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SERVICES AND PROGRAMMES FOR TEENAGE PREGNANCY AND SUPPORT FOR TEENAGE MOTHERS: RURAL AREAS OF LIMPOPO PROVINCE OF SOUTH AFRICA, AND SLOVENIA[1]

ABSTRACT: This article seeks to juxtapose the current services and programmes that deal with the prevention of teenage pregnancies and the teenage motherhood notion in South Africa and Slovenia. The paper looks at the situation in both countries and tries to detect the main problems in the two cases and therefore proposes changes on the basis of what is known about the two countries. In other words, we describe the situation, identify problems and suggest solutions. Teenage pregnancy and teenage motherhood are always viewed as inseparable and as a discourse that exists due to a variety of social and sociological variables. The notion of teenage pregnancy and teenage motherhood is assessed against related theories and scholastic (secondary) evidence. Finally, it is argued that intervention services and programmes that are linked with the life perspective of teenagers and teenage mothers yield positive results.

KEY WORDS: teenage pregnancy, teenage mothers, intervention services, prevention, programmes

Storitve in programi za najstniške nosečnosti in najstniške matere: ruralna območja južnoafriške province Limpopo in Slovenija

POVZETEK: V članku primerjamo službe in programe, ki se ukvarjajo s preprečevanjem najstniških nosečnosti ter najstniškim materinstvom v Južni Afriki in Sloveniji. Raziskali smo stanje v obeh državah ter poskusili identificirati poglavitne težave in rešitve. Najstniško nosečnost in najstniško materinstvo običajno obravnavamo kot neločljivi kategoriji ter kot diskurz, ki obstaja zaradi različnih socialnih in sociooloških spremenljivk. Pojem najstniške nosečnosti in materinstva ocenjujemo glede na sorodne teorije in glede na znanstvene

1. I pay tribute to my rock, Professor Tanja Rener in offering guidance throughout my journey in writing this article.

(sekundarne) dokaze. V članku trdimo, da intervencijske službe in programi, ki upoštevajo življenjske perspektive najstnic in najstniških mater, prinašajo pozitivne rezultate.

KLJUČNE BESEDE: najstniška nosečnost, najstniške matere, posredovanje služb, preventiva, programi

1. Introduction

"Effective strategies of prevention of teenage pregnancies and parenthood need to include sexual education, contraceptive access programmes and alternatives to pregnancy and parenthood, with a focus on education, vocational training, academic tutoring and support, career counselling, employment and involvement in community" (Slowinski 2001:3).

Practitioners and professionals need to be scientifically and theoretically informed, to have a critical indepth construction reflection about what influence their practice when they deal with the notion of teenage pregnancy and teenage motherhood (Eraut 1995). The future of the people is usually determined by the way they construct themselves (Urek 2006). Stories of teenage mothers in this regard may have an effect in shaping their future. These stories are interpreted and constructed meaningfully by professionals in order to develop effective strategies that will be utilized to prevent teenage pregnancy and support for teenage mothers. The same argument is applicable to Habermas's theory of communicative action where life world and the system world approaches are stressed in order to show how they might be completely different. The argument also shows how frequently the system world colonizes the life world of ordinary people. Arguing from inductive and deductive point of reasoning, more pregnant teenagers and teenage mothers are in a crisis situation which contribute to social exclusion in society. Failure to receive proper information puts pregnant teenagers and teenage mothers in a crisis situation, which contributes to their social exclusion. These teenagers are a vulnerable group that needs support as they are often forced to leave school due to child rearing issues.

Research in this area has shown that teenage pregnancy and teenage motherhood are multidimensional and complex phenomena which require interactions among the individual, the family, the society as well as the system context. The family system is regarded as a significant aspect and an indispensable resource in the primary prevention of teenage pregnancy and subsequent adjustment (Benson 2004; Casper 1990; East et al.2006; Olson et al. 1984; Quinlivan et al. 2003) and preferably focusing on promotion of more adjustment on the developmental trajectories of teenagers who fall pregnant and choose for motherhood (Shanok and Miller 2007). These findings are in line with recent general health findings that suggest a need for intervention approaches that are multilevel to elicit behavioral changes (Glanz et al. 2002). That said this may ultimately lead to a need for interventions that are psychosocial and specifically tailored to prevent teenage pregnancy,and also support its after effects in the case of those who carry the pregnancy to term as well as addressing different life context, rather than focussing only on the individual (Quinlivan et al. 2003). According to feminists view (Reproductive Health and HIV Research Unit 2003, Jewkes et al. 2001) inequities

in terms of gender power contributes to women's vulnerability in early unprotected sex and teenage pregnancy. Teenage mothers are potrayed as irresponsible, by media stories, advocacy organizations, and professional discourse (Lewis et al. 2007). Some studies regarded family counselling or therapy as very important when dealing with multifaceted problematic families such as those linked with teenage pregnancy (Micucci 1998), although there is a dearth of scholarship pertaining to therapy and family counselling especially in the area of support for these pregnant teenagers and teenage mothers. Social workers or other professionals may be encouraged to create conducive enviroments that enhance growth, social and health functioning, as well as capacitating these teenagers to develop resources that will assist them to cope with stressful situations (Nash et al. 2005: 34).

The behaviour of family members and the individual are significantly interdependant, so a focus in the whole family system may increase the impact of intervention (Chermiss and Herzog 1996). However, this paper seeks to present a holistic view of intervention services and programmes that deal with prevention of teenage pregnancy and teenage motherhood support in rural areas.

The investigation assessment here will encapsulate a multidisciplinary mode based on relevant theories and secondary scientific evidence on intervention services of teenage pregnancies and support services for teenage mothers. The research method is based on scrutiny of theoretical and scientific texts. In other words, this paper will evaluate the current situation in South Africa and Slovenia through theoretical and secondary scientific evidence.

2. Intervention services in rural areas of South Africa

South Africa is having a lower rate of teenage pregnancies as compared to the general rate in sub Saharan Africa (Makiwane and Udjo 2006). The country has a general population of 51,77 million people (www.statssa.gov.za/census 2011). South Africa is on the same level with many middle income countries but higher than many European countries. When we look at South African situation from a social work point of view and sociological perspective, the country has a prevailing situation of teenage motherhood that in most instance occur outside marriage as compared to other sub Saharan countries (Makiwane and Udjo 2006).

The current South African plans and policy identify reproductive and sexual health as main priority issues for intervention based on health. Prevention of teenage pregnancies and support provision to pregnant teenagers and teenage mothers contribute the main aim of increasing reproductive health (Macleod and Tracey 2001). This pose a challenge for policy makers to revise their strategic plans in line with the intersectionality of gender, values, norms and beliefs as well as engagement of the client perspective of these teenagers.

The Department of Education Health's policy guidelines for youth and adolescent health strategies for interventions embrace the following issues: promotion of a supportive and safe enviroment; providing transformation on the health system; provision

of counselling; developing of skills to have options for life and availability of health services.

Provision of services and education are key variables in accomplishing these intervention strategies. Implementation of these reproductive health services is hampered by staff turn over, insufficient time to deal or counsell young teenagers on contraceptives. According to Mqhayi et al. (2004) 17% of young women who were interviewed at rural and urban health clinics indicated that they had heard about emergency contraception. More women from urban areas knew about emergency contraception as compared to rurally-based women (Smith et al. 2001).

Studies on contraception also found that teenagers' knowledge varies, with misassumptions abounding (Ritcher and Mlambo 2005; Oni et al. 2005). For example, Rutenberg et al's (2001) survey indicates that only a few participants (8%) had knowledge about menstrual cycles and the period when a woman is at risk of becoming pregnant. Research on the dynamics of young people's education on sexuality and contraception in these communities found that young people's sexual relationships include poor communication, unequal decision-making, inadequate knowledge concerning reproductive health, sexual issues, the legality of abortion and the cost of abortion. Limited education presented on sexuality and peer pressure were significant factors on the decisions young people make in relation to sexual behaviour and reproductive health (Arai 2003; Bankole et al. 2007; Leclerc-Madlala 2002; Varga and Makubalo 1996; Varga 1998, 2003; Vundule et al. 1998; Wood and Jewkes 1997).

That said, this leaves us with a question mark about the quality of the current intervention services and programmes as whether are they designed in line with the life world of these teenagers. Furthermore, a lot of scholarship does not indicate whether the service providers, trainers and counsellors that deal with reproductive health services have received quality trainings that will benefit these teenagers and teenage mothers in terms of their different cultural and socio-economic backgrounds. In other words, even if these trainers are well equipped with a valuable information,such information may be unproductive for these teenagers as long as it does not incorporate their cultural existence. In addition Macleod (1999b) discovered a serious gap between reproductive ignorance and adolescent pregnancy that is not fully addressed by a number of scholars which deal with the reproductive ignorance hypothesis. His argument is also based on the fact that lack of sexual knowledge cannot be regarded as a valid reason for conception as there are various issues that are interrelated and further contributing for teenage pregnancy and its after effects.

The main element of health care services include large distribution and development of educational material that cover key issues such as emergency contraception, information on contraception,pregnancy signs ,the importance of early presentation, young people's rights pertaining termination of pregnancy act, early access to contraception, termination of pregnancy's benefits for early presentation,the solution of teenage pregnancy based on nonjudgemental counselling, assisting those who opt for adoption after delivery and those who keep the baby to access appropriate services such as child support grant where necessary. Community health nurses provide sensitive,accurate

information on prenatal and post natal care for the child and mother and also provide counselling for young women to return to school. A national sample study reflects 86% of adolescent mothers who regarded nurses as playing a positive role at a family clinic. In addition the majority of these teenage mothers indicated that they had waited only 30 minutes to receive help at a family clinic (Ehlers 2003). Teenagers do not want to wait for long hours to receive contraceptive services. The long waiting system might be seen as a stumbling block to access contraceptives by some teenagers as reported by Jones in Limpopo Department of Social Development (2011).

Intervention services in other Provinces of South Africa yields positive results on the life world of these teenagers, although lack of staff members tend to hamper progress especially in rural areas where resources are still scarce as compared to urban areas. Researchers suggest that scientifical knowledge and empirical evidence are not regarded by policy makers, advocacy groups and professionals for a variety of reasons (Duncan et al. 2010; Furstenberg 2007). Teenage mothers are often stigmatized as being poor, too young, single and draining public welfare (Breheny and Stephens 2010; Cassata and Dallas 2005).

Generally, the child support grant (CSG) is improving nutrition and child health and has a positive impact in increasing teenagers' school attendance. CSG is regarded as the biggest social cash transfer system and the government's most successfull protective intervention programme in South Africa, in terms of reaching out to a large numbers of participants including teenage mothers (Department of Social Development 2008). It also enables these teenagers to prepare their children for school readiness as well as helping with uniforms and school funds (Case et al. 2005), although other studies perceived the CSG as leading "perverse incentive" to conceive (Planned Parenthood Association of South Africa 2003).

Based on these views, one would argue that the CSG is very important to protect the lives of both the teenager and the child, although the teenage father is often left out in the picture in terms of showing responsibility even when he could afford to contribute financial and socially. In other words, certain cultural backgrounds are still giving teenage fathers the latitude of not taking responsibility in the upbringing of their children. Teenage mothers are seen as being oppressed as they always carry the burden of child rearing financially,socially and emotionally as compared to teenage fathers who in the most instances are gender- favoured . In the end, many children of these teenage mothers are raised without a father figure, a situation that could expose them to risk factors. So, it is best if teenage fathers are be taught responsibility in the upbringing of their children. Therefore, enviromental factors that influence behaviours and accessibility to structural support such as access to resources, standardized schools, poverty alleviation and community development should be considered together with the gender issue, in line with the teenager's life world.

Termination of pregnancy is taking place in South Africa, although statistics reflect a minority group of young women who opt for such a practice. This low level of termination of pregnancy is associated with the stigma of abortion (Buchmann et al. 2002; Pettifar et al. 2005). In other words, abortion is still not accepted in most cultures

even though it has been legalised and such practices are having an influence on some pregnant teenagers not to commit abortion.

3. School Clinic Based Approaches

Lot of clinics in rural areas of Limpopo province are integrated, applying a supermarket approach. The province has an average population of 5.404.868 (www.citypopulation.de/php/South Africa-limpopo). Health care providers, especially nurses are rendering services to clients on daily basis. Some clinics are still having insufficient humanpower in terms of health care workers and this contribute for clients to wait before they could receive help (Limpopo Department of Social Development 2011). Most of these programmes are operating mainly in Kwa Zulu-Natal. Evaluation of such programmes indicates that learners that are exposed to DramAide programmes had sufficient knowledge and attitudes towards HIV and had increased condom usage as compared to programmes that have information only (Macleod and Tracey 2009). Based on this , we will argue that extension of such programmes to areas that are still disadvantaged in Limpopo Province may bear positive prospects to teenagers. There is still a dearth of scientific evidence on the exploration and evaluation of intervention services and programmes for teenage pregnancies and support for teenage mothers in deep rural areas of South Africa. The more such services and programmes are identified and evaluated scientifically, the more services will be in line with the life world of teenagers and teenage mothers.

While relevant sections are rendering services to teenagers and teenage mothers, researchers indicate that emergency contraception knowledge is poor in general (Mqhayi et al. 2004). Intervention strategies that are currently in place should be perused in terms of the life world of these teenagers and teenage mothers. In other words, a more holistic assessment should be done on these teenagers and teenage mothers to have a deeper understanding of who they are, how they survive, what are their challenges and how they think respective service providers should intervene to promote a future healthy life style. Such intervention strategies should be informed by social and sociological variables such as socio-economic and health related factors as well as the influence of culture in general and local characteristics in particular. Based on this it looks like there is a need for adults and elderly people to receive a thorough training on how to equip these teenagers with life skills. Such training may yield positive results on the client perspective of these teenagers if they are facilitated in collaboration with relevant affected departmental sections and non-governmental sections.

The intervention strategies disclose a gap in the lifeworld of these teenagers and the manner in which the system world is dealing with the notion of teenage pregnancy and support for teenage mothers. A look at the South African perspective especially in rural areas provides a clear picture of exclusion in certain rural areas regarding the mode of service delivery as validated by approximately 11% of service providers who reported that insufficient information on reproductive health and sexual issues lead to teenage pregnancy (Limpopo Provincial Government 2011). Such situations warrant

review of policies that impact teenage life and culture in order to deal with the past and present situation of these teenagers.

A number of intervention programmes have been institutionalized in South Africa in keeping with many influential spheres on adolecent sexual behavior. These include adolescent peer education programmes, life skills education programmes, school based sex education, mass media campaigns, adolescent friendly clinic initiatives as well as community programmes. A lot of interventions are also executed by non governmental organisations[2] that are not affiliates of governmental departments. For instance, the Soul City is an awareness campaign programme that deals with health generally through a multi-media system. It reaches an estimated 12 million South Africans through health booklets, publicity awareness campaign, radio drama played on daily basis, a slot time programme on television as well as youth life skills programmes and adult education. Although the focus of these interventions has basically been dealing with the prevention of HIV, they also benefit teenagers on the issue of teenage pregnancy due to the programme's impact on sexual behavior (Department of Basic Education (www.education.gov.za; Macleod 1999).

The quality of these programme interventions is governed by the scale, range, accessibility, the manner of operation and had also some limitation on the impact of adolescent sexuality.

It is useless to empower women in sexuality issues, without involving men about gender relations that are equitable. Marginalisation of most young people across the country provide a platform for a focus on a systematic intervention that will address care, treatment and support (update report on teen pregnancy prevention www.beststart.org/resources/rep-health/pdf/teen-pregnancy.pdf).

4. South African Health System

The South African Health system is good but it is very protective for the people who are ensured. Those who are not insured are less likely to receive regular care from private doctors and are more likely to receive care from doctors, a midwife, and a nurse in a hospital setting due to lack of money and unemployment issues. Although teenagers receive services, some of them are not fully equipped with information regarding the signs of pregnancy complications, measurement for height, blood pressure and weight, taking of blood and urine samples or to receive iron supplements. Most of young women usually do antenatal tests very late in their third and second trimester.

2. Young Men's Christian Association is responsible for running a peer education programme. The programmes address sexual health issues among teenagers in general, and also focus specifically on HIV. Its target group are girls and young women aged 13-19 years through trained "HIV activists" peer educators. The Old Mutual is running a programme called ' I have Hope AIDS Peer Group Project'. The programme's focus is to implement peer education groups in secondary schools, especially youth at the age of 15 to 18 years. Teachers are also targeted. Teenagers are challenged to be aware of and to take responsibility in terms of preserving their reproductive and sexual behaviuor.

South Africa has a general and continuous problem of late reporting for pregnancy care (Myer and Harrison 2003). Furthermore issues such as lack of knowledge pertaining to significance of antenatal consultations, male partner's denial on paternity, taboos that are related to adolescent sexual activity, may contribute for teenagers to do late consultations (Phafoli et al. 2007). Based on this information, professionals and service providers are still having a challenge of dealing with different cultural, historical situations that may need thorough training on service providers and professionals to accept the current situations of teenagers and teenage mothers and also to be able to transform such situations in order to benefit the life perspective of these teenagers and teenage mothers.

5. Slovenia

Abortions and adolescent birth rates in Europe are key variables in indicating which family oriented planning programmes should be designed in order to meet the needs of people. Furthermore these also articulate the issue of unmet needs in term of adolescent contraception. Strategies to improve the use of effective contraceptive forms consist of comprehensive sexuality education programmes in local schools, communities, promoting open discussions on sexuality issues such as educational campaigns, mass media, but also safe abortion legislation, equal and easy accessibility contraception, youth friendly services and education (Albreht et al. 2006).

In this respect, the World Health Organization (WHO 2005:1) states that:

> " Children are our investment in tommorrow's society. Their health and the way in which we nurture them through adolescence into adulthood will affect the prosperity and stability of countries in the European region over the coming decades".

The quotation clearly denotes the fact that healthy lifestyle from prenatal life to adolescenthood serve as a resource for good economic and social development.

The Slovenian's health reform in 1992, structured the following five main goals:

- Co-payment for several health care services
- Emergence of social health insurance
- Introduction of health care private practice
- Handling over governmental responsibility for planning and central functions to manucipalities and professional associations and introducing licence and recertification for health professionals (Albreht and Klazinga 2009).

Research indicates that it is the responsibility of Slovenian citizens and its inhabitants, employers and the state to contribute actively to incur the health care costs through a Care Health Insurance scheme based on social health insurance principles. The health insurance and health care system is a public, non profit service which is compulsory legislatively and covers the whole population. Programmes of health service at all levels are determined through negotiation processes among partners that are equally represented (Leskošek 2012). Based on this information, it is clear that the availability of health insurance and health care system is very significant in promoting a healthy life style among the teenagers and the population at large.

6. Gender impacts on adolescents' health with focus on safe motherhood and safe abortion

The health of teenagers and sexual activity is led by the adolescent's enviromental socio-economic status, cultural, religious beliefs, accessibility to education, gender as well as ethnic background. Gender perspective plays a crucial role in shaping adolescent's view on sexuality and in turn affects sexual behaviour, accessibility on information and services, attitudes on risk taking and their use. Reproductive health needs as well as reproductive health status are also influenced by the gender perpective (Joshi 2005; WHO 2007).

The usage of teenage contraception and its prevalence differs across the European region. Adolescent pregnancy has declined over the past 20 years in the European Region. The reduction of these teenage pregnancies is associated with a combination of variables such as increasement on the importance of higher educational levels, accessibility of contraception, knowledge improvement, freedom from the pressure of childbearing and early marriage and the sexuality education lessons introduced in school (Haldre et al. 2005; Singh and Darroch 2000). Slovenia is among the European countries that have moderates rates (40-69.9) of teenage pregnancy. Interestingly, more teenagers opted for termination of their pregnancy, rather than delivery in the Russian Federation, Sweden, Denmark, Finland, France, Estonia, Netherlands, Norway, Iceland and Slovenia (Avery and Lazdane 2008).

In a study conducted by Pinter and Tomori (2000) about sixty percent (60%) of students who were sexually active often used condoms and less often the pill (14%). Approximately one-fifth (19%) of the students had applied no method, and only a few used coitus interruptus (4%) or other methods (3%). Condom was regarded as the most important method of contraception. The research depicts a different rate on the usage of contraceptives among sexually active adolescents from other countries.[3] Slovenia was rated as amongst the highest in condom usage, which is even higher than Finland which has 50%. About 19% of teenagers in Slovenia were found to be not utilizing any contraception which is comparable to the rates in other European countries. Slovenia began to experience positive changes in teenage reproductive health in 1980s, resulting with significant pregnancy rate drop. According to the European Union Health Report (2011) Slovenia is in the middle with regard to the rate of teenage pregnancy that end up with abortion (the majority of adolescents opt for abortion and 43 percent choose to have a child) as compared to other European countries. The country has a general population statistics of 2.061.403 people (www.stat.si/eng/). Statistics from 2010 show that abortion ratio among teenagers is about 7% of the amount of all abortions in that year. In addition regions like Pomurska and Podravska are seen as taking the lead with

3. Marginalisation in relation to economic success, empowerment of young girls to take control of decision making with issues affecting their life world and accessibility of health care facilities. Denmark reflected 64% of teenage girls; Netherlands 56%; Belgium 61%; UK 43%, Germany 40%; Greece 40%, Hungary 35%; Finland 32%; France 17%; the percentage is very low in Italy (8%).

high abortion rates (Albreht and Klazinga 2009; Zdrastveni statistični letopis 2010). Poor accessibility of abortion services in some rural areas in Slovenia, regarding gynaecologists is mentioned as a serious problem in Antolič's study (2005), although the State has been the main provider of abortion services and a main co-ordinator of health sector in general (Seamark 2004). One of the regional service providers in Slovenia had indicated that some teenage abortion cases are officially not reported by family members as family members prefer not to disclose such incidences[4]. Based on this, it appears that current statistics on abortion may be misleading. Furthermore it may be difficult for teenagers to commit legal abortions especially in situations where partriarchy is still dominating in terms of the religion, socio cultural and historical background. This is a challenge for affected structures to come with intervention strategies that should be implemented to challenge some features of partriarchal societies in order to make services accessible through comprehensive information with regard to the prevention methods as well as support services.

Strategies for the improvement in using contraceptive forms that are effective include sexuality education programmes that are comprehensive[5] in local communities, schools, promotion of open discussions about sexuality in the mass media, education but also legislation that deals with equal access to contraceptives, education, safe abortion and youth friendly services (Pinter and Tomori 2000).

The popularity of condom usage and AIDS prevention programme may be regarded as the main contributory factors contributing to a decline in pregnancy rates. Even though half of reproductive health issues are attended pertaining to teenagers in Slovenia, it appears that there is still a need for a holistic strategic educational comprehensive services from a network of service providers to reduce the rate of these teenage pregnancies that end up with abortion (Sales et al. 2009). Research conducted in Slovenia on the consequences of teenage pregnancies revealed the following issues:

- Participants did not receive enough assistance pertaining to social and financial help; they experienced social and health complication problems during pregnancyhood period; they had denial feelings as they could not figure out exactly how they became pregnant and still could not accept their status as teenage mothers (one of the participants never thought that she will fall pregnant because she had considered herself too young at the age of fifteen); the participants also revealed that although they had received information on sex education and sexuality education, it was not done on regular basis to enable them to understand various important issues that need to be taken into consideration in order to have options in life; they were disappointed as their partners had left them on their own and were very lonely as such; they had lost contact with their school mates; those that had married under

4. Interview with Alenka Hafner, g.p (specialist in social medicine) working in the Institute for public health in Kranj (2 April 2013).
5. Comprehensive sexuality education: sex education that includes topics such as contraception, sexually transmitted diseases, HIV/AIDS and disease-prevention methods as well as the benefits of abstinence.

pressure of being teenage mothers could not last in their marriage as they later divorced each other (Mezeg 2013). Based on this, it appears that services that are currently in place are still not meeting the needs of these teenagers.Therefore it may be important for professionals and scholars to evaluate existing services and programmes in order to identify gaps that needs to be filled.

- Research programmes (Šinkovec et al. 2010; Pinter and Grebenc 2010) conducted in Slovenia reflect a significant percentage of pupils who were sexually active with little information about protective measures and sexually transmitted infections at secondary schools (39% of pupils in second grade and 48% of pupils in final classes). Furthermore a significant percentage of adolescents did not use any protection at their first sexual intercourse as well as those who became pregnant (Rajgelj 2005). From this information it appears that the protective health measures that are currently in place need to be scientifically revised for efficiency reasons. In other words, there is a need to review intervention services that are comprehensive in order to reduce the rate of teenage pregnancies that end up with abortion. Furthermore the current services warrant a clear scrutiny based on the existing enviromental variables such as socio-economic, religious, cultural background of these adolescents and how some of these variables could be dealt with in the transformation process.

Good practices and scientific evidence assist to identify programmes that are beneficial and effective, such as teenage contraceptive services and sexuality education in school (Kirby et al. 1994). Educational awareness campaigns on safe sexual behaviour appear to be operating, although sexuality education is not part of the school curriculum in Slovenia (Mezeg 2013). A survey conducted in medical high school indicated the majority of teachers who avoid topics that relate to sexuality and further that teachers are not putting a lot of efforts to educate the youth on sexual education (Giami et al. in Mezeg 2013). Approximately 60% of sexually active 15-year olds had applied a condom at last intercourse in Central, Western and Eastern Europe (Godeau et al. 2008). The results indicate improvement in the manner of utilizing contraceptives although the situation is not applicable to all the countries especially in rural areas where people still adhere to their believes, norms and values in terms of reproductive health.

Qualitative research indicates that young Slovenians plan their parenthood with hesitation and care because of issues such as unavailable housing, uncertain labour conditions, a need for a comfortable life, self realization and obtaining new gender balance (Manuela du Bois-Reymond 2008). The delaying of early parenthood is linked with low rates of teenage pregnancies , even though not all Slovenian teenagers appears to succeed in delaying parenthood due to some of the current intervention services that do not address in detail the impasse of teenage pregnancies and its implication as reflected in some studies (Mezeg 2013). It looks like the current school policies need to be revised and amended based on the experiences of these teenage mothers. Their socio economic cultural context in which they live has to be assessed too.

7. Accessibility of services

Primary reproductive health care is extremely important in Slovenia because of the active approach to protect reproductive health of women. The main goal of reproductive health prevention programmes which take place at the primary level are to lower the risk due to diseases that are related to reproduction, prevention of unwanted and unplanned pregnancies, detection of the disease, proper measures to be in place in terms of promotion of reproductive health and reproductive rights, primary reproductive health protection, ensuring counselling regarding contraception and promotion of family planning, curing sexually transmitted disease infection, healing, treating and uncovering diseases which could lead to infertility , curing and treating pregnant women, early detection of uterus and breast cancer as well as proceedings in peri-menopause and probably before and post menopause period. The primary health care is very important from an economic point of view as diseases are detected at their earliest signs and treated at their earliest stage and this affects lower medical treating costs. Despite the fact that by the data of Institution of Health Assurance (ZZZ), as well as the data of completed questions (phone poll) in all Slovene statistical regions, gynaecologists that are still obliged to take new patients are available. The accessibility of Primary Reproductive Health Care in the local enviroment is still bad in certain areas in Slovenia (Antolič 2005). This discourse is having a negative effect for the young girls who are coming for gynaecologists for the first time. In other words, they are not well oriented to the health system and as such they experience several stumbling blocks when they access medical health care. That said, there is a need for this young girls to have health care that is accessible and and flexible in terms of proximity (availability of public transport) and time.

From this imput it is clear that the current medical system is really benefitting most teenagers and teenage mothers as almost everybody is ensured and this practice promote the health standard of these teenagers, teenage mothers and their children. However, it also looks like that part of Slovenian teenagers are left out of the existing system of provision and support as far as the reproductive health is concerned.

8. Conclusion

Teenage pregnancy and teenage parenting are both challenging experiences for teenagers in both countries especially in South Africa.The article reveals the following issues in South Africa: inequities in terms of gender power that usually contribute for women vulnerability in teenage pregnancy and unprotected sex; lack of proper interventions in teenage pregnancy and psycho-social support for teenage mothers and furthermore does not incorporate intersectionality in terms of gender. In addition men and boys are often not taught the responsibility of helping women and these teenage mothers in terms of childrearing and finance. Professionals, service providers and nurses are playing a significant role in the life world of these teenagers although most of these current services and programmes are not strategised in line with the teenagers' life world , especially when we take into account their historic, social, economic and

cultural background. For instance, some of the teenagers are not having a comprehensive information in terms of emergency contraception, abortion and reproductive health in general. Some of the people in South Africa are living without an insurance, and such practices will pose a threat to their health. On the basis of these problems it is therefore suggested that current services and programmes should incorporate the clients' views, in the case of the teenagers. Policies should be designed in such a way that teenagers, pregnant teenagers, teenage mothers and women will be protected on the issue of inequity in gender power to avoid putting them at risk. Men and teenage boys should be workshopped inline with their culture on how to provide social and economic support to women, pregnant teenagers, as well as teenage mothers. Different service providers and professionals should work as a multidisciplinary team to strategise the implementation of effective services on reproductive health and the usage of contraception, in areas which are still disadvantaged in order to assist these teenagers to have alternative options for their future. The government should work together with the people to redesign an affordable health system which could be utilized by the people who have poor economic background , to promote a protective healthy life style.

Slovenia on the other hand is having moderate rates of teenage pregnancy, although more teenagers are opting for termination of pregnancy rather than carrying the pregnancy to term. Intervention strategies that are in place are very good although such interventions are still lacking behind in certain regions as teenage mothers still need help in terms of social and financial matters as well as denial feelings about their situation (Mezeg 2013). Although condom use is relatively widespread among teenagers in Slovenia, some research show that there are teenagers who do not use any contraceptive method at all. Such situations may put teenagers at risk in terms of infectious diseases and teenage pregnancy (Avery and Lazdane 2008).

Based on these issues, it is posible to make a number of suggestions. First, comprehensive services that incorporate teenagers' own views and experiences may be rolled out to areas that are still disadvantaged. Pregnant teenagers and teenage mothers who are having denial feelings about their situation can receive proper counselling from a network of social workers, gynaecologists, nurses as well as moral support from family members.Current policies can be redesigned and implemented in accordance with the historic, social, economic and cultural backgrounds of these teenagers. Services should also be gender sensitive in terms of promoting equity on the issue of gender power to avoid women vulnerability especially in rural areas.Teenagers may be informed on regular basis about prevention programmes in order to have alternative options for success and growth and to avoid risky situations such as teenage pregnancy and contracting infectious diseases. Policy makers, advocacy groups and professionals may utilize scientific evidence to evaluate the existing services and programmes in order to identify gaps that needs to be filled for improving the intervention practice. The relevant structures that are dealing with intervention strategies on teenage pregnancy and teenage matters can coordinate and collaborate efforts to design intervention strategies that are psychosocial to deal with teenagers problems as reflected in teenage mothers's views in Mezeg's study (2013).

Finally, both countries (Slovenia and South Africa) have intervention systems that are helping the teenagers although there are some gaps which needs to be filled in taking into account the holistic view of teenagers as well as their socio-economic and cultural background. Limpopo Province is big and therefore it may reguire additional humanpower for sectors that deal with teenage matters to render effective services and to avoid staff shortage. Coordination of services with NGOs and other sectors that are dealing with prevention of teenage pregnancy and support for teenage mothers will yield positive options for the future of teenagers. Slovenia on the other hand is a small country with a good health system that may still need proffessionals and service providers to restructure it in line with the perspectives of teenagers.

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