, as well as presenting social and demographic data of the respondents included in the research.

Data presented in this chapter include results from 8 Key Informants from the village (2 Midwives; 1 Village Development Committee member; 1 Social Welfare Officer; 1 Community Development Officer; 1 Youth Officer; 1 Guidance and Counselling teacher; and 1 Police officer) and 6 adolescent mothers both from senior and junior secondary school as well as 11 adolescent mothers who dropped out of school. Twenty-five (25) respondents participated in the interviews which were conducted using an interview guide and focused group discussion guide that contained semi-structured questions. The objectives of the study included: To explore the community, institutional, family, peer, dyad-level individual-level risk and protective factors associated with adolescent pregnancy in Letlhakane and to explore the relationship between the various level factors in adolescent pregnancy.

For clarity and presentation of the research data and findings, the researcher used representative symbols instead of individual names. For the Key Informants, the researcher used KIs, and for adolescent mothers in a focus group discussion, the researcher used FDG 1 to FDG 6. The word “adolescent mother,” was used to represent out-of-school adolescent mothers instead of using symbols or individual names.

Data Analysis Process

Thematic analysis was used to analyze data because the purpose of this study was to explore emerging (new) themes on risk and protective factors for adolescent pregnancy. Using thematic anlysis method helped the researcher to identify, analyse, organize, describe, and report themes found within a data set (Braun & Clarke, 2006). Thematic analysis is one that looks at all the data to identify the common issues that repeat, and determine the central themes that summarize all the views that are collected (Braun & Clarke, 2006).

Step by Step Approach to Thematic Analysis

Transcribing and data familiarization

The first step of the thematic analysis was to transcribe the data. The researcher puts the recordings of the interviews done with the Key Informants and adolescent mothers into written format. Some of the interviews were conducted in Setswana language, therefore, they were transcibed into English language word for word. The researcher transcribed all the interviews and read them several times to obtain the sense of the whole content. It is vital that researchers immerse themselves in the data to the extent that they are familiar with the depth and breadth of the content (Braun & Clarke, 2006). Immersion usually involves repeated reading of the data; reading the data actively searching for meanings, patterns and so on (Braun & Clarke, 2006). The researcher ensured that the transcript retained the information needed, from the verbal account, and in a way which is true to its original nature.

Coding

The second stage involved the initial production of codes from the data. Coding is the organization of raw data into conceptual categories. In this study, transcripts were interpreted and the meanings were grouped into categories so as to develop themes. Categories were formulated using the social ecological framework. The transripts were analysed and organized into individual, family, peer and dyad, community, and institutional level so as to

develop themes about risk and protective factors of adolescent pregnancy. The transcripts were also grouped according the responses of the participants, e.g. views of adolescent mothers within school, KIs, and adolescent mothers out-of-school were each grouped separately and quotations were used to support the data. It is important to code the responses by staying close to the original words of the respondents (Krueger, 2002).

Searching for themes

This phase, which re-focuses the analysis at the broader level of themes, rather than codes, involves sorting the different codes into potential themes, and collating all the relevant coded data extracts within the identified themes (Braun & Clarke, 2006). In this stage, themes were identified from each category and quotations from the repondents were used to ensure trustworthiness of the data.

Defining and naming themes

Defining and naming themes means identifying the essence of what each theme is about (as well as the themes overall), and determining what aspect of the data each theme captures (Vaismoradi, Turunen, & Bondas, 2013). It is significant not to try and get a theme to do too much or be diverse and complex (Braun & Clarke, 2006). Themes were clearly defined and named according to each level of the social ecological model and this helped the researcher to get an understanding of the factors contributing to adolescent pregnancy and to report the findings of the study.

Rigor/ Trustworthiness of the Qualitative Study

Trustworthiness is referred to methodological accuracy (soundness) and adequacy of the research inquiry (Holloway & Wheeler, 2002). Guba & Lincoln (1985), proposed four principles to ensure trustworthiness of qualitative data and the principles include credibility, transferability, dependability and confirmability.

Credibility

Credibility is about establishing that the results of the research are believable (Moon, 2016). Credibility establishes whether or not the research findings represent believable information drawn from the respondents' original data and is a correct interpretation of the participants' original views (Graneheim & Lundman, 2004; Lincoln & Guba, 1985). Triangulation of sources was done to enhance the credibility of the data collection and analysis. Triangulation refers to gathering and anlyzing data from more than one source to gain a deeper understanding of the situation being investigated (Lacey & Luff, 2007). For instance, in this study, different sources were used to collect data, and data was crosschecked by repeating the same questions with different respondents and comparing the answers.

Transferability

Transferability refers to the degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents (Bitsch, 2005; Tobin & Begley, 2004). Thick description was done to ensure transferability. Thick description refers to detailed description of the population studied by providing descriptions of demographic and geographic boundaries of the study (Pandey & Patnaik, 2014). The characteristics of the repondents, contexts, and settings, data collection and analysis methods in the study are described clearly to ensure transferability.

Dependability

Dependability refers to the consistency of research findings over time and the degree to which research procedures are documented, allowing someone outside the research to follow, audit and critique the research process (Bitsch, 2005; Moon et al., 2016). To ensure dependability, the researcher described in detail how data was collected, how categories were derived, and ensured that there is justification for every decision made throughout the study. This provided an opprtunity for other researchers (my supervisors) to challenge the process

and findings of the study (Pandey & Patnaik, 2014). Feedback from my supervisors led to development of stronger and better articulated findings.

Confirmability

Confirmability refers to the degree to which the results of the study could be confirmed or supported by other researchers (Moon et al., 2016). Confirmability is about establishing that data and interpretations of the findings are not fabrications of the researcher's imagination, but rather are clearly acquired from the data (Tobin & Begley, 2004). Confirmability of this study was achieved by checking if the research findings of this study are supported by the existing research findings and making reference to what is reported by other scholars.

Socio-demographic data on Key Informants

The eight KIs involved in the research were drawn from different sectors operating in Letlhakane village such as health workers (two midwives), a member of the Village Development Committee, Youth Officer, Social Welfare Officer, Community Development Officer, Guidance And Counselling Teacher as well as the law enforcement (a Police Officer). All these are members of the society who are directly or indirectly responsible for the well being of adolescent girls in the village. Respondents were three men and five women and all above 25 years of age. Some of the KIs were married while others were single and their education levels ranged from certificate to the first-degree level.

Socio-demographic data on Adolescent mothers in School

The resercher had a focus group discussion with six adolescent mothers within school. Respondents in this category were adolescent girls aged between 17 years and 19 years old. There was one 17-year-old respondent from this category, two girls aged 18 and three aged 19 years. The adolescent girls each have a child and are enrolled in school. Five of the

respondents are from senior school, while one is still in junior secondary school. They participated in a focus group discussion with the researcher.

Socio-demographic data on Out-Of-School Adolescent Mothers

The researcher conducted one-on-one in-depth interviews with eleven out-of-school adolescent mothers. Six out of the eleven respondents were pregnant at the time of the interview, while one had a four months old child. Three of the respondents have one grown-up child each, and only one had two children at the time of interview. The youngest in this category was aged 16 years old, and the oldest was 19 years old at the time of the interview. One was 16 years old while three of them were 17 years old. Another three respondents were 18 years old each and 4 were 19-year-old girls. Five of the respondents dropped out of school at a primary level, two at the junior level and four dropped out at a senior level. To examine the risks and protective factors associated with adolescent pregnancy among adolescent girls in Letlhakane, the researcher adopted the social-ecological model as the theoretical framework for data analysis. The social-ecological model helped the researcher to investigate these factors beyond the individual level.

Individual-level risk Factors

Individual risk factors are biological or behavioural characteristics (such as knowledge, awareness, attitudes, beliefs and personality) associated with vulnerability to getting pregnant (Baral et al., 2013). For example, in this study, lack of knowledge about sexuality and the use of contraceptives, and non-utilization of contraceptives are the individual risk factors identified among adolescent girls in Letlhakane.

Lack of knowledge about sexuality and the use of contraceptives

During the interviews, both in school and out-of-school adolescent mothers were asked about their knowledge on sexuality and the use of contraceptives, and they reported

that most adolescent girls do not have sufficient knowledge about their sexual reproductive health and often rely on their peers to get information on sexuality. Majority of the participants also indicated that education on sexuality is limited. Most adolescent mothers in school reported that they get to learn about the use of contraceptives in schools, whereas others only have to learn about contraceptives in clinics after they have had their first child. When asked about their knowledge of the use of contraceptives, FGD 6 responded by saying:

> I did not know how to use contraceptives such as contraceptive pills and injection. I heard of rumours from my friends that one can use them only after giving birth. Later on, when I was pregnant, I attended antenatal care classes at the clinic where I learned about such contraceptives and how they work.

Out-of-school adolescent mothers in Letlhakane were the worst affected because they reported that they get information on sexuality through rumors and peers and relied on their sexual partners to use condoms during sexual intercourse. One adolescent mother stated that:

> In our culture, parents do not educate us about sex and the use of contraceptives. Therefore, I do not have much information about contraceptives, I am only aware of condoms of which I rely on my partner to use them during sexual intercourse.

The KIs also agreed that lack of knowledge about sexuality and the use of contraceptives among adolescent girls in Letlhakane is one of the contributing factors associated with adolescent pregnancy. They further explained that lack of knowledge among adolescent girls has been due to the failure of parents to educate their children about sex and contraceptives. Usually, sex education from parents is often limited and focused more on the curative than the preventative approach. For instance, most of the adolescent girls learnt about contraceptives when they were pregnant or when parents realized their children have started having sex. During the interview, the KI mentioned that:

> Most adolescents are not aware of the use of contraceptives because parents are not open about sex education. They (parents) only talk about sexual activities when a girl-child has started menstruation, and when they realize she is pregnant, or she has started dating.

The KIs blamed parents for not educating adolescent about the use of contraceptives. They also felt parental education on sexuality issues is limited.

From the data collected, adolescents in Letlhakane village are not well aware of their sexual reproductive health, as well as the dangers associated with childbearing at a tender age. They realize the importance of using the contraceptive methods after going through the pains of the childbearing process. The lack of knowledge makes adolescents be vulnerable to unsafe reproductive health behaviour and inappropriate choices such as having unprotected sexual intercourse which may lead to unplanned pregnancies and Sexually Transmitted Infections (Kyilleh, Tabong, & Konlaan, 2018).

Most of the studies conducted in developing countries report that adolescent girls often lack basic knowledge about sexual reproductive health (Munthali & Chimbiri, 2003). A study conducted in Eastern Uganda about teenager's views on adolescent pregnancy reported that both in-school and out-of-school adolescent girls indicated that they lacked comprehensive knowledge about their sexuality and information on the use of contraceptives. The study also indicated that out-of-school adolescents were worst affected because they reported getting sexuality information through rumors (Sekiwunga & Whyte, 2009).

In most African cultures, parents do not educate adolescents about contraceptive use because they believe that adolescents have to wait until marriage for them to have sex (Wamoyi et al., 2010; Mudhovozi & Ramarumo, 2012). The most common source of information regarding sexual matters and contraceptives for adolescent girls in Letlhakane is their peers. However, the information that adolescents get from their peers may be misleading or misguided. As a result, male partners may take advantage of the information lapse and emphasize ideas of female readiness and male sexual entitlement (Jewkes et al., 2001).

Non-utilization of contraceptives

Some adolescent mothers especially those in schools were knowledgeable about the use of contraceptives, but, were not using them. Out of nine respondents who had adequate information about contraceptives, only three were using them. Despite having adequate knowledge about the use of contraceptives, six teenage mothers were not using them (especially pills and injection) because of myths they know about contraceptives, fear of what the parents would say, and lack of decision-making power to negotiate for safer sexual intercourse. The following statements were made during the interviews:

> [Adolescent mother] I am currently not using any contraceptive because I am scared of using them. I have heard people say that they cause barrenness. It may be difficult to conceive.
>
> [FDG 2] I am aware of contraceptives. However, I am not using them because I am scared of what my parents would say when they realize I have started using contraceptives and the fact that I have started having sex.

The above statements suggest that the adolescent mother was not using any contraceptive due to myths she has heard from people while FDG 2 was also not using any contraceptive because of fear of parents' disapproval to use contraceptives.

On the other hand, some KIs believed that some adolescent girls know of the importance of contraceptives and the different methods of avoiding pregnancy. They reported that there had been many teachings about sex and the use of contraceptives in junior and secondary schools. However, some adolescent girls fail to use contraceptives because of ignorance, and failure to negotiate with their sexual partners to use contraception (condoms) as a way of pleasing their partners.

It was noted in the data presented that adolescent girls in Letlhakane village are reluctant to use the available contraceptive methods, even those who acknowledged to being aware of the availability and importance of contraceptives. There are myths in Letlhakane village according to the data that was collected about different contraceptive methods.

Learning from the data collected, girls in the village believe rumors that use of some contraceptive methods can result in barrenness. Adolescent mothers also believe that some contraceptive methods like injection and the pill can help one avoid pregnancy, but when the time comes for one to have a child, the body tends to get used to the patterns and women often face problems to do so.

The government of Botswana has launched awareness campaigns to educate the youth about the truth behind modern contraceptive methods. Despite the availability of programmes aimed at dispelling the myth, it is still an impediment to the use of different contraceptive methods in the country. It should be noted that this is not endemic to Letlhakane or Botswana only, this myth is a worldwide one. Similar beliefs have also been observed among adolescent girls in Latino communities, Ghana, Nigeria, as well as Malawi (Biggs et al., 2010).

Adolescent girls in Letlhakane have also shown hesitancy to use contraceptives due to fear that parents would find out that one is sexually active and they would negatively respond to that. Similar findings are reported in a study by (Aparicio, Pecukonis, & Zhou, 2014), which indicated that even though contraception has a well-documented ability to prevent pregnancy, most Latino teenagers are not using contraceptive due to fear of parents finding out. According to the data collected, most parents in the village feel contraceptive methods are for adults as they are likely to be in serious relationship or marriage and they do not encourage adolescent girls to use contraceptives. Therefore, adolescent girls choose not to use contraceptives because they do not want to be seen as sexually immoral by their parents.

Another mentioned reason for non-use of contraceptives from the data collected has also been lack of girls' bargaining power for safer sex. It is a patriarchal cultural arrangement in the village that has seen women feel powerless when it comes to negotiating for safer sex

with their male partners. According to Nkosana and Nkosana (2017), men usually retain control of decisions concerning sexual activity in most African societies, such as the frequency and use of contraception. For instance, in Botswana women are not expected to play an active role in sexual intercourse (Nkosana & Nkosana, 2017). Therefore, adolescent girls in Letlhakane village find themselves at the receiving end of sexual decisions, and for the sake of saving the relationship they tend to have no choice but to succumb to what the men decide.

This patriarchal arrangement in many decision-making spheres of the society is not peculiar to Letlhakane only. Most women, more especially in developing countries find themselves chained by the patriarchal arrangements which are embedded in culture and are not easy to break. According to Ngome (2016), a study conducted in Botswana by Marandu and Chamme points to the realization that men seemed to have a greater tendency to agree with beliefs that encourage non-use of a condom during sexual intercourse. Therefore, in a society where men are already empowered over women, it becomes very difficult for women to alter a man's decision in any sphere of life including issues to do with sexuality.

Individual-level protective factors

Individual-level protective factors are interventions or strategies that help adolescents to prevent adolescent pregnancy. These interventions focus on empowering adolescents through efforts such as those that build the economic and social assets as well as the resources of the adolescents (Svanemyr et al., 2014). For instance, retention of adolescent girls in schools and educating them about sex and the use of contraceptives helps them to have the knowledge and the ability to make informed decisions to practice safer sex in an intimate relationship hence decreasing the chances of being pregnant. In this study, adolescent girls are encouraged to educate themselves about contraceptives and to utilize them to prevent adolescent pregnancy.

Use of contraceptives

When asked of ways in which adolescent girls can avoid adolescent pregnancy, both in school and out of school adolescent mothers suggested that adolescent girls should learn more about contraceptives from an early age and how to use them. Participants also indicated that adolescent girls have an important role in gathering information from parents, nurses, or teachers to ensure that they are well informed and they can make the right decisions concerning their sexual lives. In light of this, FGD 3 suggested that:

> Adolescents should abstain from sexual practices, and if they cannot abstain, they should use contraceptives. Nowadays you find that the majority of adolescents are involved in sexual practices. Therefore, they should engage in protected sexual intercourse.

One adolescent mother also stated that:

> Adolescent girls should visit clinics or the hospital in order to have access to information about the use of contraceptives and stop relying on friends for information.

The above statements indicates that adolescent mothers felt girls should take the responsibility of acquiring information on contraceptives from the clinics instead of relying on friends for information. They also recommended that adolescent girls should use contraceptives to avoid engaging in risky sexual behaviours.

On the contrary, some of the KIs felt that there have been many education on sex and the use of contraceptives especially for adolescent girls in schools. However, adolescents were reported to be ignorant of the SRH information they have. Despite this realization, they disbelieved they should continue educating adolescents about the use of contraceptives and also to conduct community outreach campaigns which involve educating parents so that parents can be empowered enough to educate their children. One KI reported that:

> There has been a great deal of teaching that informs adolescents about sex and contraceptives. However, it seems like the information is not reaching everyone because adolescent girls are still getting pregnant in large numbers. Therefore we

have to conduct community outreach to raise awareness about the use of contraceptives among adolescent girls.

Some of the KIs felt that adolescent girls in schools were knowledgeable about the use of contraceptives and chose to be ignorant of the information they had, even though the numbers of adolescent pregnancy were still increasing. Nonetheless, they suggested that there should be more awareness campaigns to disseminate information about the use of contraceptives.

In Botswana, the youngest age an individual can access contraceptive services and commodities is 10 years without parental consent and without charge (Tshitenge, Nlisi, Setlhare, & Ogundipe, 2018). However, the country still has some concerns about the use of contraceptives by adolescents (Tshitenge et al., 2018). For instance, in this study adolescent girls are not utilizing contraceptives due to lack of comprehensive knowledge on the use of contraceptives, myths they have heard about contraceptives, and fear of parents' disapproval to use contraceptives.

For the fact that most of the respondents either have part information or were completely unaware shows how much the village needs wide information dissemination campaigns to sensitize the adolescents in the village about the use of contraceptive methods. Adolescent girls should be given easy and confidential access to family planning services through health centres, school-linked health centres so that they may utilize contraceptives freely to prevent unplanned pregnancies.

Family-level risk factors

Family level risk factors include the risky sexual behaviours that are directly or indirectly influenced by family (parents or siblings) which contribute to adolescent pregnancy. For example, an adolescent girl can be forced to engage in commercial sex work in order to provide for her family due to poverty at home. From the ecological perspective, the family is located within the adolescent's microsystem (the immediate environment that influences

one's development), and theoretically exerts a strong influence over their sexual reproductive health (Salazar, et al., 2010). In this study, lack of parental involvement/ guidance and lack of education on sexuality emerged as significant themes.

Lack of parental involvement/ guidance

Adolescent mothers agreed that most of the parents are not fully involved in their children's lives including their sexual lives. FGD 4 explained that:

> Some families are not involved in the lives of their children. For instance, a parent can go out in the morning and come back at night and he/she would not know what the child has eaten or done during the day. This may give the child an opportunity to engage in intimate relationships and have sex without the parents' knowledge, hence they become pregnant.

Parents were blamed for their negligence and sometimes some of them encouraged their children to engage in sexual activities for financial gain. The respondents explained that some parents encouraged their children to engage in sexual activities so that they can financially benefit from their partners especially the ones who can give them money. In so doing they give little or no regard to whether their daughter falls pregnant or not. One adolescent mother noted that:

> Some parents encourage their children to engage in intimate relationships with older men especially when the man is rich so that the man can provide for the family (buying food), and in the end, children end become pregnant.

Some of the respondents reported that at times parents let their teenage daughters stay on their own out of the parents' house. They do not mind if she is staying with a man or not. One adolescent mother explained that she was staying with her boyfriend at the time of the interview and that the parents did not have a problem with that.

The KIs had some issues to raise on the contributions of the family to adolescent pregnancy in Letlhakane village. However, coming out frequently among the respondents was lack of involvement of the family members in issues to do with sexuality and upbringing

of their daughters. The respondents mentioned that some parents have poor parental skills; they tend to go out for parties and drink alcohol and they are always absent from home which gives the child freedom to engage in intimate relationships. One KI elaborated on this by saying:

> Parents like parties and going out to drink alcohol and they do not care about the well-being of their child. They leave children alone or in care of the domestic workers. Then the child does not have anyone to confide in, to guide and support her. As a result, they end up engaging in intimate relationships and becoming prone to STI's and teenage pregnancy.

The KIs also felt that some parents are negligent in that they do not report defilement cases to the relevant authorities and this makes it a normal thing in the village. The KI expressed that:

> They [parents] do play a role because some parents do not report cases of defilement. They are fine with their children dating older men, especially when the man has money, and he is helping out in the family. They also accept the man as the husband to their child, and they do not have a problem when the child is staying with the man instead of staying with the parents.

From the data collected, there is a problem in the village for parents not being fully involved in the sexual lives of their children. From the data collected, it shows that parents (mothers) are mostly concerned with the onset of menstruation. After that, girls tend to be on their own exploring their sexuality and learning more from friends and other people in the village. Currently, in the modern society, many parents dedicate the greater part of their day finding money to take care of their families and they do not have time to take care of their children (Omozusi and Moyosore, 2016). Children growing up in such families lack parental guidance and support, therefore, they are more likely to engage in risky sexual behaviours and fall into the trap of adolescent pregnancy. Gone are those days when parents were dedicated in the raising up of their children, protecting them from disgrace and preventing any activity that will destroy their future (Omozusi and Moyosore, 2016).

Moreover, there is also a realization that most of what could qualify as defilement cases are not reported to the relevant authorities by parents of the sexually abused children. As a result, older men in the village tend to have sexual intercourse with adolescent girls and quite often impregnate adolescent girls and they are able to get away with it due to the parents' silence. Failure to report defilement cases is due to cultural or moral condemnation attached to unplanned adolescent pregnancy, family embarrassment or due to financial prospects of the person involved (Sekiwunga & Whyte, 2009). This, in the long run, tends to make the behaviour normal and men are not afraid of sexually abusing these young girls.

The silence of parents was coupled with what is regarded as weak punishment of the perpetrators who are reported, tends to intensify adolescent pregnancy in the village. These findings are consistent with the results of the study conducted in Eastern Uganda, where by adolescents reported that many parents and guardians were not applying the existing law of defilement because they decided to settle the issue with the person who impregnated the girl instead of involving the relevant authorities (Sekiwunga & Whyte, 2009). Parents also believed that sending such culprits to the police was useless because they bribed their way out and went unpunished. According to Sekiwunga and Whyte (2009), parents and guardians asked for money in compensation for the school fees spent on the girl and then allowed the man to marry her.

Lack of education on sexuality

Lack of education on sexuality emerged during the interviews with adolescent mothers and was cited as one of the factors contributing to adolescent pregnancy in Letlhakane. Parents were described as being uncomfortable talking about sex and the use of contraceptives with their children. It was said that most parents regarded talking about sex with their children as a taboo. Therefore they were not able to give education about sex or

sexuality issues. It was also revealed that parents are mostly concerned with the onset of menstruation and is the only time they give advice. FGD 1 reported this by saying:

> Some parents do not advise their children about contraceptives and sexual intercourse. They only advise their daughters not to engage in a sexual encounter after the onset of menstruation to avoid pregnancy, and in most cases, children do not listen to this.

Adolescent mothers reported that parents are not able to discuss sexuality issues with their children, and that the responsibility is left with the nurses and school teachers.

The KIs also pointed out that there is general lack of knowledge and skills on education about sexuality among most of the parents in the village which makes parents unable to provide proper guidance to their children. They also agreed that most of the parents are not comfortable to talk about sexuality issues with their children which makes the children learn sexuality issues from their friends and their intimate partners where they can easily be misguided. The KI indicated that:

> Parents are uncomfortable to talk about issues relating to sex and pregnancy. They believe it is disrespectful and a taboo to discuss sex with children. Even when we grew up, we had to learn about sex on our own, and nowadays adolescents learn from friends, or they get an education on sexuality at schools. However, the first role model for the child is the parent.

The KIs felt parents were not educating their children about the use of contraceptives and it is has become more of a norm as education on sex is regarded as taboo.

Data presented revealed that parents are uncomfortable discussing sexuality issues with their children and often relegate the responsibility to nurses and school teachers. Similarly, a study conducted in Botswana reported that parents tend to be reluctant to initiate discussions about sexual matters with their adolescents and often relegated that responsibility to school teachers and relatives such as aunts (Magowe, Seloilwe, & Dithole, 2017). Culturally, aunts have played the role of educating adolescent girls on sexuality. However,

they no longer play their role due to increased modernization and urbanization (Ministry of Health and Child Care, 2016).

Parents are expected to educate their children on such matters. However, most parents feel uncomfortable to discuss sexuality issues with their children and nowadays they relegate that responsibility to school teachers. Adolescent mothers in Letlhakane expressed that parent-child communication about sexual matters was limited and the only time parents initiated sexual discussions was during the onset of the girl child's menarche or when they realize she is pregnant or she is sexually active.

Furthermore, most parents often assume that their children are innocent and ignorant about sexual matters and they are often reluctant to initiate sexual discussions with their children at an early age. As a result, parents tend to believe that if they introduced sexuality related discussions, they will be encouraging their children to engage in sex (Seif & Kohi, 2014; Yadeta et al., 2014; Magowe et al., 2017). However, empirical evidence indicates that if adolescents are allowed early and complete access to sexual reproductive health education, they are more likely to take fewer risks when they eventually initiate sexual activity (Muhwezi et al., 2015).

Moreover, from the data collected, it has also been noted that parents are not well conversant on sexuality issues and they cannot properly advise and direct their children. Parents in Sub-Saharan Africa argue that they are not comfortable discussing sexuality-related issues with their children because they lack an appropriate language, information and skills to communicate effectively on sexual matters (Muhwezi et al., 2015). These observations are consistent with findings from a study done in Namibia, particularly mentioned was that parents do not participate in the sexuality education of their children

because they perceive themselves as being unable to provide quality and adequate sexuality information (Lukolo & Van-Dyk, 2014).

It has been argued that parent-child communication on sexual matters tend to be authoritarian and vague with parents often overwhelmed as they do not know how to provide sexuality education and instead of promoting healthy and meaningful discussions, children are often left more confused (Pfeiffer, Ahorlu, Alba, & Obrist, 2017). Thus, many parents feel incompetent, inadequate and ill-prepared, either factually, emotionally or both, to teach their children about sexual development, sexual relations and reproductive health with all its physical, social and ethical implications and consequences (Lukolo & Van Dyk, 2015).

Family-level protective factors

At the family level, there is a need to build relationships that support and reinforce positive health behaviours of adolescents (Svanemyr et al., 2014). Therefore interventions at the family level target close relationships which have an influence over the sexual reproductive health of adolescents. Family protective factors identified in this study include provision of parental guidance and provision of education on sexuality.

Provision of parental guidance

Both in school and out-of-school adolescent mothers pointed out that provision of parental guidance or involvement of parents in the sex life of their children is one way in which families could reduce adolescent pregnancies in the village. They further explained that parents should be the ones who guide, monitors and provide parental supervision so that their children are not easily misguided by friends or given incorrect information about sexuality by other people. FDG 1 suggested that:

> Parents should mould the behaviour and conduct of their children. They (parents) should monitor their child's behaviour and be able to teach them what is right or wrong so that adolescents do not become susceptible to risky sexual behaviours.

Adolescent mothers proposed that parents should be role models to their children, and to supervise the behaviour of their children and guide them so that they are not prone to risky sexual behaviours at an early age.

Similarly, KIs also agreed that parents should provide parental supervision or guidance to their children in order to tackle the issue of adolescent pregnancy. They further explained that parents should play an active role in the lives of their children and take responsibility in raising up of their children. One key informant felt there should be a law which compels parents to be accountable for their child's behaviour. The following statement was said during the interview:

> Some parents have poor parenting skills and are failing to take care of their children. However, if there can be a law which puts pressure on parents then maybe there could be change. For instance, if there can be a law which says parents whose daughter gets pregnant while she is still staying with her parents at home, then the parents would be sentenced. This would somehow make parents be accountable when that happens.

The KIs were blaming parents for the behaviours of the adolescent girls, they believed parents were not providing children with good parental skills, as a result, their children end up being pregnant. They also felt parents should be held liable for adolescent girls who get pregnant while staying with their parents.

Findings of this study indicate that there is a need for parental supervision or parental guidance for adolescent girls in Letlhakane in order to reduce cases of adolescent pregnancy. Adolescents need direction or guidance from time to time so that they cannot be easily swayed by their peers or sexual partners into risky sexual behaviours. Parents who are involved and who constantly maintain knowledge of their children's day to day activities are most likely to know about their children's whereabouts and what they are up to (Salazar et al., 2010).

Parental supervision helps parents to monitor the behaviour or activities of their children hence they are less likely to be predisposed to risky sexual activities. According to (Salazar et al., 2010), much of the literature on family factors provide evidence to suggest that adolescents who perceive that their parents know where they are and who they are with the outside school are substantially less likely to engage in risky sexual behaviours or to become pregnant.

Provision of education on sexuality

When asked of other possible ways of what families could do to reduce cases of adolescent pregnancy, both in school and out-of-school adolescent girls suggested that parents should educate their children about sexuality issues. Parents were urged to openly discuss with their children about sex and the use of contraceptives from an early age. Parents were also encouraged to enlighten teenagers about the health risks related to early child bearing and challenges of being an adolescent mother. One adolescent mother suggested that:

> Parents should provide enough education at an early age about sexuality and contraceptives to teenagers before they make a mistake of getting pregnant. Parents should also take a central role in safeguarding their daughter from getting pregnant at an early age.

Parents were encouraged to initiate sex education at early age so that adolescents are not susceptible to adolescent pregnancy due to lack of knowledge about sex and the use of contraceptives.

The KIs noted that the level of ignorance is very high among families in Letlhakane, regarding issues and laws about the sexual reproductive health of adolescents. As a result, parents fail to educate their children about sexuality issues. However, the KIs also agreed that parents should educate adolescents about sex and the use of contraceptives and stop shying away from talking about such issues. One KI stated that:

> As parents, we should avoid telling children to wait until marriage or until they are old enough to engage in sexual practices. However, we should teach adolescents good sexual practices at an early age, because adolescents nowadays are exposed to too much technology and they can access pornography, which stimulates them to engage in risky sexual behaviours at a tender age.

The KIs proposed that adolescent girls should be taught about good sexual practices at an early age. Parents should stop shying away from discussing sexuality issues because children are already exposed to sexual acts through technology or social media.

The findings of the study suggest that parents were encouraged to be more open to talking to their children about sexuality issues. Adolescent girls need to know exactly at an early age the implications of engaging in unprotected sexual intercourse, as well as about the maturity of their bodies in regards to adolescent pregnancy. Having adequate knowledge about sexual reproductive health will enable adolescent girls to make the right decisions when confronted with risky sexual behaviours. Parents, therefore, need to be empowered to initiate sexual discussions with their adolescent children at an early age so that they can influence the behaviour of the adolescents positively (Mabunda & Madiba, 2017). Many health educators have argued that comprehensive sex education would effectively reduce the incidence of adolescent pregnancies (Papri, Khanam, Ara, & Panna, 2016). Generally, compulsory sex education can help to empower adolescent girls with increased sexual knowledge to prevent early sexual debut, and increased likelihood of condom use (Aspy et al., 2007; Ayalew et al., 2014).

Peer and dyad level risk factors

Peers are individuals who share some relative equity with regard to age, power status within the society, and social contexts that they occupy daily (Veronneau, Trempe, & Paiva, 2014). Two individuals interacting on a regular basis develop a dyadic relationship, for example, intimate partners (Veronneau et al., 2014). Peer and dyad risk factors are about the influence of peers and intimate partners on sexual reproductive health behaviours of

adolescents, which ultimately results in adolescent pregnancy. Adolescent girls are most susceptible to peer pressure and the influence of their intimate partners when it comes to decisions they make about their sexual lives.

Peer pressure

There was a general agreement about the presence of peer pressure among adolescents girls in Letlhakane during the interviews. All the respondents (adolescent mothers and Key Informants) acknowledged its presence and how adolescents influence one another to engage in sexual activities and intimate relationships. In a focus group discussion, FG1 and FG2, explained that the pressure to have sex comes mostly from the partners who insist on having sex even after the girls explain their uneasiness for the encounter. FDG 1 explained that:

> Mostly the pressure comes from the partners we date, they would say to prove to me that you love me, let us have sex and as an adolescent girl, you would do exactly as they say in fear of losing the relationship.

Majority of adolescent mothers who were interviewed had friends who were sexually active and also had children. One adolescent mother mentioned that:

> Peer pressure is there and it is very high. Friends would tell you that they have had sex and it is only you who have not done it. So you should go and have sex and once you do that you might be unfortunate and end up being pregnant.

One KI responded to the issue of peer pressure by saying:

> Peer pressure is very common especially in families where there is no one who gives advice, who moulds, who mentors, the child becomes prone to peer influence.

The KIs reported that adolescent girls are susceptible to peer influence because of lack of parental guidance.

The data collected overwhelmingly admit to the huge presence of peer pressure among adolescent girls in Letlhakane village. These findings corroborate with results of the study by Fearon et al., (2015), which reported peers to be the most influential in the romantic and sexual behaviours of adolescents. Due to the lack of information from the right people

like parents and community elders, adolescent girls in Letlhakane tend to learn and be enticed to engage in sexual intercourse by their friends or their partners. Friends lure girls into sexual activities and they are convinced into unprotected sexual intercourse by partners. Adolescent girls are often under pressure to be accepted by friends and partners, which at times translates into entering sexual relationships and being involved in sexual activities when they are not yet ready.

Studies from Ghana, Nigeria, Swaziland, Kenya, Tanzania, and South Africa have demonstrated how the influence of peers contributes to adolescent pregnancy. Particularly cited in a study from Nigeria was that, peers encourage their friends to get boyfriends (Yakubu & Salisu, 2018). Similarly, many adolescent girls in Letlhakane are encouraged by their friends to engage in intimate relationships and to have sex. Usually, adolescents would have sex under pressure just to pretend that they are cool and sophisticated, and to prove that they fit in the friendship circle without a proper understanding of the implications of such actions including pregnancies and sexually transmitted infections (Kenney, 2014).

Intergenerational sex

Adolescent mothers stated that intergenerational sex occurs at a very high rate, and is one of the factors associated with adolescent pregnancy in Letlhakane village. They further explained that adolescent girls are engaging in intimate relationships and having sex with older men because of money and being fascinated by material things such as expensive smartphones. One other reason why teenagers engage in intergenerational relationships was said to be due to poverty at home. FDG 5 elaborated by saying:

> Poor socio-economic status at home…when you come from a poor household, as a girl child, you are the eldest, and you have to provide for your younger siblings, you end up engaging in sexual activities so that you may get money to take care of you siblings.

Adolescent mothers also explained that sometimes parents are not able to meet the adolescent's basic needs and the easy way out is to be involved with an older man who is financially able to support them. One adolescent mother stated that:

> Sometimes parents cannot afford to provide basic needs for their children, therefore, as an adolescent girl, one might decide to look for money elsewhere, and they start to engage in an intimate relationship with an older man in exchange for money and provision of basic needs.

Similarly, KIs also agreed that intergenerational sex is very high in Letlhakane village and it occurs mostly among adolescent girls and older men working in the mines. They explained that it is well known by the people in the village including young ones that, any man associated with work in the mines is regarded as always having money to spend on luxuries. As a result, girls tend to be very prone to such men and are ready to do what they want, including having sex without protection. The KI explained that:

> Men from the mines target adolescent girls because they know they are after money and they are not aware of specific laws and policies. Therefore they cannot report them for defilement.

There was a very strong assertion by the KIs during the interviews that the problem of adolescent pregnancy in Letlhakane village is mostly due to the presence of mines around the village. Men from the mines were reported to be targeting adolescent girls, and having sex with them in exchange for money.

Data collected shows that intergenerational sex occurs at a high rate in Letlhakane village; adolescent girls are having intimate relationships and engaging in sexual intercourse with older men. A review of the literature indicates that relationships between young women and older male partners are very common in sub-Saharan Africa (Leclerc-Madlala, 2008). Studies conducted in sub-Saharan Africa on intergenerational sexual relationships have established that lack of access to education, health services, employment and a weak

economy associated with poverty often force girls into sexual relationships with potential economic benefits (Luke, 2003).

From the study, there was a realization that poverty forces girls to engage in sexual activities with older men who tend to provide for their needs. Some adolescent mothers in Letlhakane come from families with low socio-economic status and their parents cannot provide them with basic needs. As a result, those girls end up getting into sexual relationships with older men and have sex with them in exchange for money or being provided with basic necessities; and they end up getting pregnant in the process.

There was also a revelation in the data collected that some parents are forced by hardships at home of raising the young girls, therefore, they directly or indirectly encourage adolescent girls to date older men in exchange for financial gain and they would even go to the extent of regarding the man as ‘‘husband’’ to their child. Additionally, some parents allowed their adolescent daughter to cohabit with a man outside of their home because they were not able to provide basic needs for their children.

Poverty at home is coupled with the previous insight that women have little or no bargaining power for safer sex, and this puts the adolescent girls at risk of being exploited by these older men. It is very easy for a girl to get pregnant in this set up of a relationship as the man often makes the final decisions in the relationship. According to (Leclerc-Madlala, 2008), young women and girls' power to negotiate for condom use is often compromised by age disparities and economic dependence. Therefore, in such intergenerational relationships, adolescent girls cannot insist on safer sex practices, thus putting them at risk of sexually transmitted infections and unwanted pregnancies.

In addition, from the data collected, girls are also enticed to engage in sexual activities with older men with the aim of living the life their parents cannot give them. We have a

generation of materialistic adolescents who want expensive things they cannot afford, and at the end decide some shortcut ways of getting the money to live that life. Such girls are determined to even use their bodies to achieve such financial ends needed to live the lifestyle they want. This is a case of relative poverty where even though the basic necessities would be available for the girls, they still want more luxurious items (such as expensive smartphones) usually enticed by friends who own such.

Peer and dyad protective factors

Peer and dyad protective factors comprise of interventions that target relationships, which adolescent girls interact with on a daily basis such as friends and sexual partners. For instance, interventions that aim to create positive peer influence, and increased support from partners that allows adolescent girls to practice safer sexual intercourse by using contraceptives. In this study, intergenerational sex was reported to be high therefore; respondents suggested that one way to address this issue is through the enforcement of the law.

Law enforcement

Adolescent mothers recommended that one way to address the issue of intergenerational sex is through the enforcement of the law. Participants believed that men dating and having sex with adolescent girls should be given stiff punishment. During the discussions, FGD 1 suggested that:

> Older men who date adolescent girls should be severely punished because what they are doing is defilement and some of those men are even married. Serious action has to be taken upon them so that men can refrain from sexually abusing girls.

Adolescent mothers also believed that the government needs to be strict with perpetrators who abuse adolescent girls to discourage the behaviour and reduce numbers of adolescent pregnancies. They also pointed out that parents need to report cases of defilement and refrain

from supporting such relationships for the sake of having food on the table. One adolescent mother recommended that:

> Parents should be actively involved in the lives of their children, and they need to ensure that they report cases of defilement so that action can be taken against those men.

The adolescent mothers felt that cases of defilement have to be reported so that the law can be implemented and the perpetrators of sexual abuse can be sentenced.

KIs also expressed concern over the silence of laws that are meant to protect adolescents as well as the ineffectiveness of the law enforcement institutions to implement such laws. KIs reported that there were several cases of sexual abuse (defilement and rape), however, nothing was being done to perpetrators of such cases. The KI proposed that:

> More awareness should be raised about defilement and laws should be put into practice to deter people from such misconduct.

The KIs felt that laws and policies protecting adolescent girls from sexual abuse are not implemented, as a result, men get away with sexually abusing adolescent girls.

Adolescent girls in Letlhakane are engaging in intimate relationships with older men at a very high rate and this results in increased numbers of defilement cases. However, respondents report that such cases are not reported and action is not taken against the men who sexually abused adolescent girls. Data presented reports that there is a need to raise more awareness about defilement in communities and also to sentence men who sexually abuse adolescents so that it could deter such behaviour.

Community-level Risk factors

Community environments can either promote health or be a source of stigma. Community constitutes of network ties, the relationship between organizations and groups, cultural and religious norms (Baral et al., 2013). Community-level risk factors are the social

norms, beliefs and practices that contribute to adolescent pregnancy. In this study, some cultures influence early marriage and early childbearing which results in adolescent pregnancy.

Culture

There was a consensus among adolescent mothers on the negativity that comes with adolescent pregnancy in their communities. It was explained that several cultures do not tolerate adolescent pregnancy and is viewed as a shame. Contrary to their popular stand, FG1 explained that:

> In some cultures, teenage girls are offered to men for marriage (go bewa letlhokwa) and those girls are allowed in such societies to get married at the age of 16.

It was also found out that women are not in a position to negotiate for safer sex in most of the cultures in the village. They listen and do what men want. They [women] fail to negotiate for safer sex for fear of losing the relationship.

On the interviews with the Key Informants, the issues of early child marriages and early childbearing came up. They reported that children are exposed to sexual acts very early because of the living set-ups. They further explained that some cultures especially Basarwa tend using the one-room house, where at times parents engage in sexual intercourse in the presence of their children. In such situations, children are exposed to sexual activities at an early age and become sexually active at a tender age. The young girls in such communities are then impregnated at a tender age and are very prone to sexually transmitted infections, and cases of incest are often rampant. The KI stated that:

> Children are exposed to sexual intercourse at an earlier age. You may find that both the parents and the children sleep in the same room and parents can engage in sexual intercourse in the presence of their children, thinking the children are asleep. In the end, children become sexually active early because they imitate what they see happening at home.

The KIs agreed that there is often no privacy where parents and children sleep in the same room. In such a home set up, parents at times engage in sexual intercourse in the presence of their children, consequently, children are exposed to sexual activities at an early age and become sexually active at a tender age.

According to the data collected, adolescent pregnancy is socially and morally unacceptable in Letlhakane village. However, there are still some cultures in the village which directly or indirectly encourage young girls into early childbearing and marriages or sexual relationships at tender ages. Some cultures believe that by the age of sixteen (16), a girl is mature enough to be married and they tend to "push" them into sexual relationships. Usually, adolescent girls are pushed into sexual relationships with older men with money so that those men can provide for the family. It was discovered that adolescent girls who engage in intimate relationships with older men come from poor socio-economic status. Therefore, they engage in such relationships with the aim to gain financially from their sexual partners.

Results of this study also indicate that adolescent girls are exposed to sexual acts at a very early age because of the living arrangements at home. According to the data collected, in some cultures, children often sleep in the same room with their parents and they become exposed to watching sexual activities between their parents at an early age. There is often no privacy in such home set up, as a result, children imitate what they see happening at home.

Community-level protective factors

Community protective factors are the interventions that target cultural norms to create positive social norms so that adolescents can practice safer sexual intercourse and to have access to sexual reproductive health information and services (Svanemyr et al., 2015). These interventions are aimed at the broader community members and institutions outside the family, such as neighborhoods, schools and workplaces. Therefore, community interventions

require stakeholder collaboration among community members to tackle issues regarding sexual reproductive health of adolescents.

Stakeholder collaboration

During the interviews, when adolescent mothers were asked of how community members can help in reducing numbers of adolescent pregnancy in the village, both in school and out of school adolescent mothers reported that there are no community health outreach programs educating adolescents about issues of sexual reproductive health. It was noted that nowadays community members are more individualized and they do not give attention to the upbringing of a child in society. Adolescent mothers, therefore, suggested that community members should work together to address the issue of adolescent pregnancy. One adolescent mother mentioned that:

> The community at large should engage in developing interventions that address the issue of adolescent pregnancy, and they should conduct community outreach programs where they educate adolescents about sex, contraceptives and adolescent pregnancy.

The adolescent mothers urged the community to work collaboratively and develop interventions that will empower adolescent girls with information on sex and the use of contraceptives, hence reducing the numbers of adolescent pregnancies in the village.

There was also a consensus among the KIs about stakeholder collaboration in the community as a way to address the issue of adolescent pregnancy. One KI suggested that:

> All key stakeholders should be seen playing a role in the issue of adolescent pregnancy, and people should be taught about raising a child and what it means to raise a child.

The KIs suggested that key stakeholders who play a crucial role in the lives of adolescent girls should work together in protecting adolescent girls from risky sexual behaviours which leads to unplanned pregnancies.

The findings of this study indicate that there is need to involve all stakeholders in the community (such as parents/ guardians and community leaders) in addressing the issue of adolescent pregnancy and sexual reproductive health of adolescents. The respondents of this study indicated that there no community health programs which equips adolescents with sex education. It was also noted earlier that parents and elder members of the community are not well conversant on issues to do with sexuality and reproductive health. Therefore, there is need to develop programs and interventions to equip parents/guardians and community leaders with the appropriate information and skills to address adolescent sexual reproductive health needs.

According to Esantsi et al (2015), these programs and interventions could be achieved through community workshops organized in collaboration with various key stakeholders including religious institutions, non-governmental institutions and health workers to empower communities on adolescent sexuality and contraception. As a result, this will enhance community participation and address cultural barriers and inhibitions to the optimum realization of ASRH (Esantsi et al., 2015).

Institutional-level Risk factors

Institutional level risk factors involve the insufficiency of laws and policies to protect adolescent girls from risky sexual behaviours such as early childbearing and early child marriages. Laws and policies provide the general framework for shaping the risk of marginalized populations as well as the general population (Baral et al., 2013). Laws can either promote or decrease the community's ability to provide preventative or harm reduction services. For example, findings of this study report that laws are not enforced; perpetrators of sexual abuse are not given stiff punishment hence, this sets examples that encourage the incidence of sexual abuse of adolescent girls. There is also a lack of awareness about services

which are meant to provide adolescent girls with information and services regarding sexual reproductive health.

Lack of awareness about Adolescent Sexual Reproductive Health (ASRH) services

Majority of adolescent mothers were not well informed about the existence of ASRH services in the village. From the responses, most of the adolescents in the village who know about contraceptives tend to get their information from nurses who visit schools and from their guidance and counselling teachers in school. The respondents felt the ASRH services are not being correctly delivered to them. As a result, there is so much misinformation from friends about sexual reproductive health and contraceptives. When interviewed about ASRH services, participants responded by saying:

> [FGD 1] I feel the ASRH services are not accessible for most adolescents. You find that we do not know anything about such services and we usually get information about sex from our friends because there is a lot of peer pressure.
>
> [Adolescent mother] I have heard about them (ASRH services), but I have not been able to inquire about the services or use them because I do not know what they are about and their purpose.

The respondents felt that ASRH services are not accessible to them because they are not even aware of their existence and their purpose. For the key informants, a similar picture was painted about the ASRH services in the village. The KIs reported that there had not been intensive awareness of the services, enough to get through to adolescents who are supposed to benefit the most from the services. One KI pointed out that:

> ASRH services are not effective because awareness has not been raised about them hence adolescents do not know more about their existence and purpose.

The KIs also mentioned that ASRH services are also not existing in Letlhakane clinics, but instead, they only operate at the hospital of which made them inaccessible and ineffective.

The Adolescent Sexual and Reproductive Health initiative is meant to be the torch bearer in the country as far as adolescent sexual reproductive health issues are concerned. It is

not only geared towards service provision to the youth but is also mandated to provide the much-needed information on the sexual and reproductive health of the young people in the country. However, from the data collected, the initiative is not as vibrant as it is supposed to be in the village. Majority of the adolescent mothers are not well aware of ASRH services; the purpose and importance of ASRH services. It was also observed that friendly adolescent sexual and reproductive health services are only offered in Letlhakane primary hospital whereas clinics do not have such services. As a result, this has made the services to be ineffective because some of the adolescents are neither able to utilize nor have access to the services.

The data collected also revealed that the sexual and reproductive health services that are offered in clinics are not tailor-made to suit the adolescents. This is a very important determinant of whether the youth will be free to take advantage of the services or not. Some adolescent girls are not comfortable to rub shoulders with elderly women in the same clinic especially when it comes to reproductive health. The provision of information to the youth in the village is not limited to ASRH services but extends even to law enforcement organizations like the police. It is very important that the youth understand their right and be able to understand defilement and other forms of sexual abuse to be able to report such to the police. This has also not been done properly in the village as a lot of the respondents believe that there is ignorance among the youth of the laws that protect them.

Laws are not enforced

The KIs raised concerns about the ineffectiveness of laws protecting adolescents from risky sexual behaviours. They explained that laws protecting adolescents from risky sexual behaviours are there. However, they were not enforced. One KI elaborated this by saying:

> Laws guarding against sexual abuse of adolescents are there. However, their implementation is not effective because cases of sexual abuse are not reported and action is not taken against men who sexually abuse adolescents.

One key informant also pointed out some confusion that come from the laws of the country themselves. For instance, the Children's Act defines a child as someone who is 10-18 years yet when you are 19 years; you are still an adolescent who needs the same kind of protection as the other younger adolescents. Adolescents above 18 years of age are taken as adults who can make informed decisions; hence when you are pregnant, there is no basis for legal action. The critical informant further explained that at 19 years, one cannot make effective decisions about their sexuality and are prone to abuse like the younger adolescent and need the same kind of constitutional protection. The data collected reveal that there is ineffectiveness within law enforcement, where men are not given stiff punishment for sexually abusing adolescent girls. For instance, some men are released on bail and they join the community and they sexually abuse another child while waiting for trial. Ineffectiveness of law enforcement sets precedents that encourage the occurrence of sexual exploitation of adolescents. For instance, a man who gets away with impregnating a 16-year-old could send messages to other men that they can also get away with such acts. Law enforcement is supposed to set examples from the people guilty of sexual exploitation of adolescent girls to ensure that lessons are learnt for others not to emulate the behaviour.

Ineffectiveness of laws is coupled with the culture of silence, where sexual abuse cases are not reported to the relevant authorities in the community. Consequently, these factors contribute to the escalations of adolescent pregnancies in the village. The law enforcement should work hand in hand with the communities in making sure that the adolescents are safe from sexual predators and that the number of adolescent pregnancies is tremendously decreased.

Institutional-level protective factors

At the societal level, there is need to promote laws, policies related to health, social, economic, and educational spheres, and to construct societal norms in support of ASRH and helping adolescents realize their sexual rights (Svanemyr et al., 2015). This would help in reducing numbers of adolescent pregnancy and for adolescent girls to have easy accessible to SRH services. Raising awareness about ASRH services and implementation of laws are the institutional protective factors that emerged in this study.

Raise awareness about ASRH services and the provision of youth-friendly services

According to the data collected, both in school and out of school adolescent mothers agreed that ASRH services should be responsive to their sexual reproductive needs and more awareness should be made so that adolescents are aware of the existence in the village. When interviewed about ASRH services, one adolescent mother mentioned that:

> ASRH services should be publicized so that adolescents know where to get help concerning sexual reproductive health issues. The ASRH department should have mobile clinics or roadshows to make them more vibrant and accessible to adolescents.

Adolescent mothers suggested that ASRH services should be publicized and to be youth-friendly so as to meet the sexual needs of the adolescents. The KIs also agreed that there should be more public awareness campaigns to make sure that information about the ASRH services reaches out to the concerned people in the village and that the youth themselves should be given an active role in the process. During the interview one KI mentioned that:

> The ASRH services should be visible and accessible to adolescents in Letlhakane, and their mandate should be well known by adolescents and the community at large.

The KIs emphasized that ASRH services should be youth-friendly and made accessible to adolescents. It is very important that government and other service providers dealing with adolescent sexual and reproductive health intensify their awareness campaigns to ensure that

adequate and correct information reaches out to the adolescents of Letlhakane village, so as to give them some kind of power and control over their sexuality and reproductive health.

Learning from the data, condom use seems to be the most commonly used contraceptive method but there are a lot more contraceptive methods that adolescent girls in Letlhakane village could choose from if only they were well informed about them. The awareness campaigns should also include the parents of adolescents in the village. Parents also need to be equipped with sexual reproductive health issues so that they may be able to initiate sexuality conversations with their children.

Implementation of laws

Both in school and out-of-school adolescent mothers were interviewed about what various institutions could do to reduce numbers of adolescent pregnancy in Letlhakane; it was learnt that policy formulation to do with adolescents should actively involve the adolescents themselves to make them more effective. One adolescent mother stated that:

> Adolescents should be involved in the formulation of policies and intervention measures that are geared towards their social and health development so that their sexual reproductive health needs are addressed.

Adolescent mothers believed they should be involved in the design and implementation of interventions geared towards addressing their sexual needs. The KIs also felt that laws should be implemented about cases of sexual abuse among adolescent girls. One KI suggested that:

> Cases of sexual abuse should be treated as a matter of urgency, and should not be taken lightly. Key stakeholders should make follow up on such cases to ensure that action is taken against the perpetrators.

The KIs explained that laws have to be implemented and cases of sexual abuse have to be treated as a matter of urgency so that people can have faith in the law enforcement agencies and be encouraged to report cases of sexual abuse.

Data presented reveals that laws or policies protecting adolescents from risky sexual behaviours are there, however, they are not implemented due to cases not being reported and ineffectiveness of the law enforcement agencies. For instance, long waiting trials and the ability of the perpetrators to bribe their way out. The respondents indicated that there is a need for implementation of the law, especially when dealing with cases of sexual abuse (such as rape or defilement). Implementation of laws would encourage parents or adolescents to report cases of sexual abuse hence such cases would be lessened.

The Relationship between Individual, Family, Peer and Dyad, Community and Institutional level Factors in Adolescent Pregnancy.

There are many observable interlinkages among individual, family, peer and dyad, community as well as institutional level factors associated with adolescent pregnancy in Letlhakane village. Most of the risk and protective factors tend to affect more than one level of influence. For instance, poverty does not only affect the individual adolescent girls but also affects decisions of the parents as well as the overall lifestyle of the community. If sex work, for example, proves to be a way adolescent girls can afford their material lives, then it would be a community issue not just for the individual involved.

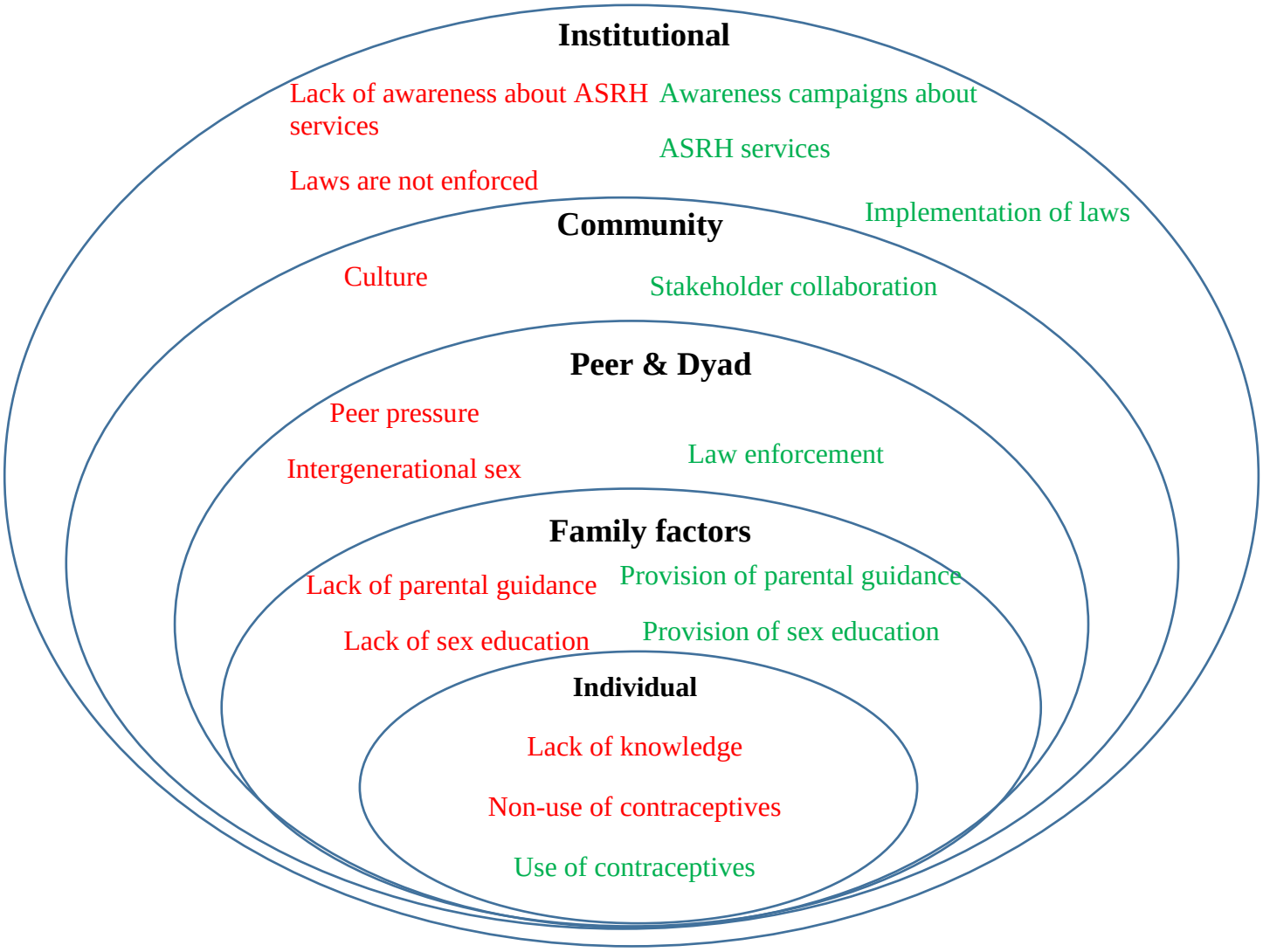
Moreover, services provided by institutions in the community have an overall impact on individual beneficiaries, and also at the overall level of the community. Strict law enforcement, for instance, does not only make individual and families feel safe with their daughter but also creates a peaceful, well organized and focused community as a village. Efforts that are applied at the community level ultimately trickle to make lasting impacts on families and individuals targeted. For instance, the impact of the presence of mines in the community is not only felt by individual families for those parents whose adolescent children get pregnant, but it also paints a different picture at the community as well as the nation as a whole.

The issue of lack of education on sexuality among adolescent girls in Letlhakane village and failure of parents to discuss sexual topics with their children could also provide a good looping thread for the issues of adolescent pregnancy in the village. Failure of institutions, governmental or non-governmental ones, to provide the much-needed education to the citizen results in uninformed parents who fail to offer proper guidance to their children. This could result in adolescent girls engaging in risky sexual behaviours such as sex work, non-use of contraceptives; consequently resulting in rampant unplanned pregnancies that affect individual adolescents, families, the community and the entire country.

Similarly, relaxation of the law enforcers in punishing crimes related to sexual immorality brings an atmosphere of lawlessness and fearlessness among those people that abuse young girls, hence increasing such behaviours of sexual abuse and affecting the village as people start living in fear. Therefore, it is important that intervention strategies designed to address the issue of adolescent pregnancy in the village could be implemented at different levels and will have a direct or indirect impact on other levels.

Application of the Social Ecological model

The research findings of this study are guided by the use of the social ecological model. The model helped the researcher to analyze the risk and protective factors according to various levels of influence, such as individual, family, peer and dyad, community, as well as institutional level factors. Within each of these levels, factors were identified as risk factors if they increase the likelihood of adverse behaviors that could lead to adolescent pregnancy; on the other hand, factors were labeled as protective if they either discourage negative behaviors or encourage positive behaviors that might prevent pregnancy such as the use of contraception (Mmari & Sabherwal, 2013).



Key:

Risk Factors

Protective Factors

The diagram above shows the identified risk and protective factors in Letlhakane according to each level of influence. For instance, in the individual level, respondents reported non-use of contraceptives and lack of knowlegde about contraceptives as risk factors that increased the likelihood of adolescent girls getting pregnant, whereas use of contraceptives during sexual intercourse was identified as a protective factor which decreases chances of being pregnant because an individual is empowered with knowledge about contraceptives and is able to say no to unprotected sex.

The model also helped to identify social and sexual networks that comprised of interpersonal relationships such as family, friends, and sexual partners that directly or indirectly influence individual health and health behaviours. For example, in this study, lack of provision of sex education from parents resulted in adolescent girls being prone to peer pressure and misinformation from friends and sexual partners, hence girls engaged in risky sexual behaviours that lead to adolescent pregnancy. However, if sex education is provided, adolescent girls can be able to negotiate for safer sexual intercourse.

The other level of influence identified was the community level, which comprises of cultural norms and practices that promotes adolescent pregnancy, such as early childbearing and child-marriages. In this study, the culture of using one-roomed house in which parents engage in sexual intercourse in the presence their children was identified as a risk factor that led to adolescents engaging in sexual practices at an early age, hence they became pregnant. However, stakeholder collaboration was proposed to be one way in which adolescent pregnancy could be reduced. For example, key members involved in raising of an adolescent can work together to eliminate negative cultural practices and create an environment where adolescents are taught about sex and allowed to use contraceptives without being labelled as promiscuous.

Another level of influence is the institutional level, in which risk factors such as ineffectiveness of the law and lack of enforcement of the laws were reported. Consequently, parents resorted to not reporting cases of sexual abuse because of lack of faith in the justice system. Poverty at home also influenced some parents to accept relationships of adolescent girls dating older men in exchange for money, and this resulted in adolescent girls being prone to defilement and other sexual abuse that consequently led to adolescent pregnancy. On the other hand, respondents proposed that laws need to be enforced so that cases of sexual could be reported and addressed adequately, hence a decrease in cases of defilement and adolescent pregnancy.

Limitations of the social ecological model

The model helped the researcher to analyze, identify, and demonstrate the risk and protective factors of adolescent pregnancy and to show that adolescent pregnancy is not only a result of individual biological or behavioural characteristic, but it is a result of various health risky behaviours that have an influence on the individual. However, the model could not explain the underlying cause of risk and protective factors. For instance, with intergenerational relationships, the model helped the researcher to categorize it as peer and dyad factor, however, the model does not explain the gender and power dynamics in intergerational relationships that ultimately leads to an adolescent girl being pregnant.

Additionally, the model does not explain that adolescent girls in intergerational relationships do not have power to negotiate for safer sexual intercourse, as result, they end up being pregnant. The model does not specify which levels of influence have more power over an individual, e.g is it individual factors, relationship factors or cultural and institutional factors. Therefore, realistically it becomes a challenge to design interventions that address all levels as it will be time consuming.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

Introduction

This chapter presents conclusions of the study and recommendations that could help reduce the numbers of adolescent pregnancy in Letlhakane village if implemented. The study examined the risk and protective factors associated with adolescent pregnancies in Letlhakane village at individual, family, peer and dyad, community as well as institutional levels.

Conclusions of the Study

Based on the findings of the study and the preceding discussions, the following conclusions can be drawn:

At the individual level, majority of adolescent girls in Letlhakane village do not have sufficient knowledge about sexual reproductive health issues and the use of contraceptives. The study has revealed that there is lack of information dissemination about sexuality issues and the available contraceptive methods which results in adolescent girls being susceptible to unplanned pregnancies. The findings of the study also indicate that there is non-utilization of contraceptives especially among adolescent mothers within schools who seem to be fully aware of the different methods of contraceptives. Non-use of contraceptives is due to myths circulating in the village about contraceptives such as pills and the injection; fear of parents' disapproval to use contraceptives; and lack of decision-making power among adolescent girls to negotiate for safer sexual intercourse.

Respondents suggested that adolescent girls should have easy access to health centres and utilize contraceptives freely without fear or being stigmatized. Respondents also felt that

information should be widely disseminated and topics about sexual reproductive health should be discussed freely without being regarded as a taboo.

At family level, lack of parental involvement and lack of parental education on sexuality seems to be significant risk factors associated with adolescent pregnancies in the village. Children tend to lack proper guidance from their parents who happen to be their immediate role models. Parents are more focused on providing for the family (putting food on the table) than monitoring or supervising their children's behaviors outside their home. Parents also feel uncomfortable to discuss sexuality issues with their children, hence this results in adolescents being prone to peer pressure and making uninformed decisions of which some results in unintended adolescent pregnancies.

Respondents of the study suggested that parents should be more involved in the sexual reproductive health of their children and they should also educate their children about the use of contraceptives and stop shying away from discussing such issues. As a result, adolescent girls would be more empowered with knowledge on SRH issues and have someone to guide them about adolescent health issues hence they are less likely to be vulnerable to adolescent pregnancies.

At peer and dyad level, there is high level of pressure from friends and intimate partners which influences adolescent girls to engage in risky sexual behaviors (such as unprotected sexual intercourse) of which results in adolescent pregnancies. Moreover, adolescent girls also engage in intergenerational relationships; they have sexual intercourse with older men in exchange for money. Some adolescent girls do it because of poverty at home whereas others want to get money to buy expensive materials and live a life their parents cannot afford to give them. Adolescent girls in such relationships cannot negotiate for safer sexual intercourse and this puts them at a risk of having unplanned adolescent pregnancies.

In addressing the issue of intergenerational sex, respondents proposed that parents should report cases of defilement and action has to be taken against perpetrators of defilement.

At community level, the findings indicate that even though most cultures do not tolerate adolescent pregnancy, there are those that encourage early child bearing and early child marriages. In some cultures adolescents are offered to men for marriage and expected to have children at an early age. Some parents were also reported to be exposing adolescents to sexual acts at a tender age because of their living arrangements (sleeping in the same room with children). Children end up imitating their parent's behaviour by engaging in sexual acts at an early age. Respondents suggested that the community members need to work together collaboratively to tackle the issue of adolescent pregnancy.

At the institutional level, there is lack of awareness about ASRH services, therefore adolescent girls are either not able to have access or utilize the services. There is also ineffectiveness in the implementation of laws protecting adolescent girls from sexual abuse, as a result men get away with sexually abusing adolescent girls. Cases of sexual abuse are also not reported because laws are not enforced. The participants of the study proposed that the ASRH services should publicized to raise awareness and laws should also be enforced.

Recommendations

Based on the findings of the study, the following recommendations are proposed:

Adolescent girls should be empowered with knowledge at an early age so that they can be able to make informed decisions when it comes to their sexual reproductive health without being predisposed to peer pressure or pressure from intimate partners. This empowerment should include educating adolescent girls about their sexual rights (e.g. the right to say no to sex and the right to have access & use any available contraceptive methods without parental consent/ any charge.)

Adolescent girls should also be educated on how to use the available contraceptive methods so as to alter their beliefs or their perceived myths. Moreover, adolescent girls should be equipped with communication and negotiation skills which will help them to bargain for safer sexual intercourse.

Sex education programs should not only target adolescents in schools, rather they should be inclusive of all adolescents even those who are out-of-school. The adolescents should also be involved in the design and implementation of such programs, e.g. having peer educators. This would ensure that adolescents are taught with people whom they can relate with and their ASRH needs could be identified and addressed.

Parents or elderly people in the community should be sensitized about the importance of educating adolescent girls about sex and the use of contraceptives at an early age. The findings indicated that parents are not well conversant on topics of sexual reproductive health, therefore this calls for health practitioners (nurses or midwives) to design self-efficacy programs for parents, which equips parents with knowledge and skills on how to effectively provide sexuality education to adolescent girls.

The community at large should also work together to come up with intervention strategies to address the issue of adolescent pregnancy. The intervention strategies require collaborative effort from non-governmental organizations, faith-based institutions, schools and elder members in the community. These interventions should be culturally relevant and include discussions about promoting positive social norms, elimination of negative cultural practices (such as early child-marriages & early childbearing) and to create a safe place in which adolescent girls can have access to contraceptives without fear of being labeled as promiscuous.

The government of Botswana should make sure that ASRH services in clinics or health centres are tailor-made to suit the needs of the adolescents to ensure easy accessibility and utility of the services. ASRH services should be adolescent/ youth-friendly: confidential, private and non-judgmental. The ASRH services should also be publicized and vibrant so that adolescent girls can be aware of their availability. The laws and policies protecting adolescent girls from risky sexual behavior should be implemented and action has to be taken against men who sexually abuse adolescent girls. Enforcing policies and laws would encourage parents and adolescent girls to report cases of sexual abuse.

Areas for Further Research

Using the social ecological model helped the researcher to identify the risk and protective factors of adolescent pregnancy across different levels of influence. However, the model does not elaborate the underlying cause of each contributing risk and protective factors of adolescent pregnancy. Therefore, future research should make intersection of other theories such as theory of gender and power, the Health belief model and self-efficacy theory to have a better understanding of the underlying causes.

The social ecological model is not specific about which levels of influence are more potent therefore it becomes a challenge to design comprehensive interventions on all levels. Further research can be undertaken to assess the identified risk and protective factors in order to comprehend which factors have a greater influence on the adolescent girls in Letlhakane. This can be done by conducting longitudinal studies, for instance, comparing whether family level factors have a greater influence over community factors.

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Appendix 1

Focus Group Discussion with In-School Adolescent Mothers

Introductions and focus group process (45 minutes)

My name is Sizwile Dlamini, a student pursuing Master's Degree of Clinical Social Work at the University of Botswana. I am conducting a study about the **Risk and protective factors for Adolescent pregnancy among Adolescent girls in Letlhakane Village.** I would like everyone to sign-in on the Attendance Sheet. Before we start the discussion, could each one of you introduce themselves and tell us something about themselves, why they are here today, and what they would be doing if they were not here.

While doing the focus group, the researcher will

a. Listen for inconsistent comments
b. Probe for understanding
c. Listen for vague comments
d. Offer a group summary of key questions and seek confirmation
e. Watch the group dominator
f. Watch the non-verbal cues

Purpose of the focus group session

Welcome to today's focus group. I am conducting a study on factors for Adolescent pregnancy in your village, Letlhakane. I request for your participation in this study because of your lived experiences of being an adolescent mother. I would also like to hear from you about your opinions and ideas. I would like to learn from you as much as possible, so I need your honest answers and everything you think is important to me. I hope that you will help me to understand issues concerning adolescent pregnancy. First, I would like you to complete an **Assent Form.**

The form I am passing out is the assent form that you accept to participate in the study and you should complete it in order for you to participate in the study. It describes the study, its purpose and how the study is going be conducted.

Review of the assent form

Did you understand the assent form?
Was the assent form clear?
Which parts of it were unclear or should be reworded?
What language should be written in the assent form: Setswana or English?
Do you think the assent form should have Setswana on one side and English on the other?

A. Group rules

Thank you. Now, I would like to develop some group rules to help us learn as much as possible from each other. I would like to have discussions that are as open as possible. What are some of the rules you think we should agree on in this group?

Examples of group rules:

a. One person speaks at a time.
b. You don't need to agree with others, but you must listen respectfully as others share their views.
c. Be honest.
d. Maintain confidentiality.
e. No put downs or insults
f. I ask that you turn off your phones or pagers. If you cannot and if you must respond to a call please do so as quietly as possible and re-join us as quickly as you can.

We will start by talking about the state of Adolescent pregnancy in the village, and the effects of Adolescent pregnancy on adolescent girls in Letlhakane.

Let us now look at the Community factors associated with Adolescent pregnancy.

1. How is adolescent pregnancy viewed in your society?
2. What are the cultural traditions or religious beliefs that contribute to adolescent pregnancy?
3. In your society, at what age are you expected to get married? At what age are you expected to start having children?
4. In your society, can women negotiate for safer sex?
5. What do you think can be done in your society to address Adolescent pregnancy?
6. Which cultural practices, norms and religious beliefs should be eliminated to reduce

adolescent pregnancies?

The next area of discussion is about the **Institutional factors** associated with Adolescent pregnancy.

1. What do you think about adolescent sexual reproductive health services? Are you aware of them? Do you have easy accessibility? Is the service delivery effective?
2. What challenges are you facing regarding ASRH services?
3. What do you think can be changed or improved in the Adolescent Sexual Reproductive Health (ASRH) services?
4. What do you think decision makers can do to protect Adolescent girls from unplanned pregnancies and cultural practices that contribute Adolescent pregnancy?

Peer and dyad factors associated with Adolescent pregnancy

Let us talk about your peers/friends and romantic relationships; how they increase the likelihood of one becoming pregnant or how they can also protect one from becoming pregnant.

1. What is the role of peers in adolescents having sex?
2. Does the pressure to have sex come from friends or partners?
3. Do you think adolescent girls plan on having sex? Are the pregnancies planned?
4. What are your feelings and attitudes towards sex and contraceptives? Are your peers using contraceptives? What is their reaction towards contraceptives?
5. What are some of the reasons why adolescent girls are having sex?
6. In any intimate relationships, do adolescent girls negotiate for safer sex?
7. What do you think about intergenerational sex? Is it something that is happening among your peers? Can they negotiate for safer sex in such relationships?
8. In your view, what do you think can be done to address negative peer influence?
9. What do you think can be done to address intergenerational relationships?

Family-level factors

1. How do families contribute towards one becoming pregnant?
2. In what kind of families are adolescents vulnerable to Adolescent pregnancy?
3. Do you think your family played a part towards you becoming an Adolescent mother? If so, how?

4. In your family, are you expected to have children? At what age are you expected to have children?
5. In your own family, do you talk about sexual activities? Whom do you discuss with, is it parents, siblings or a close relative? How often does your family do that?
6. What can families do to promote sex education?
7. In your view, what can parents/ siblings do to protect adolescent girls from risky sexual behaviours and unplanned pregnancies?

Individual-level factors associated with Adolescent pregnancy

1. In your opinion, what are the general factors associated with adolescent pregnancy?
2. What factors do you think contributed towards you becoming pregnant?
3. At what age did you get pregnant? Did you have knowledge about sexual activities and the use of contraceptives?
4. In your own view, would you say you are knowledgeable about sex, contraceptives and ASRH services? Where do you get information on sexual education?
5. What have you done to avoid another unplanned pregnancy?
6. What do you think other adolescent girls can do to avoid unplanned Adolescent pregnancies?

Wrap up

1. Ask the participants:

How did you feel about participating in this session? What was easy? What was hard?

2. Summarize and thank the participants:

I appreciate all of your great ideas. You have been a big help, and I want to thank you very much for all the information you have shared with me today. I know that your ideas will help to make this study successful.

Thank you once again for your participation- I really appreciate you!

Appendix 2

Pampiri ee fang lesedi ka tsamaiso ya dipuisano le Banana ba ba nang le bana ba le mo Sekolong

Matseno le tsamaiso ya dipuisano

Leina lame ke Sizwile Dlamini, ke moithuti wa ko Mmadikolo mo Botswana, ke ithuta dithuto tsa boipelego. Ke dira dipatisiso ka diemo tse di tsenyang banana ba basetsana mo diphatseng le tse di ba sireletsang mo boimananeng jwa banana mo motseng wa lona wa Letlhakane. Ke tla kopa gore mongwe le mongwe yo tsileng a kwale leina la gagwe mo pampireng go supa fa a le teng mo bokopanong jo. Re ka simolola ka go ipolela maina, le sengwe ka ga wena, lebaka le le go tsisitseng fa, le gore fa o kabo o se fa o kababobo o dira eng.

Fa go le mo dipuisanong tse, mothothomisi o tla:

a. Reetsa dikakgelo tse di sa lomaganeng sentle.
b. Botsisisa gore a tlhaloganye.
c. Reetsa dikakgelo tse di sa tlhaloganysegeng.
d. Soboka dintlha tsa botlhokwa abo a netefatsa gore ke tsone.
e. Lebelela tse eseng puo ya loleme, jaaka maikutlo le boitshwaro.

Mosola wa bokopano:

Ke a le amogela mo bokopanong jo. Ke dira dipatisiso ka dikgang tse di amanang le boimana jwa banana mo motseng wa Letlhakane. Ke tla kopa tirisano mmogo ya lona mo dipuisanong tse ka gore le itse botoka ka go nna motsadi o santse o le monana. Ke amogela dikgakololo tsa lona mo kgang e. Ke ka rata go ithuta mo go lona ka tsotlhe tse le bonang di le botlhokwa. Ke solofela fa le tla nthusa go tlhaloganya dikgwetlho tse di amanang le boimana jwa banana. Santlha ke tla rata gore le tlatse pampiri e e netefatsang gore le dumetse go tsaya karolo mo dithothomisong ka dikgang tsa boimana jwa banana.

Pampiri e ke sesupo sa gore o dumela go tsaya karolo mo bokopanong jo. Le kopiwa gore le e tlatse gore le dirisane le rona. E tlhalosa dipatisiso ka botlalo, mosola le mokgwa o dipatisiso di tla dirwang ka teng.

Tshekatsheko ya pampiri ya tumalano:

A o tlhalogantse se se kwadilweng mo pampiring ya tumalano?

A pampiri ya tumalano e ne e tlhaloganyesega?

Ke dife dikarolo tsa yone tse di neng di sa tlhaloganyesege?

Go dirisiwe puo efe ya mokwalo mo pampiring e: Setswana/ Sekgoa

A o akanya gore pampiri e, e nne le Sekgoa mo tsebeng e nngwe le Setswana mo go e nngwe.

Melao ya bokopano:

Ke a leboga. Ke tla rata go lebelela melawana e tla re thusang gore re dirisanye sentle mmogo. Ke ka itumela fa re ka nna le dipuisano tse di phuthologileng. Ke eng se re ka dumalanang ka sone gore re nne le tsamaiso ee siameng?

Dikai tsa melawana:

a. Go sena ope yo o tsena o mongwe ganong.
b. Ga o patelesege go dumalana le ba bangwe, mme re tlamega go reetsa le go tlhompha se se buiwang ke ba bangwe.
c. Bua nnete/ boammaruri.
d. Tshegetsa diphiri tsa ba bangwe.
e. Ga go buiwe matlhapa ebile mafoko a lekgotla a mantle otlhe.
f. Le kopiwa go tima megala ya lona ya letheka, mme fa o patelesega go araba mogala, dira jalo o sa tsose modumo, mme o boele ko bokopanong ka bonako.
g. Re tla simolola ka go bua ka boimana jwa banana mo motseng, le dikgand tse di amanang le jone.

Jaanong re tla lebelela **dikgang tsa Sechaba mo motseng** tse di amanang le boimana jwa banana.

1. Maikutlo a sechaba ka boimana jwa banana ke eng?
2. Ke ngwao kgotsa ditumelo dife tse di nang le seabe mo boimaneng jwa banana?
3. Mo ngwaong ya lona, tsholofelo ya gore o ka nyalwa ke dingwatse di le kafe? O solofelwa go nna le ngwana o le dingwaga di le kafe?
4. Mo ngwaong ya lona, a bomme ba kgona go ipuelela go nna le thakanelo dikobo ee babalesegileng?
5. Fa o bona, go ka dirwa eng mo sechabeng go lwantsha boimana jwa banana?
6. Ke ditumelo le melawana efe ya ngwao tse di ka emisiwang go fokotsa dipalo tsa boimana jwa banana?

Mo go latelang mo puisanong ya rona ke ka **maphata a amanang le boimana jwa banana**

1. O akanyang ka lephata le le thusang banana ka kitso ya thibelo boimana, tlhakanelo dikobo ee babalesegileng? O itse sengwe ka lephata le? O na le bokgoni jwa go dirisa ditsompelo tsa lephata le?boleng jwa thuso e tswang mo lephateng le, ke jo bo ntseng jang?
2. Ke dife kgwetlho tse o nang le tsone mabapi le lephata le?
3. Fa o bona go ka fetolwa kgotsa ga tokafadiwa eng mo lephateng le?
4. O akanya gore ba dira melao ba ka dira eng go sireletsa banana mo boimaneng jwa tshoganetso, kgotsa go sireletsa banana mo dingwaong tse di rotloetsang boimana jwa banana?

Seabe sa **ditsala/balekane le baratani** mo boimaneng jwa banana. A re bueng ka ditsala/balekane le baratani: ka fa ba rotloetsang kgotsa ka fa ba sireletsang monana mo boimaneng.

1. Seabe sa ditsala ke eng mo tlhakanelo dikobo ya banana?
2. A go patelesega go tlhakanela dikobo go tswa mo ditsaleng kgotsa motho yo o ratanang le ene?
3. O akanya gore banana na nna le lenaneo/ maikaelelo a gore ba tla thakanela dikobo? A boimana jwa banana bo a bo le mo lenaneong? A banana ba dira lenaneo la gore ba itsholofela leng?
4. Maikutlo a gago ke eng mabapi le tlhakanelo dikobo le tsa thibelo boimana? A ditsala tsa gago ba dirisa tsa thibelo boimana? Maikutlo a bone ke eng ka tsa thibelo boimana?
5. Ke afe mabaka a dirang gore banana ba tlhakanele dikobo?
6. A banana ba basetsana ba kgona go ipuelela gore ba nne le tlhakanelo dikobo ee babalesegileng?
7. O ka akgela o reng ka tlhakanelo dikobo ee diragalang fa gare ga monana le mogolo? A ke sengwe se se tlwaelesegileng mo di tsaleng tsa gago? A bana le bokgoni jwa go ka ipuelela go nna le tlhakanelo dikobo ee babalesegileng mo botsalanong jo?
8. Fa o lebile, go ka dirwa eng go lwantsha thotoetso ee sa siamang ya ditsala?
9. Go ka dirwa eng go lwantsha tlhakanelo dikobo ya monana le mogolo.

Seabe sa **ba lelwapa** mo boimana jwa banana.

1. Ba lelwapa ba na le seabe jang mo go reng monana a feletse a itsholofetse?
2. Ke malwapa a ntseng jang a banan ba tshabelelwang ke go nna baimana?
3. A lelwapa la gago le na le seabe mo goreng o bo o le motsadi o santse o le monana? Fa o dumela, ke eng o rialo?
4. A ba lelwapa ba solofela gore o nne le bana? Ba solofela gore o nne le bana o le ngwaga tse di kafe?
5. A le kgona go bua ka tsa tlhakanelo dikobo mo lelwapeng la lona? O bua le mang ka dikgang tse; ke batsadi, bo kgaitsadi, kgotsa ke lesika le le gaufi? Ke makgetho a le kafe ba lelwapa ba bua ka ts tlhakanelo dikobo?
6. Fa o bona, malwapa a ka dirang go rotloetsa thutho kana kitso ka tsa tlhakanelo dikobo?
7. Fa o lebile, batsadi kgotsa bokgaitsadi ba ka dirang go sireletsa basetsana mo tlhakanelo dikobo ee sa babalesegang ga mmogo le boimana jwa tshoganetso?

Seabe sa **monana** mo diemong tse di mo tsenyang mo diphatseng jwa go amiwa ke boimana le tse di mo sireletsang mo boimaneng jwa banana.

1. Go ya ka wena ke dife diemo ka kakaretso tse di amanang le boimana jwa banana?
2. Ke eng se se bakileng gore o feletse o itsholofetse?
3. O ne o le dingwaga di le kafe fa o ne o itsholofetse? O ne o na le kitso ka tsa tlhakanelo dikobo ga mmogo le tiriso ya thibelo boimana?
4. Go tsweng mo go wena, a o kare o na le kitso ka tsa tlhakanelo dikobo, tsa thibelo boimana ga mmogo le lephata le le thusang banana ka botsogo?
5. O dirile eng go itshireletsa mo go itsholofeleng ka tshoganetso kana o se mo maikaelelong?
6. Ke eng se se ka dirwang ke basetsana ba bangwe go itshireletsa gore ba seka ba itsholofela ba sena maikaelelo a teng?

Tshoboko:

1. Botsa na tsenelela dipuisano:

O ikutlwa jang ka go tsenelela dipuisano tse? Ke eng se se neng se le mothofo? Ke eng se se neng se le thata?

2. Soboka o bo o leboga ba tsenelela dipuisano:

Ke lebogela megopolo le dikakgelo tsa lona tse di ntle. Le nthusitse fela thata, ebile ke lebogela kitso yotlhe ya lona ee neng le e amogana le nna tsatsing leno. Ke itse gore megopolo ya lona e tla dira gore dipatisiso tsa rona di atlege.

Ke a leboga gape go bo le tseneletse dipusiano tse. Ke a le leboga fela thata.

Appendix 3

Interview guide for out-of-school adolescent mothers

Research topic*:* **Risk and Protective Factors for Adolescent Pregnancy among Adolescent girls in Letlhakane Village.**

1. Introduction

Welcome to today's interview. My name is Sizwile Dlamini, a student pursuing Master's Degree of Clinical Social Work at the University of Botswana. I am conducting a research study on factors for adolescent pregnancy in your village. It is part of my educational requirement upon the completion of my Master's degree in Clinical Social Work.

Purpose of the interview

I am conducting a study on individual, family, peer and dyad, community and institutional factors for Adolescent pregnancy in Letlhakane. I requested for your participation in this study because of your lived experiences of being an adolescent mother. I would also like to hear from you about your opinions and ideas. I would like to learn from you as much as possible, so I need your honest answers and everything you are thinking is important to me. First, I would like you to complete an **Assent form.**

2. Demographic Profile

Age of the respondent…….

Marital status……

Highest level of education…….

Place of residence…….

Number of family members……...

Number of children you have**.....**

Individual factors associated with Adolescent pregnancy

1. Tell me a little bit about yourself
2. At what age did you get pregnant? Was your pregnancy planned? Did you have any knowledge about sexual activities and the use of contraceptives? Do you have access to ASRH services?
3. According to your observation, what are the general factors of adolescent pregnancy?
4. What factors do you think contributed towards you becoming pregnant?
5. What are your feelings, and attitudes towards contraceptives?
6. In your own view, would you say you are knowledgeable about sex?
7. In your own view, would you say you are knowledgeable about ASRH services? Where do you get information on sexual education?
8. Why are you not in school? Do you intend on going back to school?
9. What have you done to avoid another unplanned pregnancy?
10. What do you think other adolescent girls can do to avoid unplanned adolescent pregnancies?

Peer and dyad factors associated with Adolescent pregnancy

1. Do you have friends? Tell me a little about your friends. Are they sexually active?
2. According to your observation, do you think there is peer influence/ pressure for one to engage in sexual activities? What kind of pressure do Adolescents put on each other to have sex?
3. In your view, what are the attitudes, feelings of Adolescent girls towards sexual activities and contraceptives?
4. What do you think about intergenerational sex? Is it something that is happening among your peers? Can they negotiate for safer sex in such relationships?
5. What do you think are some of the reasons why Adolescents engage in intimate relationships?
6. What do you think can be done to address intergenerational relationships?
7. What role can be played by peers to reduce risky sexual behaviors among adolescent girls?

Family factors associated with Adolescent pregnancy

1. Describe your family to me…
2. How do families contribute towards one becoming pregnant? In what kind of families are adolescents vulnerable to adolescent pregnancy?
3. Do you think your family played a part towards you becoming an adolescent mother?
4. In your own family, do you talk about sexual activities? Whom do you discuss with, is it parents, siblings or a close relative?
5. In your family, are you expected to have children? At what age are you expected to have children?
6. In your view, what can parents/ siblings do to protect adolescent girls from risky sexual behaviors and unplanned pregnancies?

Community factors associated with Adolescent pregnancy

1. Which factors do you think contribute to adolescent pregnancy in your society? (Religion, neighborhood, culture).
2. In your culture or religion, how are women expected to behave in heterosexual relationships? Can they negotiate for safer sex?
3. At what age are you expected to get married?
4. At what age are you expected to start to have children?
5. Do elder members of the community educate adolescents about sex and sexuality issues?
6. What do you think can be done in your society to address adolescent pregnancy?
7. Which cultural practices, norms and religious beliefs should be eliminated to reduce adolescent pregnancies?

Institutional factors associated with Adolescent pregnancy

1. What do you know about ASRH services? Do you think they are important? Is the service delivery effective? Is there easy accessibility?
2. What do you think can be changed or improved in the adolescent Sexual

Reproductive Health (ASRH) services?

3. What do you think decision makers can do to protect Adolescent girls from unplanned pregnancies and cultural practices that contribute Adolescent pregnancy?
4. Is there anything that the government can do to help you go back to school?

Wrap up

1. Ask the participants:

How did you feel about participating in this session? What was easy? What was hard?

2. Summarize and thank participants

I would like to appreciate all of your great ideas. You have been a big help, and I want to thank you very much for all the information you have shared with me today. I know that your ideas will help to make this study successful.

Thank you once again for your participation- I really appreciate you!

Appendix 4

Pampiri ee fang lesedi ka tsamaiso ya dipuisano le banana ba ba nang le bana.

Setlhogo sa dipatisiso: **Diemo tse di tsenyang banana ba basetsana mo diphatseng le tse di ba sireletsang mo boimananeng jwa banana mo Letlhakane.**

1. **Matseno:**

O a amogelesega mo puisanong ya tsatsi leno. Leina lame ke Sizwile Dlamini, ke moithuti wa ko Mmadikolo mo Botswana. Ke ithuta dithuto tsa boipelego. Ke dira dipatisiso ka diemo tse di amanang le boimana jwa banana mo motseng wa Letlhakane. Ke karolo ya nngwe ya dithuto tsame e ke tshwanetseng go e dira gore ke fetse dithuto tsame.

Mosola wa puisano e:

Ke dira dipatisiso ka boimana jwa banana mo motseng wa Letlhakane, ke lebeletse seabe sa monana, ba lelwapa, ditsala/balekane le baratani, morafe le maphata a lebaganeng le botsogo jwa banana mo dikgang tse di amanang le boimana jwa banana. Ke kopile tirisano mmogo ya gago mo dipatisisong tse ka gore o itse botoka go nna le ngwana o sale monana. Ke tla rata go utlwa megopolo le dikgakololo tsa gago.

Ke tla rata go ithuta go le gontsi mo go wena, ka jalo ke tla kopa boammaruri mo go wena ga mmogo le megopolo eo ka nang le yone. Santlha ke tla rata gore o tlatse pampitshana ya tumelano, ee supang gore o tsere tshwetso ya go tsaya karolo mo dipatisisong tsa boimana jwa banana mo motseng wa Letlhakane.

2. Go itsana le wena:

Dingwaga tsa gago……
Seemo sa nyalo…….
Seemo se se ko godimo sa thuto……
Ko nnang teng……
Palo ya ba lelwapa la gago…….
Palo ya bana ba o nang le bone…….

Seabe sa **monana** mo diemong tse di mo tsenyang mo diphatseng tsa go amiwa ke boimana le tse di mo sireletsang mo boimaneng jwa banana.

1. Mpolelele ka wena ka boripana.
2. O ne wa itsholega o le dingwaga di le kafe? a boimana jwa gago e nnile jwa tshoganetsho? A o ne o na le kitso ka tsa tlhakanelo dikobo ga mmogo le tsa thibelo boimanan? A o na le bokgoni jwa go etela lephata le le thusang banana ka botsogo mabapi le tsa tlhakanelo dikobo le thibelo boimana?
3. Go ya ka wena ke afe mabaka ka kakaretso a tsisang boimana jwa banana?
4. Ke eng se se bakileng gore o feletse o itsholofetse?
5. Maikutlo a gago ke eng mabapi le tsa thibelo boimana?
6. Go ya ka wena, o kare o na le kitso ka tsa tlhakanelo dikobo?
7. Fa o lebile, o ka re o na le kitso ka lephata le le thusang banana ka tsa botsogo mabapi le le tsa tlhakanelo dikobo le tsa thibelo boimana? O tsaya kae thuto ya tsa tlhakanelo dikobo?
8. Ke eng o sa tsene sekolo? A o na le maikaelelo a go boela sekolong?
9. O dirile eng go leka itshireletsa kgathanong le boimanan jwa tshoganetso?
10. Fa o bona, banana ba bangwe ba ka dira eng go itshireletsa kgathanong le boimana jwa tshoganetso?

Seabe sa **ditsala/balekane le baratani** mo diemong tse di tsenyang banana mo diphatseng tsa go amiwa ke boimana le tse di mo sireletsang mo boimaneng jwa banana.

1. A o na le ditsala? Mpolelele ka ditsala tsa gago ka boripana. A ba simolotse go tlhakanela dikobo?
2. Fa o lebile, ditsala/balekane le baratani ba na le thotoetso e kaa bakang gore monana a tsene mo go tsa tlhakanelo dikobo? Ke thotoetso e ntseng jang e banana ba e rotoetsanang mo go tsa tlhakanelo dikobo?
3. Go ya ka wena, maikutlo a banana mo go tsa tlhakanelo dikobo le tsa thibelo boimana ke eng?
4. O ka akgela o reng mo go tlhakanelo dikobo fa gare ga mogolo le monana? Ke sengwe se se diragalang/ tlwaelesegileng mo ditsaleng tsa gago? A ba na le bokgoni jwa go ka ipuelela go nna le tlhakanelo dikobo ee babalesegileng mo botsalanong jo?
5. O akanya gore ke afe mabaka a dirang gore banana ba tsene mo go tsa marato?
6. Go ka dirwa jang go lwantsha tlhakanelo dikobo ya monana le mogolo?

7. Fa o bona, banana ba ka dira eng go itshireletsa mo diphatseng tsa tlhakanelo dikobo?

Seabe sa **lelwapa** mo diemong tse di tsenyang banana mo diphatseng tsa go amiwa ke boimana le tse di mo sireletsang mo boimaneng jwa banana.

1. Ntlhalosetse ka lelwapa la gago?
2. Ba lelwapa ba na le seabe jang mo go reng monana abo a felela a itsholofetse? Ke malwapa a ntseng jang a banana ba tshabelelwang ke go nna baimana?
3. A lelwapa la gago le na le seabe mo go nneng motsadi o santse o le ngwana?
4. A le kgona go bua ka tlhakanelo dikobo mo lelwapeng la gago? O bua le mang ka dikgang tse; ke batsadi, bo kgaitsadi, kgotsa lesika le le gaufi?
5. A ba lesika ba solofela gore o nne le bana? Ba solofela gore o ka simolola go nna le bana o le dingwaga di le kafe?
6. Fa o lebile batsadi kgotsa bokgaitsadi ba ka dirang go sireletsa basetsana mo tlhakanelong dikobo ee sa babalesegang le boimana jwa tshoganetso?

Seabe sa **morafe/Sechaba** mo diemong tse di tsenyang monana mo diphatseng tsa go amiwa ke boimana le tse di mo sireletsang mo boimaneng jwa banana.

1. Ke efe ngwao, tumelo, kana sengwe se se dirwang ke morafe se se bakang boimana jwa banana mo motseng?
2. Mo ngwaong ya lona, basadi ba solofelwa gore ba itshware jang mo lelwapeng? A ba gololesegile go ka ipuelela gore ba nne le tlhakanelo dikobo ee babalesegileng?
3. Ka ngwao ya lona, o solofelwa fa o lekane go nyalwa o le dingwaga di le kafe?
4. O solofelwa fa o lekane go nna le bana o le dingwaga di le kafe?
5. Ka ngwao ya lona, a bagolo ba ruta banana ka tsa tlhakanelo dikobo?
6. Go ka dirwa eng mo sechabeng go lwantsha boimana jwa banana?
7. Ke ditumelo le melawana efe ee ka emisiwang go fokotsa dipalo tsa boimana jwa banana?

Seabe sa **maphata** a amanang le boimana jwa banana.

1. O itse eng ka lephata le le thusang banana ka tsa tlhakanelo dikobo le thibelo boimana? A o akanya gore le botlhokwa? A thuso ee ba e fang banana ke ya maemo a ntlha? O na le bokgoni jwa go dirisa ditsompelo tsa tsa lephata le?
2. O akanya gore go ka fetolwa kgotsa ga tokafadiwa eng mo lephateng le?

3. O akanya gore badira melao ba ka dira eng go sireletsa banana mo boimaneng jwa tshoganetso, kgotsa go sireletsa banana mo dingwaong tse di rotoetsang boimana jwa banana?
4. A go na le se goromente a ka se dirang go go thusa gore o kgone go boela sekolong?

Tshoboko

1. Botsa mo tsenelela dipuisano:

O ikutlwa jang ka go tsenelela puisano e? Ke eng se se neng se le mothofo? Ke eng se se neng se le thata?

2. Soboka o bo o leboga mo tsenelela puisano:

ke lebogela megopolo le dikakgelo tsa gago tse di ntle. o nthusitse fela thata, ebile ke lebogela kitso yotlhe ya gago ee neng o e amogana le nna tsatsing leno. Ke itse gore megopolo ya gago e tla dira gore dipatisiso tsame di atlege.

ke a leboga gape go bo o tseneletse puisano e. Ke a le leboga fela thata.

Appendix 5

Interview guide for the Key Informants

Research topic*:* **Risk and Protective Factors for Adolescent Pregnancy among Adolescent Girls in Letlhakane Village.**

1. **Introduction**

My name is Sizwile Dlamini, a student pursuing Master's Degree of Clinical Social Work at the University of Botswana. I am conducting a research study on the factors for Adolescent pregnancy in Letlhakane village. It is part of my educational requirement upon the completion of my Master's degree in Clinical Social Work.

Purpose of the interview

Welcome to today's interview. I am conducting a study on factors of adolescent pregnancy in Letlhakane, due to the alarming rates of adolescent pregnancy in the village. I requested for your participation in this study because you often interact with Adolescent mothers and provide them with assistance or guidance they need. I would also like to hear from you about your opinions and ideas. I would like to learn from you as much as possible, so I need your honest answers and everything you are thinking about the topic is important to me. First, I would like you to complete a **Consent form.**

2. Demographic Profile

Occupation …….

Gender ……

Highest level of education…….

Organisation…….

Institutional factors associated with Adolescent pregnancy

1. What is your opinion regarding Adolescent pregnancy in Letlhakane? (Probe on prevalence, and effects).
2. In your opinion, are policies and ASRH services in place effective in lessening the factors for adolescent pregnancy?
3. Are there any laws protecting adolescent girls from sexual behaviours, or there are no laws, or laws are not implemented?
4. What laws or policies should be put in place to protect adolescent girls from sexual behaviours?
5. What do you think can be done to make ASRH services more effective?
6. Are there any other strategies or interventions that can be done to address Adolescent pregnancy?

Community factors associated with Adolescent pregnancy.

1. What are the factors associated with Adolescent pregnancy in the community? (Probe on culture, religion, and neighbourhood).
2. Of the mentioned factors, which one do you think is the leading factor?
3. Which cultural practices; norms or religious beliefs promote sexual behaviours that lead to pregnancy?
4. Some cultures tolerate early age marriage and early child bearing. How is Adolescent pregnancy viewed in the society?
5. Do elder members of the community educate adolescents about sexual behaviours?
6. As a key member of the community, what role can you play in lessening the factors of adolescent pregnancy?
7. What do you think can be done by other members of the community to address Adolescent pregnancy?

Peer and dyad factors associated with Adolescent pregnancy

1. According to your observation, do you think peer pressure is a factor for Adolescent pregnancy among adolescent girls in Letlhakane?
2. How do adolescents influence one another?
3. Does the pressure occur amongst friends or between intimate partners?
4. What do you think about Intergenerational sex? Is it happening among adolescent girls in Letlhakane?
5. Can adolescent girls negotiate for safer sex in any intimate relationship?
6. In what other situations do adolescent girls have unplanned pregnancies?
7. What do you think can be done to address negative peer influence?
8. What can be done to address intergenerational relationships?

Family factors associated with Adolescent pregnancy

1. In your view, is poverty in the family a factor associated with Adolescent pregnancy? What are the other factors in a family that can increase the likelihood of an adolescent becoming pregnant?
2. Do families in Letlhakane encourage early age marriage and early child bearing?
3. Do elders in the family talk to adolescents about sex and sexuality issues? How often do they do that? In what kind of situations do they do it?
4. What do you think families can do to protect adolescent girls from sexual behaviours and unplanned adolescent pregnancies?

Individual factors associated with Adolescent pregnancy

1. In your view, what types of Adolescent girls are exposed to Adolescent pregnancy in Letlhakane? Do they have knowledge about the use of contraceptives? What is their attitude towards sex and contraceptives?
2. Which age group of adolescent girls is most likely to be exposed to Adolescent pregnancy?
3. Which cases are more prevalent? (Sexual abuse, intergenerational sex, planned or unplanned pregnancies).
4. What do you think Adolescent girls can do protect themselves from sexual activities

and Adolescent pregnancy?

Wrap up

1. Ask the participants:

How did you feel about participating in this session? Was the interview easy? Was the interview difficult?

2. Summarize and thank participants

I would like to appreciate all your great ideas. You have been a big help, and I want to thank you very much for all the information you have shared with me today. I know that your ideas will help to make this study successful. Thank you once again for your participation- I really appreciate your help!

Appendix 6

Pampiri ee fang lesedi ka dipuisano le ba ba nang le kitso ee kgethegileng.

Setlhogo sa patlisiso: **Diemo tse di tsenyang banana ba basetsana mo diphatseng le tse di ba sireletsang mo boimananeng jwa banana mo Letlhakane.**

1. **Matseno:**

Leina lame ke Sizwile Dlamini, ke moithuti wa ko Mmadikolo mo Botswana. Ke ithuta dithuto tsa boipelego. Ke dira dipatisiso ka diemo tse di amanang le boimana jwa banana mo motseng wa Letlhakane. Ke karolo nngwe ya dithuto tsame e ke tshwanetseng go e dira gore ke fetse dithuto tsame.

Mosola wa patlisiso:

O a amogelesega mo puisanong ya tsatsi leno. Ke dira patlisiso ka diemo/mabaka a a tsenyang banana mo diphatseng tsa amiwa ke boimana le tse di ba sireletsang mo boimaneng jwa banana mo Letlhakane. Lebaka la go dira patlisiso e ke ka ntlha ya matshwenyego ka dipalo tse di ko godimo tsa boimana mo motseng. Ke kopile tirisano mmogo ya gago ka gore o bereka le banana ebile o ba fa thuso le dikgakololo tse ba di tlhokang.

Ke ka rata go utlwa megopolo le dikgakololo tsa gago. Ke ka tla rata gape go ithuta go le gontsi mo go wena, ka jalo ke tla kopa boammaruri mo go wena ga mmogo le megopolo eo ka nang le yone. Santlha ke tla rata gore o tlatse pampitshana ya tumelano, ee supang gore o tsere tshwetso ya go tsaya karolo mo dipatisisong tsa boimana jwa banana mo motseng wa Letlhakane.

1. Go itsana le lona:

Maemo a ko tirong……

Monna/mosadi……..

Seemo se se ko godimo sa thuto……

Ko o direlang teng……

Seabe sa **maphata** a amanang le boimana jwa banana

1. O ka akgela o reng mabapi le dipalo tsa boimana jwa banana mo Lelthakane ga mmogo le ditlamorago tsa boimana jwa tshoganetso mo bananeng?

2. Go ya ka wena, a melao le lephata le le thusang banana ka tsa tlhakanelo dikobo le tsa thibelo boimanan di nonofile thata go ka lwantsha mabaka a boimana jwa banana?
3. A go na le melao e sireletsang banana mo diphatseng tsa tlhakanelo dikobo, kana ga gona melao gothelele, kgotsa melao ga e diragetswe kana ga e salwe morago?
4. Ke melao kgotsa melawana efe e tshwanetseng go nna teng go ka sireletsa banana mo bodiphatseng jwa tlhakanelo dikobo?
5. O akanya gore go ka dirwa eng gore lephata le le thusang banana ka tsa tlhakanelo dikobo le tsa thiblo boimana le kgone go thusa banana ka mokgwa o maleba ebile o le botoka go na le seemo sa gompieno?
6. A go na le mananeo kgotsa maranyane a ka dirwang go lwantsha boimana jwa banana?

Seabe sa **morafe/Sechaba** mo diemong tse di tsenyang monana mo diphatseng tsa go amiwa ke boimana le tse di mo sireletsang mo boimaneng jwa banana.

1. Ke efe ngwao, tumelo, kana sengwe se se dirwang ke morafe se se nang le seabe mo boimaneng jwa banana mo motseng?
2. Mo mabakeng a tsenyang banan mo diphatseng tsa go amiwa ke boimana, ke lefe lebaka le le eteletseng ko pele?
3. Ke ditumelo le melawana efe ee rotloetsang tlhakanelo dikobo e ditlamorago tsa yone e leng boimana?
4. Dingwao tse dingwe di rotloetsa/ di amogela yalo ya mosetsana a na le dingwaga tse di ko tlase le go nna le ngwana a santse a le monana.
5. Ka ngwao ya lona, A a bagolo ba ruta banan ka tsa tlhakanelo dikobo?
6. Jaaka o le mongwe wa boleng mo sechabeng, seabe se o ka se dirang go leka go fokotsa dipalo tsa boimana jwa banana ke eng?
7. O akanya gore baagisane ka wena mo sechabeng ba ka dira eng go lwantsha boimana jwa banana?

Seabe sa **ditsala/ balekane le baratani** mo diemong tse di tsenyang monana mo diphatseng tsa go amiwa ke boimana le tse di mo sireletsang mo boimaneng jwa banana.

1. Go ya ka wena, a thotoetso ya ditsala/balekane le baratani e na le seabe mo diemong tse di tsenyang banana mo diphatseng tsa go amiwa boimana?
2. Banana ba rotloetsana jang?
3. A thotoetso e, e tswa mo ditsaleng kgotsa mo go ba ba ratanang le bone?

4. O ka akgela o reng ka tlhakanelo dikobo fa gare ga mogolo le monana? A ke sengwe se se diragalang kana se se tlwaelesegileng mo Letlhakane?
5. A banana ba na la bokgoni jwa go ka ipuelela gore ba nne le tlhakanelo dikobo ee babalesegileng mo botsalanong jo?
6. Ke diemo dife tse dingwe tse banana ba nnang le boimana jwa tshoganetso?
7. O akanya gore go ka dirwa eng go lwantsha thotoetso ee sa siamang ya ditsala/balekane le baratani?
8. Go ka dirwa jang go lwantsha tlhakanelo dikobo ya monana le mogolo?

Seabe sa **lelwapa** mo diemong tse di tsenyang monana mo diphatseng tsa go amiwa ke boimana le tse di mo sireletsang mo boimaneng jwa banana.

1. A lehuma mo lwapeng ke nngwe ya diemo tse di bakang boimana jwa banana? Ke dife diemo tse dingwe tsa mo lwapeng tse di rotloetsang boimana jwa banana?
2. A malwapa a mo Letlhakane ba rotloetsa go nyalwa ga monana a le dingwaga tse di ko tlase? Le go nna le ngwana ga monana a le dingwaga tse di ko tlase?
3. Mo lwapeng, a bagolo ba nna le dipuisano le babana ka tsa tlhakanelo dikobo? Ba nna le dipuisano tse makgetho a le kafe? mo diemong dife?
4. Fa o lebile, batsadi le bo kgaitsadi ba ka dira eng go sireletsa banana mo bodiphatseng jwa tlhakanelo dikobo le boimana jwa tshoganetso?

Seabe sa **monana** mo diemong tse di mo tsenyang mo diphatseng tsa go amiwa ke boimana le tse di mo sireletsang mo boimaneng jwa banana.

1. Go ya ka wena, ke banana bafe ba ba tshabelelwang ke go nna le boimana jwa tshoganetso mo Letlhakane? A ba na le kitso ka tsa thibelo boimana? Maikutlo a bone ke afe mabapi le tsa tlhakanelo dikobo le tsa thibelo boimana?
2. Ke banana ba dingwaga tse di kafe ba ba tshabelelwang ke go nna le boimana jwa tshoganetso?
3. Ke dikgang dife tse di eteletseng pele? i) kgokgontsho ya tsa tlhakanelo dikobo?
   ii) tlhakanelo dikobo ya monana le mogolo
   iii)boimana jo bo dirwang ka maikaelelo/lenaneo
   iv) boimana jwa tshoganetso
4. O akanya gore banana ba ka dira eng go itshireletsa kgathanong le diphatsa tsa tlhakanelo dikobo ga mmogo le boimana?

Tshoboko

1. Botsa mo tsenelela dipuisano:

O ikutlwa jang ka go tsenelela puisano e? Ke eng se se neng se le mothofo? Ke eng se se neng se le thata?

2. Soboka o bo o leboga mo tsenelela puisano:

ke lebogela megopolo le dikakgelo tsa gago tse di ntle. o nthusitse fela thata, ebile ke lebogela kitso yotlhe ya gago ee neng o e amogana le nna tsatsing leno. Ke itse gore megopolo ya gago e tla dira gore dipatisiso tsame di atlege.

ke a leboga gape go bo o tseneletse puisano e. Ke a le leboga fela thata.

Appendix 7

INFORMED CONSENT FORM (Key Informants)

PROJECT TITLE*:* Risk and Protective Factors for Adolescent Pregnancy among Adolescent Girls in Letlhakane Village.

Principal Investigator: **Sizwile Dlamini (MS)**

Phone number(s): **77051257/ 71425652**

What you should know about this research study:

- You are given this informed consent document so that you may read about the purpose, risks, and benefits of this research study.
- You have the right to refuse to take part, or agree to take part now and change your mind later.
- Please review this consent form carefully. Ask any questions before you make a decision.
- Your participation is voluntary.

PURPOSE

You are being asked to participate in a research study of Ms. Sizwile Dlamini as a partial fulfillment of Master's Degree of Clinical Social Work. The purpose of the study is to investigate individual, family, peer and dyad, community and institutional factors of Adolescent pregnancy in Letlhakane**.** The study is hoped to contribute to the existing body of knowledge and fill existing knowledge gaps, and assist practitioners to develop multi-level context-specific intervention strategies that lessen the risk factors and promote protective factors associated with Adolescent pregnancy. You are therefore selected as a possible participant in this study because you often interact with Adolescent mothers and provide them with assistance or guidance they need. Before you sign this form, please feel free to ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

PROCEDURES AND DURATION

If you decide to participate, you will be invited to a semi-structured interview that will last about 45 minutes, whereby you will share your knowledge and ideas on the topic at hand.

RISKS AND DISCOMFORTS

There are no foreseeable risks. The researcher will minimize any harm towards the participant. If at any time you feel uncomfortable due to the questions being asked by the researcher, you may opt not to answer the questions. However if you experience psychological discomfort due to the questions asked, you will be referred to a social worker for further assistance.

BENEFITS AND/OR COMPENSATION

There are no personal benefits, such as token of appreciation for participating in this study. However, if you agree to take part in this study, findings from the study will serve as baseline information through which social workers, nurses, teachers and parents in the village can act on to address the issue of adolescent pregnancy.

CONFIDENTIALITY

The data from this investigation will be kept confidential and will not be shared without your consent. Your name will remain anonymous as it will not be written in the research findings. None of these will be used for commercial use.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the University of Botswana, its personnel, and associated institutions**.** If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty. Any refusal to observe and meet appointments agreed upon with the central investigator will be considered as implicit withdrawal and therefore will terminate the subject's participation in the investigation without his/her prior request.

AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

_____ _____ _____

Name of Research Participant (please print) Signature Date

_____ _____

Signature of Staff Obtaining Consent Date

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP.

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research participant; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the Office of Research and Development, University of Botswana, Phone: Ms. Dimpho Njadingwe on 355-2900, E-mail: research@mopipi.ub.bw, Telefax: [0267] 395-7573.

Appendix 8

FOMO YA TUMALANO YA GO TSAYA KAROLO (Key Informants)

SETLHOGO SA PATLISISO: **Diemo/ Mabaka a tsenyang Basetsana mo diphatseng tsa go amiwa ke boimana le tse di ba sireletsang mo boimaneng jwa banana mo Letlhakane.**

Mogolwane wa Dipatlisiso: **Mme Sizwile Dlamini**

Nomore ya mogala: 77051257/ 71425652

Se o tshwanetseng go se itse ka patlisiso e:

- Ke go neela pampiri e ya tumalano ya go tsaya karolo gore o ka bala ka mosola, dikgwetlho le dipoelo tsa patlisiso e.
- O na le tshwanelo ya go gana go tsaya karolo kana go dumela jaanong kana go fetola mogopolo mo tsamaong ya nako.
- Tswee tswee bala pampiri e ya tumalano ya go tsaya karolo ka kelotlhoko. Botsa dipotso dipe fela pele ga o tsaya tshwetso.
- Go tsaya karolo ga gago ke ga boithaopo.

BOTLHOKWA/MOSOLA WA PATLISISO

O kopiwa go tsaya karolo mo patlisisong ya ga Mme Sizwile Dlamini, Ke karolo nngwe ya dithuto tsame tsa Boipelego e ke tshwanetseng go e dira gore ke fetse dithuto tsame. Botlhokwa jwa patlisiso e, ke go sekaseka seabe sa monana, lelwapa, ditsala/balekane le baratani, morafe/sechaba le maphata a thusang banana ka tsa tlhakanelo dikobo le tsa thibelo boimana mo Letlhakane. Go dira patlisiso e ke solofela go tla; oketsa kitso e ntseng e le teng, le go tsibosa mo di dikgang tse di sa tlhaloganyesegeng. Ga mmogo le go thusa babereki ba ba amanang le botsogo jwa banana go tswa ka maano le mananeo a fokotsang diemo tse di tsenyang banana mo diphatseng tsa go amiwa ke boimana.

Ke solofela gape gore patlisiso e, e ka rotloetsa mabaka aa sireletsang banana go ikgapha mo boimaneng jwa banana. O tlhophilwe jaaka moitseanape ka go bo o bereka le banana ebile o ba fa thuso le dikgakololo tse ba di tlhokang. Pele ga o ka baya pampiri e monwana, tlhomamisa gore o botsa ka ga sepe fela se o sa se tlhaloganyeng ka patlisiso e. O ka tsaya nako ya gago go akanya ka yone.

TSAMAISO LE SEBAKA

Fa o tsaya tshwetso ya go tsaya karolo, o tla lalediwa go tsenelela dipuisano tse di tla tsayang lobaka la metsotso e le masome a mane le botlhano, e mo sebakeng se o tlabong o amogana kitso le megopolo ka setlhogo se go tlabong go buiwa ka sone.

DITLAMORAGO LE DIKGORELETSI

Ga ke solofele go tla nna le diphatsa dipe. Mmatlisisi o tla fokotsa diphatsa dipe fela tse di ka lebaganang le wena. Ka nako nngwe le ngwe fela fa o ikutlwa o sa gololosega go ka araba, lebaka e le dipotso tse di botswang, go a le tlelesega gore o seka wa araba. Gape, fa o ka kgoberega maikutlo ka lebaka la dipotso tse di botswang, o tla romelwa ko go Mma/Rra-boipelego gore a go thuse.

DIPOELO LE/KANA DIKATSO

Ga gona dikatso dipe, jaaka dimpho tse o di neelwang e le go lebogelwa go tsaya karolo mo patlisisong e. Le fa go ntse jalo, fa o ka dumela go tsaya karolo mo patlisisong e, maduo a patlisiso e a ka bereka e le motheo o bo Mma/Rra-boipelego, baoki, barutabana, le batsadi ba ka o dirisang go lwantsha mathata a boimana jwa banana.

TSHOMARELO SEPHIRI

Sengwe le sengwe se se tla fitlhelwang ga sena go amoganwa le ope go sa dirwa tumalano le wena. Leina la gago le tla nna sephiri, ga le na go kwalwa mo go sepe se se fitlhelwang mo patlisisong e. Ga go sepe sa patlisiso e se tla dirisiwang go dira madi.

GO ITHAOPA GO TSAYA KAROLO

Go a ithaopiwa go tsaya karolo mo patlisisong e. Fa o tsaya tshwetso ya go seke o tsee karolo, ga go kake ga ama tirisano ya gago le University of Botswana mo nakong e tlang kgotsa le makalana a amanang le yone. Fa o tsaya tshwetso ya go tsaya karolo, o gololesegile go ka boela morago nako nngwe le nngwe ntleng ga tuediso epe. Ga o ka gana go kopana le mmatlisisi ka nako e le e dumalaneng, go tla a tsewa e le sesupo sa gore o ikgogetse morago mme ka jalo kamano ya gago mo patlisisong e tla busediwa morago le fa o sa fa kopo epe.

TESELETSO

O dira tshwetso ya go tsaya kgotsa go seke o tsee karolo mo patlisisong e. Monwana wa gago o supa fa o badile e bile o tlhalogantse ditlhaloso tse o di filweng fa godimo, e bile dipotso tsa gago tsotlhe di arabesegile, gape o tsere tshwetso ya go tsaya karolo.

_____ _____

Leina la mo tsaya karolo (kwala) Letsatsi

_____

Monwana wa mo tsaya karolo

_____

Monwana wa mmereki yo o tsayang tumalano

O TLA A NEELWA PAMPIRI E NNGWE YA TUMALANO GORE O E BEE SENTLE.

Fa o na le dipotso tse di amanang le patlisiso e, kgotsa tumalano e ntleng ga tse di arabilweng ke mmatlisisi, ga mmogo le dipotso ka ga patlisiso e, ditshwanelo tsa gago o le mo tsaya karolo; kana o akanya gore ga o a tsewa sentle, ka tswee-tswee utlwa o gololesegile go ka ikgolaganya le ba ofisi ya patlisiso le ditlhabololo (Research and Development) ko University ya Botswana, mogala: Ms Dimpho Njadingwe on 355-2900, E-mail:research@mopipi.ub.bw, Telefax: [0267] 395-7573.

Appendix 9

PARENT/GUARDIAN CONSENT FORM

PROJECT TITLE*:* **Risk and Protective Factors for Adolescent Pregnancy among Adolescent Girls in Letlhakane Village.**

Principal Investigator: **Sizwile Dlamini (MS)**

Phone number(s): **77051257/ 71425652**

What you should know about this research study:

- You are given this informed consent document so that you may read about the purpose, risks, and benefits of this research study.
- Your child has the right to refuse to take part, or agree to take part now and change her mind later.
- Please review this consent form carefully. Ask any questions before you make a decision.
- Participation of your child is voluntary.

PURPOSE

Your child is being asked to participate in a research study of Ms. Sizwile Dlamini as a partial fulfillment of Master's Degree of Clinical Social Work. The purpose of the study is to investigate individual, family, peer and dyad, community and institutional factors of Adolescent pregnancy in Letlhakane**.** The study is hoped to assist practitioners to develop multi-level context-specific intervention strategies that lessen the risk factors and promote protective factors associated with Adolescent pregnancy. Your child is therefore selected as a possible participant in this study because she has experiences of being an adolescent mother. Before you sign this form, please feel free to ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

PROCEDURES AND DURATION

If you decide that your child will participate, she will be invited to a focus group discussion that will last about 45 minutes, whereby she will share her knowledge and ideas about Adolescent pregnancy.

RISKS AND DISCOMFORTS

There are no foreseeable risks. The researcher will minimize any harm towards your child. However, in case whereby your child experiences psychological discomfort during or after an interview, she will be referred to a social worker for further assistance.

BENEFITS AND/OR COMPENSATION

There are no personal benefits, such as token of appreciation, for participating in this study. However, if you agree to your child taking part in this study, the findings of the study will serve as baseline information through which social workers, nurses, teachers and parents in the village can act on to address the issue of adolescent pregnancy.

CONFIDENTIALITY

The data from this investigation will be kept confidential and will not be shared without your consent. The name of your child will remain anonymous as it will not be written in the research findings. None of these will be used for commercial use.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide to your child not participating in this study, your decision will not affect your future relations with the University of Botswana, its personnel, and associated institutions**.** Your child has the right to stop participating in this study at any time, even if you have already given your consent. Refusal to participate or withdrawal from the study will not involve penalty. Any refusal to observe and meet appointments agreed upon with the central investigator will be considered as implicit withdrawal and therefore will terminate the subject's participation in the investigation without his/her prior request.

AUTHORIZATION

You are making a decision whether or not your child should to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided that your child will participate.

As parent or legal guardian, I authorize _____ (**Child's name**) to become a participant in the research study described in this form.

Researcher/Research Assistant signature: _____

Name of Parent or Legal Guardian

_____

Parent or Legal Guardian's Signature Date

_____

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP.

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your child's rights as a research participant; or if you feel that your child has been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the Office of Research and Development, University of Botswana, Phone: Ms Dimpho Njadingwe on 355-2900, E-mail: research@mopipi.ub.bw, Telefax: [0267] 395-7573.

Appendix 10

FOMO YA TUMALANO YA GO TSAYA KAROLO

(Motsadi/ Motlhokomedi wa ngwana)

SETLHOGO SA PATLISISO: **Diemo/ Mabaka a tsenyang Basetsana mo diphatseng tsa go amiwa ke boimana le tse di ba sireletsang mo boimaneng jwa banana mo Letlhakane.**

Mogolwane wa Dipatlisiso: **Mme Sizwile Dlamini**

Nomore ya mogala: 77051257/ 71425652

Se o tshwanetseng go se itse ka patlisiso e:

- Ke go neela pampiri e ya tumalano ya go tsaya karolo gore o ka bala ka mosola, dikgwetlho le dipoelo tsa patlisiso e.
- Ngwana wa gago o na le tshwanelo ya go gana go tsaya karolo kana go dumela jaanong kana go fetola mogopolo mo tsamaong ya nako.
- Tswee tswee bala pampiri e ya tumalano ya go tsaya karolo ka kelotlhoko. Botsa dipotso dipe fela pele fa o tsaya tshwetso.
- Go tsaya karolo ga gago ke ga boithaopo.

BOTLHOKWA/MOSOLA WA PATLISISO

Ngwana wa gago o kopiwa go tsaya karolo mo patlisisong ya ga Mme Sizwile Dlamini, Ke karolo nngwe ya dithuto tsame tsa Boipelego e ke tshwanetseng go e dira gore ke fetse dithuto tsame. Botlhokwa jwa patlisiso e, ke go sekaseka seabe sa monana, lelwapa, ditsala/balekane le baratani, morafe/sechaba le maphata a thusang banana ka tsa tlhakanelo dikobo le tsa thibelo boimana mo Letlhakane. Go dira patlisiso e ke solofela go tla thusa babereki ba ba amanang le botsogo jwa banana go tswa ka maano le mananeo a fokotsang diemo tse di tsenyang banana mo diphatseng tsa go amiwa ke boimana.

Ke solofela gape gore patlisiso e, e ka rotloetsa mabaka aa sireletsang banana go ikgapha mo boimaneng jwa banana. Ngwana wa gago o tlhophilwe jaaka moitseanape ka go bo a na le kitso ka go nna motsadi a le monana. Pele ga o ka baya pampiri e monwana, tlhomamisa gore o botsa ka ga sepe fela se o sa se tlhaloganyeng ka patlisiso e. O ka tsaya nako ya gago go akanya ka yone.

TSAMAISO LE SEBAKA

Fa o tsaya tshwetso ya gore ngwana wa gago o tla tsaya karolo, ngwana o tla lalediwa go tsenelela dipuisano tse di tla tsayang lobaka la metsotso e le masome a mane le botlhano, e mo sebakeng se o tlabo a amogana kitso le megopolo ka setlhogo se go tlabong go buiwa ka sone.

DITLAMORAGO LE DIKGORELETSI

Ga ke solofele go tla nna le diphatsa dipe. Mmatlisisi o tla fokotsa diphatsa dipe fela tse di ka lebaganang le ngwana. Le fa go ntse jalo, fa ngwana wa gago a ka kgoberega maikutlo dipuisano di santse di tsweletse kgotsa morago ga dipuisano, o tla romelwa ko go Mma/Rra-boipelego gore a mo thuse.

DIPOELO LE/KANA DIKATSO

Ga gona dikatso dipe, jaaka dimpho tse a tla di neelwang e le go lebogelwa go tsaya karolo mo patlisisong e. Le fa go ntse jalo, fa o ka dumela gore ngwana wa gago o ka tsaya karolo mo patlisisong e, maduo a patlisiso e a ka bereka e le motheo o bo Mma/Rra-boipelego, baoki, barutabana, le batsadi ba ka o dirisang go lwantsha mathata a boimana jwa banana.

TSHOMARELO SEPHIRI

Sengwe le sengwe se se tla fitlhelwang ga sena go amoganwa le ope go sa dirwa tumalano le wena. Leina la ngwana wa gago le tla nna sephiri, ga le na go kwalwa mo go sepe se se fitlhelwang mo patlisisong e. Ga go sepe sa patlisiso e se tla dirisiwang go dira madi.

GO ITHAOPA GO TSAYA KAROLO

Go a ithaopiwa go tsaya karolo mo patlisisong e. Fa o tsaya tshwetso ya gore ngwana wa gago a seka a tsaya karolo, ga go kake ga ama tirisano ya gago le University of Botswana mo nakong e tlang kgotsa le makalana a amanang le yone. Ngwana wa gago o na le teta ya go ka emisa go tsaya karolo nako nngwe le nngwe, le fa o ne o setse o dumetse gore o ka tsaya karolo. Fa o tsaya tshwetso ya gore ngwana wa gago o ka tsaya karolo, o gololesegile go ka boela morago nako nngwe le nngwe ntleng ga tuediso epe. Fa ngwana a ka gana go kopana le mmatlisisi ka nako e ba e dumalaneng, go tla a tsewa e le sesupo sa gore o ikgogetse morago mme ka jalo kamano ya gagwe mo patlisisong e tla busediwa morago le fa o sa fa kopo epe.

TESELETSO

O dira tshwetso ya gore ngwana wa gago o ka tsaya karolo kgotsa o ka seke o tsee karolo mo patlisisong e. Monwana wa gago o supa fa o badile e bile o tlhalogantse ditlhaloso tse o di

filweng fa godimo, e bile dipotso tsa gago tsotlhe di arabesegile, gape o tsere tshwetso ya gore ngwana wa gago o ka tsaya karolo.

Jaaka motsadi kgotsa motlhokomedi wa ngwana, ke dumela gore_____ a tsenelele patlisiso e tlhalositsweng fa godimo.

Monwana wa Mmatlisisi/ mothusi wa gagwe _____

Leina la Motsadi/ Motlhokomedi wa ngwana _____

Monwana wa Motsadi/ Motlhokomedi) _____

Letsatsi _____

O TLA A NEELWA PAMPIRI E NNGWE YA TUMALANO GORE O E BEE SENTLE.

Fa o na le dipotso tse di amanang le patlisiso e, kgotsa tumalano e ntleng ga tse di arabilweng ke mmatlisisi, ga mmogo le dipotso ka ga patlisiso e, ditshwanelo tsa ngwana wa gago a le mo tsaya karolo; kana o akanya gore ngwana wa gago ga a tsewa sentle, ka tswee-tswee utlwa o gololesegile go ka ikgolaganya le ba ofisi ya patlisiso le ditlhabololo (Research and Development) ko University ya Botswana, mogala: Ms Dimpho Njadingwe on 355-2900, E-mail:research@mopipi.ub.bw, Telefax: [0267] 395-7573.

Appendix 11

PROJECT TITLE: Risk and Protective Factors for Adolescent Pregnancy among Adolescent Girls in Letlhakane Village.

ASSENT FORM (Adolescent mothers)

My name is Sizwile Dlamini. I am trying to learn about factors contributing to Adolescent pregnancy among Adolescent girls in Letlhakane. This is because of the concerning rates of Adolescent pregnancy in Letlhakane. If you would like, you can be in my study.

If you decide you want to be in my study, you will be invited to a discussion that will last for about 45 minutes. In this discussion, you will be asked to share your knowledge and ideas regarding Adolescent pregnancy.

There are no anticipated risks, however if you experience emotional discomfort during or after the interview, you will be referred to a Social Worker for further assistance. If you agree to take part in this study, the study will be used as a baseline information to assist practitioners to develop interventions that address Adolescent pregnancy.

Other people will not know if you are in my study. I will put things I learn about you together with things I learn about other Adolescents, so no one can tell what things came from you. When I tell other people about my research, I will not use your name, so no one can tell who I am talking about.

Your parents or guardian have to say it's OK for you to be in the study. After they decide, you get to choose if you want to do it too. If you don't want to be in the study, no one will be mad at you. If you want to be in the study now and change your mind later, that's OK. You can stop at any time.

My cellphone number is **77051257/ 71425652**. You can call me if you have questions about the study or if you decide you don't want to be in the study any more. I will give you a copy of this form in case you want to ask questions later.

Agreement

I have decided to be in the study even though I know that I don't have to do it. Ms. Dlamini has answered all my questions.

_____ _____

Signature of Study Participant Date

_____ _____

Signature of Researcher Date

Appendix 12

FOMO YA TUMALANO (Banana ba ba nang le bana).

SETLHOGO SA PATLISISO: Diemo/ Mabaka a tsenyang Basetsana mo diphatseng tsa go amiwa ke boimana le tse di ba sireletsang mo boimaneng jwa banana mo Letlhakane.

Leina lame ke Sizwile Dlamini, ke leka go ithuta ka dikgang tse di amanang le boimana jwa banana ba basetsana mo Letlhakane. Patlisiso e ke ka ntlha ya lebaka la matshwenyego ka boimana jwa banana mo motseng wa Letlhakane. Fa o rata, o ka tsaya karolo mo patlisisong e.

Fa o ka dira tshwetso go tsaya karolo mo patlisisong e, o tla lalediwa go tsenelela dipuisano tse di tla tsayang lobaka la metsotso e le masome a mane le botlhano. Mo dipuisanong tse, o tla kopiwa go amogana kitso le megopolo e o nang le yone mabapi le dikgang tsa boimana jwa banana.

Ga ke solofele go tla nna le diphatsa dipe. Le fa go ntse jalo, fa o ka kgoberega maikutlo dipuisano di santse di tsweletse kgotsa morago ga dipuisano, o tla romelwa ko go Mma/Rra-boipelego gore a go thuse. Fa o dumela go tsaya karolo mo patlisisong e, maduo a patlisiso e a ka bereka e le motheo o bo Mma/Rra-boipelego, baoki, barutabana, le batsadi ba ka o dirisang go lwantsha boimana jwa banana.

Batho ba bangwe ga bana go itse gore o tsaya karolo mo patlisisong e. ke tla kopanya dilo tse ke di ithutang mo go wena, ga mmogo le tsa banana ba bangwe, gore go sena ope o ka lemogang gore ke dife dilo tse di tswang ko go wena. Fa ke bolelela batho ka patlisiso e, ga kena go bua ka leina la gago gore go sena ope o itseng gore ke bua ka mang.

Motsadi kgotsa motlhokomedi wa gago o tshwanetse gore are go siame gore o ka tsaya karolo mo patlisisong e. Fa a sena go dumela, ke gone o ka tsayang tshwetso ya go tsaya karolo. Fa o sa batle go tsaya karolo mo patlisisong e, ga gona ope yo o ka go tenegelelang. Fa o batla go tsaya karolo gompieno, obo o fetola mogopolo moragonyana, go ntse go siame fela. O ka emisa nako nngwe le nngwe.

Nomore ya mogala wame ke **77051257/ 71425652.** O ka nteletsa fa o na le dipotso ka patlisiso e, kgotsa fa o tsaya tshwetso ya gore ga o sa tlhole o batla go tsenelela patlisiso e. Ke tla go neela pampiri e nngwe ya tumalano gore o e bee sentle.

TUMALANO

Ke tsere tshwetso ya go tsaya karolo mo patlisisong e, le fa ke itse gore gake patelesege go dira jalo. Mme Dlamini o arabile dipotso tsotlhe tsame.

_____ _____

Monwana wa mo tsaya karolo Letsatsi

_____ _____

Monwana wa Mmatlisisi Letsatsi

Appendix 13

UNIVERSITY of BOTSWANA

Office of the Deputy Vice Chancellor (Academic Affairs)

Office of Research and Development

Corner of Notwane and Mobuto Road, Gaborone, Botswana

Pvt Bag 00708 Gaborone Botswana

Tel: [267] 355 2900
Fax: [267] 395 7573
E-mail: research@mopipi.ub.bw

Ref: UBR/RES/IRB/SOC/GRAD/113

4th May 2018

The Permanent Secretary
Ministry of Local Government and Rural Development
Private Bag 006
Gaborone, Botswana

RE: REQUEST FOR EXPEDITED REVIEW OF A RESEARCH PROPOSAL SUBMITTED BY MS SIZWILE DLAMINI.

Since it is a requirement that everyone undertaking research in Botswana should obtain a Research Permit from the relevant arm of Government, The Office of Research and Development at the University of Botswana has been tasked with the responsibility of overseeing research at UB including facilitating the issuance of Research Permits for all UB Researchers inclusive of students and staff.

I am writing this letter in support of an application for a Research Permit Ms Sizwile Dlamini, a master's student from Department of Social Work at the University of Botswana. Ms Dlamini has proposed to conduct a study titled **"Risk and Protective Factors for Adolescent pregnancy among Adolescent Girls in Letlhakane Village."** The overall objective of the proposed study is to explore the risks and protective factors of Adolescent pregnancy using the Social-ecological model. It is hoped that the findings of this study could help to raise awareness among decision-makers about the intensity of the risk factors associated with Adolescent pregnancy. Furthermore, this study may reveal the risk and protective factors of Adolescent pregnancy across different levels of influence hence it may motivate other scientists to engage in research to explore these factors more.

The Office of Research and Development is satisfied with the process for data collection, analysis and the intended utilisation of findings from this research. We will appreciate your kind and timely consideration of this application.

We thank you for your continued cooperation and assistance

Sincerely,

UNIVERSITY OF BOTSWANA Office of Research & Development 2018 -05- 04 P/BAG UB 00708 GABORONE TEL: +267 355 2900 FAX: 3957573 research@mopipi.ub.bw

Dr M. Kasule
Assistant Director, Research Ethics, Office of Research & Development

Appendix 14

TELEGRAMS: MERAFE

Telephone: 3658400
Fax: 3902263/1559

Ministry of Local Government

& Rural Development
Private Bag 006
Gaborone
BOTSWANA

REPUBLIC OF BOTSWANA

Ref Number CLG 14/14/3/1 II (164)

May 8, 2018.

Ms. Sizwile Dlamini
Department of Social Work
University of Botswana
Private Bag 0022
Gaborone

Dear Madam,

RE: RESEARCH PERMIT

This serves to acknowledge your application for a research permit in order to carry out a study entitled **"Risk and Protective Factors for Adolescent Pregnancy Among Adolescent Girls in Letlhakane Village."**

We are pleased to grant you a permit. This permit is valid for a period of two (2) months commencing on **May 8, 2018** to **July 8, 2018** – and it is granted subject to the following conditions:

1. Copies of the final product of the study are to be directly deposited with the Ministry of Local Government, National Archives and Record Services and University of Botswana Library.
2. The permit does not give you authority to enter any premises, private establishment or protected areas. Permission for such entry should be negotiated with those concerned.
3. You conduct your study according to particulars furnished in application you submitted taking into account the above conditions.
4. Failure to comply with any of the above stipulated conditions will result in the immediate cancellation of the permit.

Yours Faithfully,

MINISTRY OF LOCAL GOVERNMENT
0 8 MAY 2018
LIBRARY

K. Senthufhe
/For Permanent Secretary- MLGRD

BOTSWANA
Our pride, your destination

MLG – A centre of excellence in local governance & social service provision for improved quality of life

Appendix 15

SAVINGRAM

FROM: Chief Education Officer
Boteti Sub-Region

M Nduna

TEL NO: 2978365/238

FAX NO: 2978966

TO: School Heads
All Primary Schools - Letlhakane
All Secondary Schools - Letlhakane

REF NO: BSR 1/13/ I (21) 7 June 2018

PERMISSION TO CONDUCT A RESEARCH – MS SIZWILE DLAMINI

This sserves to inform you that the above named student has been granted permission to carry out research in a population of Letlhakane Schools.

She is a student in the Department of Social Work, University of Botswana, and she is carrying out a Research on a **"Risk and Protective Factors for Adolescent Pregnancy Among Adolescent Girls in Letlhakane village"**.

Thank you.

MINISTRY OF EDUCATION & SKILLS DEVELOPMENT
CHIEF EDUCATION OFFICER
ADMINISTRATION
07 JUN 2018
P. O. BOX 30, LETLHAKANE
BOTETI SUB REGION TEL: 297

MoBE
MINISTRY OF BASIC EDUCATION
MoBE CONTACT CENTRE 16885
BOTSWANA 50
BOTSWANA

RESIST, REJECT AND REPORT CORRUPTION - TOLL FREE: 0800 600 990

Appendix 16

TELEPHONE: 2976172
FAX: 2976187
TEL: RABONGAKA

BOTETI DHMT
Private Bag 49
LETLHAKANE

Republic of Botswana

REF: BDHMT 1/003 I (49) **11th June 2018**

Ms Sizwile Dlamini
Private Bag 051
Letlhakane

Dear Madam,

PERMISSION TO CONDUCT INTERVIEWS WITH MIDWIVES IN LETLHAKANE

Reference is made to your request and permission granted to conduct interviews with midwives and teenage mothers in Letlhakane.

Thank you for choosing Letlhakane village as your first choice of research study as this will guide us on what could be done to lessen the numbers of unwanted teenage pregnancies as stated in the letter.

It is my pleasure to inform you that you are hereby granted authority to conduct the research provided that all conditions of the research permit will be followed. You are also advised that at the end of the research, a copy of the report be sent to DHMT Head' office including consent obtained from each client.

Please submit copy of the research proposal, questionnaire and consent form.

Thank you

Yours faithfully

.....
Dr S. W. Tegegne
DHMT Head

cc.. Chief Medical Officer
Letlhakane Primary Hospital