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Empower the girl child: An integrated approach to making a difference in reducing adolescent pregnancy in South Africa

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Abstract

Adolescent pregnancy, which often occurs in impoverished environments such as rural areas, is one of the major public health concerns globally, including in South Africa. It is an issue that has received inadequate attention. This article aims to empower the girl child and female adolescents through an approach that informs choices and enables control over decisions affecting sexual and reproductive health. Such an approach should facilitate protection against the risk of adolescent pregnancy and, hopefully, contribute to reducing its incidence in South Africa. The empowerment theory served as the theoretical framework for the study. A qualitative research method was employed. Data were collected through a descriptive exploratory study design. A sample of ten (10) pregnant adolescents was purposefully recruited from a population of all pregnant adolescents attending an antenatal clinic at a public hospital in the North-West province on the day of data collection. Additional data were gathered from relevant documents related to the study. Data were analyzed and interpreted using Colaizzi's seven steps of data analysis. The findings indicate that a lack of empowerment among female adolescents plays a major role in the occurrence of adolescent pregnancy in South Africa. This calls for integrated, multi-sectoral interventions to address the root causes of adolescent pregnancy.

Keywords: *adolescent, empowerment, girl child, integrated approach, reduction of adolescent pregnancy theory*

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1. Introduction

Adolescent pregnancy, that is, the pregnancy of females who have entered puberty anytime from ten (10) years to twenty-one (21) years old, is one of the concerning public health problems globally, including in South Africa (UNFPA, 2020; Wall-Wieler et al., 2016). It often occurs in the context of poor social settings such as rural areas in South Africa (Akella, 2018; Amoadu et al., 2022; UNFPA Eastern and Southern Africa, 2024). Adolescent pregnancy mostly affects adolescent females, who are exposed to a greater risk of maternal complications and mortality. Accordingly, empirical evidence suggests that babies born to adolescent girls may not survive or may suffer from low survival rates (WHO, 2024).

Maternal complications often encompass maternal anaemia, pre-term birth, and caesarean section delivery, while neonatal complications include low birth weight, perinatal mortality, increased infant mortality, and unsafe abortions (Anand et al., 2022; UNFPA, 2024). UNFPA (2024) warns that girls aged 15–19 years are twice as likely to die during the delivery of a baby compared to women aged 20 years and above. The problem of adolescent pregnancy is accompanied by approximately 1,300 newly human immunodeficiency virus (HIV)–infected adolescent girls in South Africa per week, as reported in News24 in September 2021 (News24, 2021). It is of concern that, over and above pregnancy, many adolescent mothers drop out of school and are thus subjected to the risk of illiteracy, lower education levels, and are trapped in a cycle of poverty that hinders their future progress (Jochim et al., 2021). They depend on family members and/or the public for assistance (Jochim et al., 2021). Some of them even enter into early and/or forced marriages for survival (Desai et al., 2024).

It was reported that 30% of adolescents between 10 and 19 years old became pregnant in 2020 in South Africa (Basic Education Portfolio Committee, 2021). It is further observed that over 90,000 adolescents aged 10–19 years old were pregnant in the financial year 2022/2023 in South Africa, with more than 65% of pregnancies unplanned (Statistics South Africa, 2022). While the government of South Africa has established programmes such as the Sinovuyo Caring Families Programme for Parents and Teens to help cultivate open, caring, and trusting relationships, the problem of high adolescent pregnancy persists.

The preceding concerns, respectively and collectively, suggest that not much has been done to prevent early sexual intercourse (ESI) among adolescents and adolescent pregnancy. This article argues that preventing adolescent pregnancies means understanding their determinants and empowering the girl child through effective interventions that enable

adolescents to make healthier sexual choices. It also describes adolescent pregnancy from the perspective of rural female adolescents in the communities of South Africa. WHO (2024) maintains that adolescent pregnancy prevention is essential for achieving SDGs related to maternal and newborn health.

The aim of this study was to assess factors associated with adolescent pregnancy in South Africa and recommend interventions to root out this phenomenon through an integrated empowerment approach. Specifically, it aims to investigate the factors that led to adolescent pregnancy in rural North West Province of South Africa and to develop recommendations to empower adolescents to make informed choices and take control of decisions that affect sexual and reproductive health.

2. Literature Review

2.1. Factors Associated with Adolescent Pregnancy

About 12 million adolescents in low- and middle-income countries give birth each year (WHO, 2020). Various factors lead to adolescent pregnancy, and this exacerbates further complications among adolescent girls. These young females not only face potential risks such as anaemia, haemorrhage, and maternal mortality, but further consequences for their babies include low birth weight, stillbirths, and neonatal deaths (Pike et al., 2020; Poudel et al., 2022; Diabelková et al., 2023). Bangladesh, a country that leads in adolescent pregnancy in South East Asia (WHO, 2020), faces economic and socio-cultural factors that contribute to this phenomenon. Factors such as low levels of education and healthcare, social and gender norms, limited freedom of movement, gender-based violence, and poor decision-making contribute to adolescent pregnancy in Bangladesh (Pike et al., 2020). For instance, married adolescent girls have no power to oppose decisions and directives from male family members and in-laws (Pike et al., 2020). In addition, Poudel et al. (2022) affirm that traditional social norms that encourage early marriage, low socio-economic status, lack of independence among adolescent girls, and lack of inclusive sexual education lead to adolescent pregnancy in Bangladesh, Nepal, and India. Similarly, Shukla et al. (2023) assert that in Maharashtra, India, adolescent pregnancy stems from economic hardships, having more sexual partners, early marriages, social norms, and lack of knowledge on contraceptives. In Slovakia, not only low education and lack of knowledge on contraceptives are high-risk factors for adolescent pregnancy, but poverty and lack of family support also worsen the crisis (Diabelková et al., 2023).

Mozambique, with the highest adolescent fertility rate in the Southern African Development Community (SADC), records a high rate of adolescent pregnancy driven by socio-economic status, low education levels, and poverty (Jaen-Sánchez et al., 2020). Moreover, social pressure and cultural marital norms contribute to adolescent pregnancy in the country (Nhampoca & Maritz, 2022). In Ethiopia, adolescents are mainly affected by indirect personal decision-making leading to pregnancy. Mezmur et al. (2021) accentuate that factors causing adolescent pregnancy in the country include school dropouts, lack of formal education, being married, having an older sister with a history of teenage pregnancy, minimal knowledge of the fertile period during menstrual cycles, and parental divorce or deceased parents. Additionally, Bol et al. (2022) elucidate that in some cases, adolescent girls in the Ngueyyiel Refugee Camp in Ethiopia tend to live with non-biological parents or with only one biological parent. Subsequently, this makes it difficult to guide the girl child on matters of sexual and reproductive health, thus leading to negligent pregnancy.

Similar to most low-income countries, adolescent pregnancy in Ghana is caused by a number of factors. School disruption, early marriages, isolation by parents and friends, poverty, unemployment, intimate partner violence, misconceptions, and non-use of contraceptives contribute to adolescent pregnancy (Senkyire et al., 2022; Amoadu et al., 2022). In Nigeria, lack of sexual education, low public health awareness, low number of women in wage employment, lack of educational achievement, peer pressure, and lack of parental support contribute to adolescent pregnancy (Bolarinwa et al., 2022; Alukagberie et al., 2023).

Even though different global organisations such as the United Nations Population Fund (UNFPA), United Nations Women, and Family Planning have tried rolling out programmes to deal with adolescent pregnancy (Poudel et al., 2022), there seems to be no convincing strategy to effectively reduce the phenomenon worldwide, including in South Africa. In the case of South Africa, some legislative frameworks and policies aimed at reducing adolescent pregnancy include: the South African Schools Act 84 of 1996 (SASA), the National Policy on Prevention and Management of Learner Pregnancy, the Criminal Law Amendment Act, the Choice on Termination of Pregnancy Act 1 of 2008, school health programs, and youth-friendly clinic services, to mention a few. In a nutshell, there is no clear evidence of positive outcomes from these initiatives aimed at lowering adolescent pregnancy in South Africa, pointing to a significant gap between the desired outcomes and what has been achieved.

Considering the empirical evidence, a comprehensive sexual and reproductive health (SRH) intervention is necessary, one that will empower adolescents in decision-making and help them adopt a healthy sexual and reproductive lifestyle. Thus, the study aimed to close this gap by assessing factors associated with adolescent pregnancy in South Africa and recommending interventions to root out this phenomenon.

2.2. Theoretical Framework

At the heart of "empowerment" lies the concept of power. Weber (1946, as cited in Presser & Sen, 2023) pointed out that power is related to the ability of human beings to make others do what the ones who have power want, even in the face of resistance. The recognition of this ability and claiming it for oneself empowers one to make their own decisions and control their life (O'Hara & Clement, 2018). Freire (1990, as cited in Nadlir & Zamzamani, 2023) argued that a prerequisite for gaining power and freedom is the ability to move away from being an object (where others determine how you are defined or what happens to you) to becoming a subject with agency (where you define yourself, your goals, and your actions).

The empowerment in this article seeks to inspire female adolescents to be able to analyse existing power relations and be empowered to recognise and claim their rights, as well as influence sexual relations and overall reproductive health. In the same vein, the empowerment process within the gender and development context seeks to address the powerlessness of women and girls and has the greatest potential to reduce adolescent pregnancy. In line with this argument is Stein's idea that there is a relationship between health, empowerment, and self-determination of young women and girls (Stein, 1997).

3. Methods

This article took the form of a qualitative study. Ten (10) adolescents who were attending an antenatal clinic for their first pregnancies at a public hospital in the North-West Province, South Africa, were purposefully recruited to participate in the study. Interviews were conducted between the 1st of July and the 20th of August 2023. An audio tape recorder was used to gather in-depth, narrative data from each participant. The interviews were conducted in Setswana (a locally spoken official language of South Africa) because participants were uncomfortable expressing themselves in English. Their views were later translated into English by the researchers, who are fluent in both languages, to avoid influencing the content.

Colaizzi's seven steps of data analysis were used in the study (Kumar & Grace, 2003). These included: first, reading and revisiting the transcribed notes for a better understanding of the complete content; second, extracting essential elements from participants' statements; third, formulating senses of ideas into meaningful concepts; fourth, organising the formulated statements into themes, categories, and sub-categories; fifth, combining the key findings into in-depth descriptions of situations; sixth, detailing descriptions of the important structures of the phenomenon; and seventh, validating the research findings with the research participants (Shosha, 2012).

Table 1

Adolescents' socio-demographic characteristics

Pseudo-name	Age	Average House-hold Income (SA Rand/year)	Primary Care Giver			Provision of Water	Sanitation
			Mother	Father	Both Parents		
Leano	17	303.33	✓			Piped water from public tap	Pit latrine without ventilation pipe
Sonto	15	416.08		✓		Piped water inside dwelling	Pit latrine without ventilation pipe
Lerato	16	N/A			✓	Piped water from public tap	Flush toilet connected to a public sewage system
Jessie	17	332.66	✓			Piped water from public tap	Pit latrine without ventilation pipe
Kagiso	18	532.33			✓	Spring water	Pit latrine without ventilation pipe
Boitumelo	15	182.55			✓	Spring water	N/A
Bonolo	16	N/A	✓			Piped water from public tap	Flush toilet connected to a public sewage system
Zanele	14	182.55	✓			Piped water from public tap	Pit latrine without ventilation pipe
Boikanyo	14	332.66			✓	Piped water from public tap	Pit latrine without ventilation pipe
Dipuo	17	168.33		✓		Piped water from public tap	Pit latrine without ventilation pipe

Direct quotes and results from the coding and categorization were used to develop the report. Table 1 shows participants who were adolescents and had been pregnant in the past two (2) years. Two (20%) of the participants had flushing toilets at home while the rest (80%) were using outside toilets with seven (70%) using pit toilets and one (10%) who did not have a toilet. The latter's family helped themselves in the nearby field/countryside or in the neighbour's

toilets when nature called. When asked if they have a radio or television, all the participants said they do not have either, which can serve to distribute messages.

The table exposes conditions under which the adolescents live. The socio-economic characteristics of the participants therefore indicate that they were disadvantaged and economically poor. Such information point to some of the important factors determining female adolescence pregnancy and a precursor to tackling the situation.

Data were collected over a period of six (6) weeks. An interview guide was used to solicit responses from pregnant adolescents on the determinants of their pregnancies. Interviewees' permission was sought to audiotape their responses. Interviews were conducted in Setswana, a local language, which all participants speak fluently. The researchers, who themselves speak and understand Setswana well, translated interviewees' responses into English without editing anything.

The researchers sought permission from the Northwest provincial Department of Health to conduct research in one hospital in the province. They shared the approval letter as well as approved ethical clearance number HSHDC/681/2017. The name of the facility is not mentioned for ethical reasons. The parents had to sign an informed assent form after agreeing for their children to participate in the study. The researcher then invited selected participants who was younger than 18 years, to an area adjacent to the service point to obtain informed assent prior to face-to-face interviews. Individual in-depth, narrative interviews were conducted in a private room allocated to the researchers at the hospital. Issues of confidentiality, anonymity and the right to withdraw from the study were continuously emphasized. Each adolescent was given a pseudonym to protect her true identity. All information including consent forms were stored in a locked cupboard in the research unit.

4. Results and Discussion

4.1. Results

The following four (4) key themes emerged in the final step of the data analysis: exposure to sexual activities and changes in the sexual behavior of young people; age and educational level at first pregnancy; low access and uptake of sexual reproductive services; and non-contraceptive usage due to the providers' attitudes.

Theme 1: Exposure to sexual activities and changes in the sexual behavior of adolescents

It emerged that sexual intercourse of uninformed adolescents and those who could be younger is a concern because it could lead to early pregnancy in life. The study further showed that exposure to sexual activities which could either be physical or through verbal engagements with anyone could lead to changes in sexual behaviors of the adolescents. Some participants indicated that they have engaged in casual unprotected sexual intercourse with more than one older partner. Such risky sexual behaviors did not seem to be a concern to them. Here is what Jessie said:

> *He was five years older than me. He knew everything about sex. He was working and always dressed up when he comes to see me, driving a 'nice' car. I liked that. He would always give me money to spend at school. On most days he just kissed me and told me that he loved me and left. One day he kissed me but also undressed me and pushed my legs apart and pushed himself on me. I was so scared. He told me that he will not hurt me. I complied to what he asked me to do. We had sex.*

Dipuo reported that she had been repeatedly warned by her parents never to engage in sexual activities. She heeded to the warning because they told her about the dangers of 'sleeping' around with boys. One day, according to her, she agreed to engage in sex with a partner who was older and forceful. Nothing happened to her. She shared that this was the beginning of telling lies to her parents.

> *I would tell my parents lies, that I am visiting a friend for the weekend whereas I was going to spend time making love with my boyfriend at a hotel or guesthouse. A few months later that year, I fell pregnant.*

Study findings revealed that most participants discussed sexual affairs with friends or peers who influenced their behavior and less with parents. Bonolo said:

> *My friend who lives next door, told me that sleeping with a boy shows that he loves you. If the boy does not ask you for sexual intercourse, he does not love you. I also had a boyfriend who has been asking me to show him that I love him, but I refused. I later agreed, due to his insistence and a talk with my next door friend. So we had sex for the first to time. I missed my period after having sex with him for a second time. I went to a clinic and was told by a nurse that I was 10 weeks pregnant. I am now 24 weeks pregnant.*

The study further showed that same age group relatives were likely to be influential to some adolescent participants. They influenced their cousins while ignoring parental guidance as it emerged from interaction with the adolescent girls. Boikanyo stated:

> *My cousin who lives in Krugersdorp often comes to my home for school holidays and shared with me that she has a boyfriend for a year now. The boyfriend is 2 years older but only a class higher than her. The boyfriend come visit her on Saturday. Sometimes they just kiss and sometimes they kiss and have sex. My cousin said she thinks her boyfriend loves her because she makes love to her and rewarded her with expensive gifts.*

When the researcher followed up and asked if the cousin referred to has a baby or has ever fallen pregnant, she said:

> *My cousin does not have a baby and never heard her saying she is pregnant. I tried to get my boyfriend's attention to show him that I am convinced that he loves me because I loved him too.*
>
> *I then agreed to sleep with him at his home as his parents had visited his grandparents at another village. He refused to use a condom when I asked him to. He started spoiling me with expensive gifts. He first bought me iPhone 12. I was excited as I never dreamt of owning an iPhone. He then gave me monthly girlfriend allowance which was more than what my parents offered me. After 5 months of regular sexual interactions, I fell pregnant.*

The adolescent continued:

> *I regretted to have acted against my parents' advice to delay sexual intercourse, stay at school to achieve higher education that would provide me an opportunity for a good job and payment. My boyfriend has disappeared.*

Some adolescents who are close and discuss intimate matters such as love-making, live with parents or attends the same school. It emerged from the findings that they could influence each other on engaging in sex and how to avoid occurrence of pregnancy. One participant said a peer advised her to use birth control tablets to avoid falling pregnant, guard against sexually transmitted diseases then engage in sex without fear. She (Sonto) said:

> *Specifically, when our peers tell us, they tell us in detail so that we should be encouraged to do it. They tell us to just do it and enjoy life. They advise us that*

we should use birth control effectively and guard against contracting sexually transmitted diseases.

It can be drawn from the preceding narratives that several factors lead to adolescent pregnancy. They include, among others, deprivation and lack as most adolescent girls engage in unprotected sexual intercourse in exchange for money and gifts. Further, unplanned births and the spread of sexually transmitted infections (STIs) are facilitated by the partner's refusal or resistance to use any kind of contraception including condoms, especially when they are older than an adolescent girl. Peer pressure has also been found to influence teenage pregnancy in this study.

Theme 2: Age and Educational Level at First Pregnancy

The interviews with the adolescents in the study revealed that peer pressure, boyfriends or home circumstances exposed them to the risk of pregnancy while they were still pursuing their studies. Table 2 below displays pregnant adolescents by age at first pregnancy, the gestational age and the education level at the time of the study.

Table 2

Pregnant adolescents disaggregated by age at first pregnancy, gestational stage and educational level

Pseudo-names of adolescents	Age at first pregnancy	Gestational stage	Educational level in school grades
Leano	17	6 months	11
Sonto	15	6 months	10
Lerato	16	7 months	10
Jessie	17	8 months	11
Kagiso	18	8 months	12
Boitumelo	15	7 months	7
Bonolo	16	6 months	10
Zanele	14	6 months	9
Boikanyo	14	8 months	7
Dipuo	17	6 months	10

All pregnant adolescents who participated in the study were between fourteen (14) and eighteen (18) years old. The gestational age of pregnancy for all the adolescents was six (6)

months and above yet they were attending antenatal clinic for their first booking. They were enrolled between grades seven (7) and twelve (12).

The findings revealed that some adolescents did not seem to be aware of the risk they were exposing themselves to by engaging in sexual activities with men. They shared different experiences which cannot all be included in the article because of limited space during interviews. An example thereof is that of Boitumelo, a 15-year-old pregnant adolescent who shared a home with both parents, her younger brother and an uncle who was the sole provider had been in grade seven for nine months. She was eight (8) months pregnant when the researchers met and arranged to interview her at the antenatal clinic. She had gone to book for antenatal clinic attendance for the first time. She said, during the interview, that she did not know how one falls pregnant. She was not aware of contraceptives. Her boyfriend, Nhlanhla (pseudo name) asked her to play 'husband and wife' with him and she agreed. The researchers probed on what she meant. She explained that:

> *Nhlanhla showed me, he said I should undress my panties, I did, and he put in his manhood into my vagina*.

Boitumelo, at her age and level of education, appeared completely ignorant and unaware of what she was doing. The researcher probed further by asking her: *Were you already getting your period?"* She said:

> *I got my period only once prior to falling pregnant and it disappeared. I informed my mother. She said it disappears and does come again.*

She confessed, upon further inquiry, that she did not inform her mother about the game her boyfriend and she played which included indulging in sexual activity. She looked apologetic, ashamed, innocent, and shy of her pregnancy. She voluntarily shared that her boyfriend's parents have promised to adopt the baby so that both her boyfriend and her can return to school. It came to surface that most of the pregnant adolescents were innocent and unaware of the risk of engaging in unprotected sex with sexually active and or mature males.

Theme 3: Low Access to Low Uptake of Sexual Reproductive Services as well as Unmet Need

Lack of access to reproductive health information and services perpetuate adolescence pregnancies, particularly in developing countries (Okot et al., 2023). All adolescents in the

study were asked individually if they ever heard or were ever educated about how one gets pregnant and reproduction of human beings. They were further asked their responsibility to prevent unwanted pregnancy and accessing sexual and reproductive services. They said they received patchy information about sexuality and pregnancy from peers. Their parents initiated on education about SRH only when they started to menstruate. They could not explain why it was only done then. Kagiso expanded:

> *You know, at that age you ask yourself why vaginal bleeding is associated with avoiding sleeping around with boys whom you grew up playing with. You become curious and become exposed to those challenges of sexual and reproductive health information. Only then do parents prepare their children by starting to talk to them about sexuality openly so that we avoid trouble. One wonders why the discussion was not initiated earlier before menstruation.*

Using contraceptives and attending family planning seemed to be a taboo among people who uphold religion and culture in South Africa. Lerato said:

> *… there are families who do not bring their daughters to the clinic for FP at an earlier age to prevent them from getting pregnant even if they notice that that the girl could be moving about with boys … I would think there is stigma attached on FP due to they're believers.*

The researcher probed further: *What do you mean?*

> *Mothers start shouting and asking if a daughter has started sleeping with boys and the reaction from their daughters is no even if they do sleep with boys.*

Leano said:

> *Churches actually warn us about sexuality, telling us that we should preserve ourselves for our husbands. They never just discuss such issues."*
> *Some South African cultures do not encourage parents to discuss reproductive health with children. Actually, most families hardly talk about it. Its taboo to talk freely about sex in our area.*

Based on the preceding assertions, it could be assumed that the adolescents in this area experienced an unmet need in relation to sexual and reproductive health education and awareness. The causes of unmet reproductive health needs include among others, limited

access to health care services, disapproval of family members and others, and lack of knowledge and information of services that are provided.

Theme 4: Non-contraceptive Usage due to the Providers' Attitudes

This study revealed that the negative attitudes displayed by some officials at family planning and other reproductive health facilities discourage adolescence to access contraceptives in South Africa. Two (2) participants have sought contraception as the need arose while eight (8) have never used contraception. One reason given for not using contraception was that they were discouraged by the nurse's attitude who (un)knowingly contributed to limiting adolescents to accessing sexual and reproductive health services offered by the health facilities of North-West province as elaborated hereunder.

The study revealed that most nurses feel uncomfortable to provide adolescents with contraception because of their belief systems; they feel that adolescents should not be having sex at an early age. This study further found that the nurses' attitude to requests for contraception was highly judgmental and they were perceived as unhelpful to the pregnant adolescents. A participant in this study, Zanele, complained:

> *I attended FP clinic in town. I did not want to attend at our nearby local clinic at because the nurses there know me and know my parents. I was scared that they might tell d them that I want FP injection.*
>
> *I stood in a queue. When it was my turn, I went in and I was attended to by a nurse. The nurse asked questions according to the card to which I answered. Then the nurse asked if I have started opening thighs outside marriage. She further asked if I know what the bible say about sex before marriage. I said yes but I felt guilty. She said I should not allow boys to satisfy themselves with my body. I stopped fetching contraceptives.*

Sonto expressed:

> *I do not go to FP to get contraception as the nurses shout at us especially when one is young. Like, if I go for prevention, they will say "you have started sleeping around with different boys when you are so young …. The nurse would make such judgemental statements frowning and in front of other people. Such an attitude chase people of my age away*.

Attitudes impact on the morale, self-esteem and determination of adolescents. These attitudes hinder the adolescents from seeking protection and it therefore, contributes to adolescence pregnancy.

4.2. Discussion

Exposure to sexual activity and changes in the sexual behavior of young people. Changes in adolescent behavior were historically observed during the transition from being a 'girl' to entering adult sexual life for young women (UNFPA, 2020). The behavioral and physical changes that occur when girls reach puberty often coincided with the expectation of marriage (Sarfo et al., 2020). However, in this study, all pregnancies were unintended, and the adolescents were single and still attending school. In the contemporary world, the living conditions of many young people, including adolescents, have changed, along with patterns of sexual behavior (UNFPA, 2020). Even in contexts where postponement of adolescent sexual intercourse is encouraged, peer pressure and intense exposure to sexual stimuli have made adolescent sexual activity more common. This was evident in the narratives of the adolescent participants in this study. Additionally, changes in sexual behavior are often associated with the rejection of cultural norms upheld by the family or the church (Akella & Jordan, 2015). Such behavior is often viewed as defiant and permissive of premarital sexual intercourse, and it was similarly frowned upon in the case of all the pregnant participants in this study (Okot et al., 2023).

Age and educational level at first pregnancy. What was striking from the findings is that girls in the rural districts of North-West engage in early sexual activity, as revealed by the mean age of 16 years for first childbearing. The relatively low mean age at first pregnancy in this study indicates a decreasing age of sexual initiation. Adolescents who engage in sexual activities are often unprotected against pregnancy, exposed to sexually transmitted infections including HIV and AIDS, and face the risks of early childbearing, potentially difficult labor, and the challenges of early motherhood (Chandra-Mouli et al., 2019). These adolescents have children before they are physically and psychologically ready for pregnancy and motherhood, which increases their susceptibility to maternal ill health and mortality (Mmusi-Phetoe et al., 2019). Further analysis showed that factors such as the level of education, geographical location, and poverty influenced childbearing and demographic behavior. For example, while half (five) of the adolescents had attained Grade 9–11 education, the remaining five had either

completed up to Grade 5–8 or had no education at all. None of the adolescents had tertiary education. All participants lived in rural districts of the North-West province and were generally poor. Moreover, all pregnancies resulted from premarital conception.

Hayford and Guzzo (2010) highlight the relationship between a young mean age at first pregnancy, unplanned pregnancies, and negative health outcomes for both mothers and infants. Similarly, this study revealed that the unplanned nature of early pregnancies and the non-use of contraception among the ten (10) pregnant adolescents could potentially lead to poor reproductive health outcomes. Notably, the adolescents who participated in the interviews were all at least six months (24 weeks) pregnant, yet were attending antenatal care (ANC) for the first time. According to WHO guidelines, the first ANC visit should occur between 8–12 weeks of gestation, with the second visit between 24–26 weeks (WHO, 2016). The findings indicate that none of the sampled adolescents adhered to the WHO-recommended timing and frequency of ANC visits.

Further analysis also confirmed that education level, geographical location, and poverty, evident in their household circumstances, played significant roles in influencing adolescent sexual behavior and childbearing patterns. Specifically, while half of the participants had reached Grade 9–12, the other half had only completed up to Grade 8 or had no education at all. Again, none had attained tertiary education. All adolescents lived in rural areas of the North-West province, and their families were generally poor; for example, the average household income was R734.00 per annum. Furthermore, adolescent pregnancy and childbearing may lead to serious consequences, such as dropping out of school, limited opportunities for gainful employment, reduced capacity to support their children, and a generally poor quality of life. The risk of remaining trapped in poverty is therefore high.

Low uptake of sexual reproductive services, family planning and unmet need. The absence of knowledge about sexuality and pregnancy, compounded by the cultural secrecy surrounding these topics, as well as limited access to reproductive health information and services, continues to sustain the problem of adolescent pregnancy. Most adolescents in developing countries are in need of information on sexual and reproductive health and related services. These adolescents are already sexually active and face a high risk of experiencing unplanned pregnancies, primarily due to the non-use of contraception, which results in an unmet need (UNFPA, State of the World Population Report, 2022). This unmet need is further exacerbated by health system issues, such as poor-quality care delivered by incompetent or

uncaring health care professionals, as revealed in this study. Contraceptives should be made freely available to all who need them through family planning services within the health system (United Nations, 1995; Harries et al., 2019). These authors emphasize that every pregnancy should be intended and supported by robust reproductive health policies and services, including access to family planning (United Nations, 1995; UNFPA, 2022). Achieving this requires the empowerment of adolescents through access to information, education, and knowledge (United Nations, 1995).

Non-contraceptive usage due to the providers' attitudes. South Africa's Choice on Termination of Pregnancy Amendment Act (Act 1 of 2008) stipulates that a woman of any age who is eligible for an abortion may access abortion services upon request, provided she is less than 13 weeks pregnant (South Africa Republic, 2008). This provision includes adolescents who find themselves pregnant and do not wish to carry the pregnancy to term. The Act ensures that reproductive rights are upheld and that women of all ages can live fulfilling lives with dignity; it also empowers women.

Boitumelo, one of the study participants, stated that she was hearing about contraception for the first time from the researcher during the interview. She had come to the clinic for her first antenatal booking on the day of the interview. Boitumelo's comments reinforced the concern that schools are failing both boys and girls by not providing comprehensive sex education, thereby increasing adolescents' vulnerability to unintended pregnancy. A similar sentiment applies to parents, who are responsible for guiding their children on matters of sexuality and reproduction. This lack of guidance reflects an unmet need within the home environment.

Adolescent girls need access to sexual and reproductive health information, which they seldom receive. Adolescents remain inadequately informed (UNFPA Eastern and Southern Africa, 2023). Female adolescents are both psychosocially and biologically more vulnerable than boys to sexual misinformation and to the consequences of unprotected and premature sexual relations (UNFPA Eastern and Southern Africa, 2023). Amoadu et al. (2022) confirm that early sexual experiences, when combined with a lack of information and access to services, increase the risk of unwanted and premature pregnancy, adolescent births, unsafe abortions, HIV infection, and other sexually transmitted diseases. The authors also note that early childbearing continues to hinder the attainment of educational, economic, and employment

opportunities, as well as the social independence and status of women globally (Amoadu et al., 2022).

Low use of health care services and resultant adolescent pregnancies have also been associated with poor interpersonal relations and negative attitudes among health workers, as revealed in participants' narratives (Küng et al., 2021). Women often encounter unsympathetic and insensitive health care providers at clinics. Such negative attitudes are most commonly experienced by poor, rural, and Black women in South Africa, whereas elite Black and White women tend to receive better treatment. These attitudes significantly affect the quality of health care. A major issue is that services tend to be target-oriented rather than focused on the provision of quality care.

5. Recommendations

5.1. An Approach to Prevent Adolescent Pregnancy: Empower the Girl Child to Protect Herself from Falling Pregnant

Achieving meaningful change in the lives of adolescents requires strategic shifts supported by accurate demographic data for targeted interventions. The effectiveness of such interventions depends on the extent to which they address the root causes of the problem. The findings reveal that girls and female adolescents are uninformed and lack knowledge about sexual and reproductive health. They are subjected to peer pressure and often submit to the sexual demands or advances of male partners. Additionally, negative attitudes among healthcare providers exacerbate the issue. Cumulatively, these factors reflect a lack of empowerment.

This article, therefore, assumes a causal link between the empowerment of the girl child and female adolescents and the incidence of adolescent pregnancy. In order to reduce the risks of adolescent pregnancy, the empowerment of girls and female adolescents must be addressed. The article adopts Rachmad's (2022) definition of empowerment, viewing it as a process of gaining control over oneself, one's ideology, and the resources that determine power. Based on this definition, once empowered, adolescents should be able to make informed choices within a framework of expanding information, knowledge, and analysis of available options.

The ICPD (1995) emphasizes the empowerment and autonomy of women, and the improvement of their political, social, economic, and health status, as an important goal in itself. Power relations shape women and girls' access to both material and non-material

resources, including reproductive health care, their ability to control their lives, and their decision-making capacities (Mmusi-Phetoe et al., 2019).

5.2. Strategic Determinants

An intervention at this level requires the integration of services and collaboration among government departments to implement strategies aimed at empowering the girl child and female adolescents. The design and implementation of intervention strategies to improve the socio-economic status of girls and adolescents could be led by the Population Unit and the Department of Labour.

Efforts to reach and educate more girls and female adolescents should be strengthened through practical outreach in schools, under the Department of Education. Although Life Orientation provides some strategic content to address the issue, it is generally considered insufficient, as it mainly covers theoretical aspects. It is essential to provide adolescents with evidence-based sexuality education. Such education should be comprehensive and serve as a strong foundation for preventing unwanted pregnancies, reducing the spread of sexually transmitted infections, and promoting gender equality.

Family planning clinics in rural areas should be made available through the Department of Public Works. A multidisciplinary body needs to be established, comprising the aforementioned departments, the private sector, NGOs, female adolescents themselves, and women's organizations that represent their interests. This body should work to address contextual factors such as social norms, empowerment, skill development, and personal growth. Moreover, the target group should not be limited to adolescent girls but should also include boys who impregnate these girls.

All mentioned stakeholders should be involved in every stage of designing, implementing, monitoring, and evaluating reproductive health care policies and action plans.

5.3. Practical Determinants (at the Household, School, and Service Levels)

There is a need to instill resilience in adolescents regarding bodily autonomy through comprehensive, culturally sensitive, adolescent-friendly, and easily understandable sexual and reproductive health (SRH) information and education. Girls and female adolescents must learn that they have the right to control their bodies. The information provided should be sufficient

to empower them to stand up for themselves and resist pressure to engage in sexual activity or enter into child marriages.

Adolescents who are already sexually active should be encouraged to use contraception, which should be readily available through adolescent-friendly services. Regular meetings between health professionals, adolescents, and women's representatives should be established. Specifically, accessible centers should be created where health issues, related social challenges, healthy behaviors, and corrective actions can be discussed in a practical and supportive environment.

6. Conclusion

The article is guided by the principle that high rates of adolescent pregnancy will decline if the root causes of the issue are effectively addressed. Therefore, this study assessed the factors associated with adolescent pregnancy in South Africa and recommended interventions to eliminate this phenomenon. The study focused on addressing the underlying social and economic factors contributing to adolescent pregnancy and on equipping young girls and women with the knowledge, skills, and means to make informed decisions about their sexual and reproductive health.

Based on the findings, the study demonstrated that adolescent pregnancy is shaped by prevailing social and economic conditions characterized by deprivation and hardship. Economically and socially underprivileged female adolescents are the most vulnerable and disempowered in terms of protecting themselves from the risk of pregnancy. This vulnerability is further influenced by limited education, restricted access to accurate information on sexuality and reproductive health, and poor material living conditions. The participants' narratives provided insights into their experiences of exposure to sexual activity.

The key themes that emerged from the study include exposure to sexual activities and changes in sexual behavior among young people, age and educational level at first pregnancy, limited access to and low uptake of sexual and reproductive health services, unmet needs, and non-use of contraception, often due to negative attitudes of healthcare providers. These factors have affected adolescents' ability to control their sexual and reproductive behavior and have increased their risk of unintended pregnancy.

The article has, therefore, shown that empowerment is closely linked to adolescent pregnancy, and as such, the recommended approach marks a shift away from narrow, traditional sex education models.

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This study was conducted in accordance with the ethical guidelines set by University of South Africa. The conduct of this study has been approved and given relative clearance(s) by the University of South Africa.

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