

**NARRATIVES OF PREGNANT TEENAGERS ABOUT REPRODUCTIVE HEALTH CARE
SERVICES IN A CLINIC IN GAUTENG PROVINCE**

by

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DECLARATION

I declare that, Narratives Of Pregnant Teenagers About Reproductive Health Care Services In A Clinic In Gauteng, is my own work and all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

L A Nkosi

DATE

Dedication

This dissertation is dedicated with love to all the teenagers who have experienced pregnancy and to those teenagers who are not pregnant. My parents, Violet and the late Paul Molamu, my loving and supportive husband, Herbert Nkosi, and my two loving and supportive daughters, Sibongile and Phindiwe Nkosi.

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ABSTRACT

Teenage pregnancy is an ever increasing dilemma in South Africa. Dealing effectively with pregnant teenagers is a continuous challenge for the health care providers particularly the nursing staff. The present study focuses on the reproductive health care services in a Gauteng province clinic and pregnant teenagers' experiences of their interaction with the nursing staff. Six pregnant teenagers were included in the study. Data consisted of the participants' narratives regarding the health care services provided by the nursing staff. Themes from the narratives were identified and explored according to a Social Constructionism stance within the Postmodernist paradigm. Factors found to affect the experiences of the pregnant teenagers included acceptance, respect, effective communication, privacy, trust and the dedication and professionalism of the nursing staff.

KEY CONCEPTS

Teenage pregnancy, teenage reproductive health services, prenatal care, Social Constructionism, qualitative research design, Gauteng Province and narrative analysis.

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CHAPTER 1

ORIENTATION

1.1 Introduction

This research report entails the exploration of the narratives of pregnant teenagers about reproductive health care services at a clinic in the Gauteng province. For the purpose of this research, the word adolescent and teenager will be used interchangeably.

There is no single definition to a teenage period. Teenage period or adolescence is defined by the World Health Organization (1998) as encompassing the 10 to 19 years range. Drake (1996) defines the teenage period as a developing period from 11 to 20 years. Mapanga (1997) concurred with this definition but emphasized that this period is not only developmental, but should also be seen as a transitional period between puberty and adulthood. According to Mngadi, Albergh, Thembi and Ransio-Arvison (2002), the teenage period encompass the age range of 10 to 19 years. Nichol, Manoharan, Marfell-Jones, Meha-Hoerera, Milne, O'Connell, Oliver, and Teekman (2002) on the other hand, define the adolescent or teenager as a person between the age of 13 and 24 years old.

In spite of the conflict regarding the demarcation of the teenage period, most researchers seem to agree that adolescence is a recognizable phase of life characterized by rapid cognitive, physiological, psychological and psychosocial

development, whose beginning and end is not easily demarcated (Blake & Beard, 1999; Canuso, 2000; Dlamini & van der Merwe, 2002; Mngadi et al. 2002; Parsons, 2003).

Adolescence is a physiological and psychological period in the life of a teenager that provides a launch pad for future development and progress. It is also a time where daring and risk-taking behaviour is rife. This may be highlighted by engaging in unprotected sex, which frequently results in teenage pregnancy (Drake, 1996; Mapanga, 1997; Nichol et al. 2002).

Pregnancy can be a stressful period for all women. According to De Lee and Greenhill (1943), pregnancy makes women to be susceptible to certain general diseases such as hypertension, hyperemesis gravidarum (vomiting in pregnancy), eclampsia, renal and liver disease. However, in most cases matured pregnant women are able to endure this period because of the support that they get from their partners and the society (De Lee & Greenhill, 1943).

On the other hand, pregnant teenagers in most communities are seen as social deviants (Mngadi et al. 2002). Their pregnancies are frequently unplanned and unwanted. According to (Dlamini & van der Merwe, 2002; Montgomery, 2003; Sadler & Daley, 2002), up to 90% of these teenage pregnancies are unplanned and unwanted. Hence they do not get the same support and joy from their pregnancies as matured women. The above scenarios leave pregnant teenagers psychologically

stressed to cope effectively with the prospect of early motherhood challenges. Due to the high stress level, pregnant teenagers are often in dire need of an empathic and supportive context. However in many instances, teenagers are confronted with contexts that authors (Blake & Beard, 1999; Crouch, 2002; Drake, 1996; Magwentshu, 1990; Mapanga, 1997), describe as judgemental, hostile and unempathic.

Fear of judgment by nurses in most cases will discourage the pregnant teenagers to hide their pregnancies for as long as possible and will thus present themselves for antenatal care when their pregnancies are in advanced stages (Voydanoff & Donnelly, 1990). This late presentation poses a serious psychological, behavioural and medical problem in that early detection of problems cannot be made possible. Due to the advancement in the pregnancy, it is impossible to consider termination of pregnancy as an option to those pregnant teenagers who would like to. Most of the teenagers are then compelled to continue with their unwanted pregnancies. Both fetal and maternal health is compromised due to late reporting for pre-natal services.

It seems that there is a generalization that the nursing professionals at the antenatal health care services clinics visited by the pregnant teenagers from time to time, are not aware of the pregnant teenagers' stress levels and their need for support and empathy. It is argued that it is important to study the context in which nurses interact with pregnant teenagers using a Social Constructionist epistemology. Themes and meanings that emerge from this newly constructed context will be discussed.

1.2 Problem statement

Teenage pregnancy continues to be a multidimensional worldwide challenge that is facing families and communities at large, bringing about a wide range of psychosocial problems (Blake & Beard, 1999; Canuso, 2000; Crouch, 2002; Drake, 1996; Dlamini & van der Merwe, 2002; Ehlers & Maja, 2001; Hellerstedt, Smith, Shew, Resnick, 2000; Koniak-Griffin, Anderson, Verzemnieks, Brecht, 2000; Mapanga, 1997; Montgomery, 2003; Mngadi et al., 2002; Nichol et al., 2002; Shaefer & Emerling, 1997; Tsai & Wong; 2003).

According to the World Health Organisation's report (World Health Organisation, 1997), every year 15 million children are born to teenage mothers worldwide. In America approximately 1 million teenagers become pregnant yearly (Scarr, 2002; Koniak-Griffin et al., 2000). In South Africa, according to Ehlers and Maja (2001), approximately 17 000 babies are born to teenagers younger than 16 years every year.

In most instances the pregnant teenager has to leave school before completing her studies. This in turn leads to poor educational attainment, low economic status, unemployment and dependency on social grants. Presently in South Africa, the state is over-burdened with the payment of child grants to parents who are unemployed.

1.3 The aim

The aim of the report is to explore the narratives of pregnant teenagers with regard to the antenatal care services that they receive at the clinic, in order to have a clearer understanding of their experiences from an emotional point of view.

The study will also investigate the psychological support that pregnant teenagers receive from the nursing staff at this clinic.

An attempt will also be made to highlight the importance of raising the awareness of the nursing staff working at the antenatal health care clinics to the plight and dilemma of pregnant teenagers in as far as they need support and encouragement to continue with their studies after giving birth.

Finally, the study will also investigate the frustrations of the pregnant teenagers at the clinic that form a barrier to their psychological development, and how such barriers can be overcome.

1.4 The importance of the study

According to Statistics S A (2005), 72 000 teenage girls aged between 13-19 years did not attend school or other educational institutions in 2005 because of pregnancy. To be more specific, 2 542 teenage girl-learners dropped-out of school and other learning institutes in the Gauteng province and never returned to complete their studies as a result of poverty, illness and pregnancy. Many of these pregnant

teenagers end up with no academic qualification and tend to increase the levels of youth unemployment in this country.

It is hoped that by supporting these teenagers in a holistic way at the clinics, most of them could be persuaded to go back to school to complete their studies. Such an action could save them from becoming social burdens to the state.

1.5 Chapter overview

In chapter 1, the aim of the report and its importance is given.

Chapter 2 contains literature review on teenage pregnancy and teenagers' development, i.e. psychosocial, cognitive, emotional and biological maturity. An overview of health services especially those services meant for pregnant teenagers is also evaluated.

In Chapter 3, the Social Constructionist epistemology as a theoretical basis is presented and related to the study. Social Constructionist is referred to as a sociological description of knowledge (Berger & Luckman 1996; Burr, 1995; Gergen, 1985; Hruby, 2001). Neimeyer (1998) sees Social Constructionist as a means for constructing a platform for alternative social realities, which in turn creates possibilities for new meanings or realities. This epistemology is appropriate for this qualitative study as it is conducted through the use of language in a social context.

Dialogue between the participants and the researcher is used to co-construct reality. Social Constructionists do not believe in a universal truth (Fourie, 1996).

Chapter 4 contains the research design and methodology. Data collection is done within a qualitative methodology. Qualitative research methods have the advantage of producing a wealth of detailed information about social phenomena. It is also suited to give people a feeling for people's experiences in social settings (Terre Blanche & Durrheim, 1999). According to Allan (1991), qualitative research welcomes the viewpoint, cultures and worldviews of the participant's account of the social setting.

A narrative approach is used because according to Anderson and Goolishian (1992), this approach assumes that all human systems are linguistic systems, and participants will make use of a language to describe their feelings. Language in this study is the vehicle through which all data is collected and thus making the narrative approach most appropriate for this study. The discussion includes the research instrument and method of data analysis.

In chapter 5, a detailed presentation of the results of the research interviews is done. The narrative method of analysis is used to identify themes and meanings arising from the narratives of the participants. Daiute and Lightfoot (2004), state that the narrative analysis method does not have a fixed set of techniques.

Chapter 6 contains the summary of the study, the limitations, conclusions and recommendations drawn from the findings.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The crux of this chapter is to review literature on pregnancy as it pertains to the teenage period and the provision of health care services for the youth. The literature on the relationships between pregnant teenagers and health care providers will also be explored.

In this chapter the researcher aims at finding a sound theoretical knowledge and an in-depth understanding of the research topic and what pregnant teenagers go through emotionally and psychologically, particularly when they consult antenatal care centres. This chapter will also look at factors such as accessibility of health care centres in the public health sector.

2.2 Reproductive health services in the public sector: A reflection

The *Batho Pele* (Service to the people) programme of the public service in South Africa encapsulates the proposed quality of care in health services. *Batho Pele* has been identified through the public service commission as one of the five key programs of the Reconstruction and Development Program. Criticism seems to have mounted on the way in which services are rendered in government institutions. Amongst others, the services rendered by the government institutions have been experienced and described as unfriendly and unacceptable (Magwentshu, 2000).

This is disturbing when one considers that the initial introduction of *Batho Pele* was aimed at introducing a more efficient and effective service provision in public service institutions which included a more people centered approach in health centers. However, authors such as Magagula (1998), Magwentshu (2000) and Mpshe, Gmeiner & Van Wyk (2002) argue that South African public health services for pregnant teenagers have remained in a lamentable state and calls for further research in this area. A reflection on public health services as it pertains to reproductive health care services of pregnant teenagers is therefore necessary.

At the present moment, it is substantially argued that there is a desperate need to improve reproductive health services for pregnant teenagers within the public health sector. The problems resulting from teenagers using the public health services result in feelings of fear of chastisement, humiliation and distress, lack of confidentiality, trepidation of medical procedures, lack of information and operational barricades which include non-convenient operating hours in respect of young people (Johnson, Nelson, & Schierhout, 2002). Magwentshu (2000) reinforces that several teenagers described health service providers as unkind, rude, brusque unsympathetic, uncooperative, judgmental and outright hostile. Such experiences in the public health institutions resulted in pregnant teenagers linking these institutions with punishment (Magwentshu, 2000).

2.3 Social understandings of teenage pregnancy

Most teenagers are at a stage where they can comprehend when they are given a chance to ask questions and to construct meaning regarding that which is happening to them. The cognitive development stage (formal operational stage of Piaget) that the teenagers are entering enables this ability. They tend to respond better to explanation than orders. This implies that the adolescent is now able to challenge certain opinions and ways of doing things including that of the adults (Craig, 1986; Lloyd, 1985; Manaster, 1989; Matteson, 1975; McCandles; 1970).

By helping teenagers to recognize what they are doing well, rather than punishing them for their mistakes, their development and behaviour will be influenced much more readily. This steers us to the distinct role of the counselor, which is to enable teenagers to make informed decisions that give them confidence and assist them in controlling their own lives (Blake & Beard, 1999; Scarr, 2002; Shaefer & Emerling, 1997). Perhaps the fundamental considerations for clinicians should be those that are important in the eyes of the pregnant teenager.

A study by Smith-Battle (2003) indicates that the teen mother feels stigmatized when clinicians do not take into account what is meaningful to her, her parenting legacies, and the social milieu. Whilst the pregnant teenager may see the pregnancy as a triumph for herself (Lloyd, 1985), the clinicians may see the pregnant teenager as a failure and as someone with unruly behaviour. The clinicians and other members of society may consider this behaviour as a deficit and take it upon themselves to

'rebuke' this behaviour. In general, to my experience as a professional nurse, clinicians tend to treat mothers as passive, voiceless recipients rather than as active subjects whose concerns, priorities and practices accurately reflect the imperatives and contradictions of the family and social worlds they inhabit.

Prevailing Afro-centric cultural world-views (upholding the collective, intuitive and communal unity as means of success) subconsciously influence the social construction of 'appropriate' sexual behavior through sustaining specific religious undertones (such as the ones favouring sex only within the context of marriage). Although controversial, dominant ideological beliefs, such as the ones mentioned are important because they help individuals to make sense of their realities. What needs to be critically dealt with is preventing the subjective opinions of the clinicians (such as pregnancy only being for married women and not for teenagers who are supposed to be at school) from negatively influencing the way they treat and relate to their younger patients. It should also be noted that these dominant traditional values upheld by society are not necessarily the view of all pregnant teenagers (Blake & Beard, 1999; Savage, 1996).

The negative effects of such socially constructed values along with their interpretations are that they come across as being judgmental to those pregnant teenagers who interpret them as being less supportive to them. The need for appropriate pregnant teen services that are sensitive to the developmental and

psychological needs of these teenagers is evident. The assertion that pregnant teenagers do not deserve proper health care services calls for more investigation.

2.4 Reproductive health services in Southern Africa

In most countries in Southern Africa, midwives are the main providers of reproductive health care services to pregnant and childbearing women, owing to a shortage of obstetricians and pediatricians. From the time of Florence Nightingale nursing has been seen as a 'helping' profession. The responsibilities of nurses are three-fold, namely; to preserve life, to alleviate pain and suffering, and to promote health (Vlok & Schreiber, 1976). One of the professional responsibilities of a midwife is to manage the process of pregnancy up until delivery and to provide postpartum care. The midwifery role also includes providing counseling and family planning services (De Lee & Greenhill, 1943).

In order to provide quality care, the World Health Organization (1997) recommends that midwives should adhere to the mother-baby package (essential care for all pregnant mothers, including pregnant teenagers, to ensure good health for both mother and baby at the time of delivery). The mother-baby package consists of a cluster of interventions designed to support countries striving to attain the goals of the safe motherhood initiative. These interventions focus on fundamental maternity care for all human pregnancies including teen pregnancies and unique care for the prevention and management of complications during pregnancy as well as postpartum (Mngadi et al., 2002). According to Dlamini and van der Merwe (2002),

investments in health care services were made in the form of family planning clinics to curb the crisis of teenage pregnancy in Swaziland. Unfortunately this was not reflected in the behavioural change of the female teenagers in Swaziland. The complete isolation of the female teenagers' opinions calls for greater understanding of the cognitive and biological development of teenagers and their social influences as well.

It is argued that the psychological impact of teenage pregnancy is not given high priority in public health institutions. Based on the present status quo in our public health service shortages of nurses and overcrowding in government institutions is common. Afro-centric cultural world-views uphold cultural biases which often prioritize pregnant adults. The pregnant youth is positioned as an extra burden on an already burdened health care service. It is against this backdrop, that existing reproductive health programs for teenagers in Southern Africa could be perceived.

2.5 Pregnant teen services in South Africa

According to Magwentshu (2000), each South African district health authority and provincial department has been given the responsibility of providing maternal, child, women, and family health and nutrition services. Children and women are mentioned in the above provision detailing what their services entail. What is worth noticing is that nowhere in this health service provision are teenagers specifically referred to. It therefore leaves one wondering whether the public reproductive health services were ever intended to accommodate pregnant teenagers.

It is questionable why teenagers are not specifically talked about in this service provision. Being in a transitional stage from childhood to adulthood, it seems that it might not be clear for nurses where to position teenagers. The teenager seems to be a misfit when grouped together with adults and does not fit either when grouped with children.

Adolescence is a recognized phase of life but its demarcations are not always very clear (Blake & Beard, 1999; Montgomery, 2003) and this also seem to be the case in South Africa as seen by the lack of inclusion of teenagers in health services. Erickson, cited in Matteson (1975), seems to agree with this notion when he talks about the psychosocial moratorium in adolescence. This is when teenagers or adolescents are required to partially extricate themselves from society in order to find themselves.

The health services in South Africa need to come up with more specific guidelines with regards to the health care of teenagers in order to bring clarity to both the health care givers (nurses) and the teenagers. The current state of the teen health care services rendered in the Gauteng Province, inclusive of its strengths, shortcomings and proposed solutions is going to be proposed and thoroughly discussed.

2.6 Reproductive health services for teenagers: The Gauteng landscape

Gauteng province, passionately known as the place of gold, is the economic mainstay of South Africa and competitively one of the most vibrant provinces in South Africa. It is a place where teenagers, because of their numbers, are forced to compete vigorously for work, recognition and mere survival in the economy. Preston-Whyte (1997) refers to survival sex. In South Africa and especially in the Gauteng province, sex is seen as just another commodity for sale in order to make ends meet. Men, women and teenagers engage in survival sex. They do not consider themselves as prostitutes. Selling sex is occasionally turned to when there is no other means of survival. It is about making money to survive from poverty (Boikanyo & Donnell, 1997). Survival sex is common in the Gauteng Province. 'The children, especially those from Pretoria and Johannesburg, said that survival sex was the best way to get money and that it generated a greater income than other street activities such as parking cars and begging' (Boikanyo & Donnell, 1997. p. 65). The teenagers admitted to practicing survival sex without condoms and are thus engaging in unprotected sexual activity (Blake & Beard, 1999; Dlamini & van der Merwe, 2002; Hellerstedt et al., 2000; Montgomery, 2003; Sadler & Daley, 2002; Savage, 1996; Tsai & Wong, 2003). The consequences of unprotected survival sex where teenagers are involved, may add an extra burden on public reproductive health services. Poverty then negatively influences the states initiatives to improve access to health services and the *Batho Pele* principle is thus not readily achieved.

2.6.1 Reproductive health services

Health care services within the Gauteng Province are mostly reported to be not accessible, available, and affordable and do not respect the privacy and confidentiality of its consumers (Magwentshu, 2000). The providers of these health services do not provide sufficient information in order to enable the teenagers to make informed decisions. Negative attitudes and lack of sensitivity towards youth and their sexuality discourages them from seeking further help from these services. The *Batho Pele* programme is therefore not effective. Health services are provided from an all knowing point of view and rarely considers inputs from the youth (Magwentshu, 2000), the people who are supposed to benefit from these services. Health services are not appropriate in terms of education (teaching the youth what is relevant for them) and communication (appropriate ways of conveying information) to young people and communities in general. Such services are not fully utilized by the youth due to various reasons of which bad or negative attitudes from nurses forms a part thereof. There are few health providers who are trained to meet the health needs of the teenager (Magwentshu, 2000).

2.6.2 Reproductive health programmes for teenagers: A review

Generally, services for teenagers are not user friendly due to the attitude of health professionals especially towards pregnant teenagers. There is a lack of programs for teaching parenting skills to pregnant teenagers as pregnancy is generally regarded as something for married women who are more mature. Such services do not provide support groups for pregnant teenagers and teenage mothers (Magwentshu, 2000).

No training programs for health care workers specifically in the area of managing teenage pregnancy are provided. Training is given in a more general form. With the escalation of teen pregnancies, the researcher asserts that programmes that specifically target the handling of pregnant teenagers should be developed and incorporated into the training of health care workers.

2.6.3 Teenage - friendly services

There have been guidelines in respect of the World Health Organization (1998) with regards to ensuring friendly services for teenage clients or patients. Teenage friendly services must be blameless and acceptable to potential users and responsive to cultural and social norms taking into consideration aspects such as privacy and confidentiality. It might be the teenager's first visit to the health facility to confirm a pregnancy and the teenager may like to keep the pregnancy a secret until she decides what to do about it or who to involve. The guidelines further states that health workers should be non-judgmental and civil as they provide these services to adolescents. The decision of the teenager to become pregnant should be respected. They should be treated like worthy and deserving clients with all the respect given to them. The issue of teenagers having the choice to procreate or not seems to be emphasized by World Health Organization (1998). This however seems to be a contradiction because society talks about curbing teenage pregnancy which is a prominent discourse. The teenager's right to choose does not really exist.

Magwentshu, (2000) suggests that an adolescent - friendly service should be pleasing, welcoming, helpful, comfortable and relaxing. This means a stress free atmosphere that every teenager can enjoy. Such a program should offer a broad band of services, especially those services that appeal to the needs of teenagers. Time should not be a limitation for the utilization of such services. Teenagers would be pleased to be able to visit the clinic after school hours, in the evenings and during weekends. The health care providers should be knowledgeable- especially about teenagers' needs, empathic and trustworthy counsellors. Privacy should be maintained as most teenagers have the desire to prevent others from knowing what their health problems are. All disclosures that are made by teenagers should be kept in confidence as some of them have not yet disclosed to their parents. Services ought to be affordable as well. Teenage health services should be staffed with sensitive service providers who have the interest of the pregnant teenagers at heart (Magwentshu, 2000; Montgomery, 2003).

It would appear that teenage friendly services as suggested by Magwentshu (2000) do not exist in most public health institutions in Gauteng Province. Pregnant teenagers are mostly seen as silly children who need to be brought in line with societal norms and values. This kind of attitude leads to negative treatment and deny pregnant teenagers their right to privacy (Magwentshu, 2000).

2.6.4 Ethics and teenage reproductive health

According to De Vos (1998. p. 24), ethics is defined as ‘a set of moral principles which is suggested by an individual or group, is subsequently widely accepted, and which offers rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors other researchers, assistants and students.’ Being ethical at all times can ensure that participants in any research project do not suffer any harm physically or emotionally. A dissection of two related ethical issues, namely, *privacy* and *confidentiality* will be discussed.

2.6.5.1 Privacy

It is crucial to first begin by defining ‘privacy’ so as to ensure a mutually shared understanding of the term. Privacy is the desire to prevent others from knowing everything that one says and does at present (or has done in the past or will say and do in the future). Baron and Byrne (1991) continue in stating that privacy is achieved by arranging one's physical and social world so that it is not open to others.

Macmillan (2002) defines privacy as the freedom to do things without other people watching you or knowing what you are doing. These definitions should be synchronized in order to get the wider, more complete sense of what privacy means and to attach a value to it. Privacy is one of the aspects to be considered when dealing with pregnant teenagers.

In practice, numerous pregnant teenagers feel a lack of privacy in government health care institutions. Pregnant teenagers are belittled publicly and made to feel undeserving of health care by nurses. This has psychological and emotional implications on the pregnant teenagers, especially their entitlement to confidentiality (Magwentshu, 2000).

2.6.5.2 Confidentiality

Confidentiality is of supreme importance to teenagers when seeking prenatal care. It [confidentiality] needs to be implemented by those who initiate care, from pregnancy testing to the initial visit, as most of the pregnant teenagers have not informed their parent(s) or guardians of the pregnancy. It is vital for the teenager to understand that she has a right to obtain confidential prenatal care. Reassurance that the confidentiality extends to all information shared during the communication transaction with the health worker is important to the client. The client must know that nothing she discusses with the health worker will be disclosed to anyone else without her permission (Scarr, 2002). The confidentiality agreement needs to be discussed with the teen and secured prior to the provision of the services (Sadler & Daley 2002).

2.7 Teenage behaviour: Why youth engage in sexual behaviour

Sexual development and maturity is one of the developmental tasks of teenagers (Blake & Beard, 1999; Drake, 1996; Matteson, 1975; Montgomery, 2003; Thobejane, 2001). One of the developmental tasks of the teenager is to satisfy his or her sexual needs in a way that carries the approval of society. This will also help the teenager to

make a positive contribution to the development of her or his identity. However, in the process of satisfying his or her sexual needs the teenager engages in risky sexual behavior such as unprotected sex (Blake & Beard, 1999; Dlamini & van der Merwe, 2002; Hellerstedt et al., 2000; Savage 1996; Montgomery, 2003; Sadler & Daley, 2002; Thobejane, 2001; Tsai & Wong, 2003). The above mentioned findings substantiate the desires within teenagers to engage in risky behaviours. One of these risky behaviours is unprotected sex. This (unprotected sex) and other characteristic teenage risky behaviours are going to be identified and discussed.

2.7.1 Teenagers: Little Risk Takers

Nationally and internationally, teenagers have indulged in unprotected sexual intercourse and ignored the long-term implications of teenage pregnancy such as dropping out of school, unemployment, poverty and the impact on themselves, their families, and the community at large (Blake & Beard, 1999; Crouch, 2002; Drake, 1996; Dlamini & van der Merwe, 2002; Ehlers & Maja, 2001 Hellerstedt et al., 2000; Scarr, 2002; Koniak- Griffin et al., 2000; Mapanga, 1997; Montgomery, 2003; Mngadi et al., 2002; Mpshe et al., 2002; Nichol et al., 2002; Shaefer & Emerling, 1997; Sadler & Daley, 2002; Tsai & Wong, 2003). This is in spite of the warnings that unprotected sex puts the teenager at risk of pregnancy and other sexually transmitted diseases (Ehlers & Maja, 2001; Mapanga, 1997; Montgomery, 2003; Nichol et al., 2002; Sadler & Daley, 2002; Tsai & Wong, 2003). According to a survey conducted in the United States, more than fifty percent of students in high school reported that they have had

sexual intercourse. Even more disturbing were the revelations of the onset age of sexual intercourse that showed a downward trend going as far as age 15.

A similar trend is reported within the South African context. Early engagement in sexual activity has been on the increase in South Africa (Ehlers & Maja, 2001; Magwentshu, 2000; Mpshe, 2002). Various reasons have been given for these trends which are divided into *cognitive* factors such as faulty use of contraceptives and ignorance about sexual activity. The *social factors* are progeny, poor reproductive health services, and desire to please boyfriends. The physiological factors are as a result of the earlier onset of menarche (first menstrual period), (Ehlers & Maja, 2001; Wood, Mafora & Jewkes, 1998). High teenage pregnancy rates and sexually transmitted diseases have been reported across the racial divide. According to Preston - Whyte and Zondi (1991) in a qualitative study undertaken in KwaZulu - Natal, youths between the ages of 13 years and 22 years admitted to having been sexually active by the twelfth and thirteenth year. The rare significance of these deductions was that they included both male and female.

The desire to please others (particularly peers) can influence teenagers to participate in behaviours in which they might normally not be interested in (Crouch, 2002; Montgomery, 2003; Nichol et al., 2002; Shaefer & Emerling, 1997). During teenage years, the misleading notion of invincibility predominates and is typified by the belief that 'it won't happen to me'. In addition, teenagers are concerned about how others view their behavior, that is, their 'imaginary audience' (Craig, 1986; Lloyd, 1985;

Manaster, 1989; McCandless, 1970). The teenagers are concerned with impressing these audiences and will do whatever it takes to impress this audience even if it is risky. It is this very capable desire to please that usually contributes to participation in high risk-behaviour such as unprotected sex with all its undesirable consequences, drugs, reckless driving, and even staying away from school (Montgomery, 2003). Risky behaviours of teenagers include sexual-experimentations as they consider themselves to be sexually active and sexually ready.

2.7.2 Teenagers: Sexual maturity and sexual activity

Various well substantiated arguments have been raised with regards to the relationship between sexual maturity and sexual activity. Immediately, vital questions that need to be given thought emerge. Biologically speaking, the teenage years or puberty can be viewed as a maturing period during which the primary sex characteristics begin to develop and function. These are the structures necessary for reproduction to take place, both in the male and the female teenager. These changes are structural as well as hormonal (Craig, 1986; Lloyd, 1985; Manaster, 1989; McCandless, 1970). The hormonal changes are from the pituitary gland which is situated in the hypothalamus – a structure in the brain. The gonadotropic hormones or gonad stimulating hormones are essential for the sexual maturation process. As these hormones increase in the blood circulation, the ovaries and testes develop and produce ova (egg cells) and sperm respectively, as well as their own hormones the gonadal hormones. This stage is characterized by high hormonal activities which contain the hormones responsible for an increase in sex drive. Taking stock of these

biological processes, one can appreciate the fact that teenagers are physically and biologically ready and equipped to engage in sexual activities.

Stimulating viewpoints surface that hold that a number of teenagers use pregnancy as a mechanism by which a young woman could control who her husband would be rather than her parents selecting a husband for her (Blake & Beard, 1999). It is also imperative to also look at this from a multi-cultural perspective. Some communities perceive pregnancy as a sign of fertility. When a teenager who already has a child gets married, she will be highly priced and valued by her in-laws. Parents of such teenagers will usually boast to other parents about the fertility of their daughters. In some cases parents of teenagers will encourage progeny due to the desire to have grandchildren (Wood et al., 1998). Teenagers are at a stage where they become less dependent as children and more independent as they approach adulthood. Amongst other ways, their transition to adulthood is expressed by becoming sexual beings.

According to Tolan and Cohler (1993, p. 95), 'humans are sexual beings from birth, but adolescence is a period when sexuality takes on different meanings and has different manifestations than previously'. Although engaging in sexual activity becomes normative with increasing age, for young teenagers it is behaviour that parents do not condone (Moore & Rosenthal, 1993). The particular focus on the initiation of sexual activity is due to its special place as transition behaviour, reflecting the transition from childhood to adulthood. These practices are still continuing in most black cultures, namely, 'koma' for boys and 'kgopa' for girls (Wood et al., 1998). For

although these cultural practices serve as important educational avenues that mimic acceptable cultural behaviour and reinforce social identity, they are somewhat connected with disputable subtle interlinks linking the initiation of sexual activity with maturity. It is such interlinks that have been challenged as sending out an ambiguous message to teenagers about the implications and functions of their sexuality.

If badly timed, sexual activity may be detrimental to the psychological, emotional, and social well-being and development of the teenager. In most instances, the teenager does not have the experience or knowledge to deal with pregnancy. Thus the teenager needs to have the cognitive ability to cope with pregnancy.

2.7.3 Teenagers: Cognitive Development

Cognitive development in adolescents will be described within the context of Piaget's theory. What is worth noting with regard to this theory are the immense cognitive advances demarcated for the individual during the adolescent period. By the age of eleven to fifteen years, most individuals enter Piaget's stage of formal operations (his final stage of cognitive development). This stage is characterized by the expansion of knowledge and inference. In adolescence this includes the development of advanced forms of levels of thinking, reasoning, and development (Moshman, 2005). Cognitive structure refers to the rules for processing or connecting experienced events (Matteson, 1975). The cognitive view emphasizes the active role of a person in understanding his environment. Curiosity is well put in place by adolescence.

Curiosity facilitates intellectual growth and the drive to explore the environment and is one of the strongest motivators for learning (Morgan, 1979; McCandless, 1970).

Manaster (1989) concurs in his statements that, the final stage of cognitive development, called formal operations, develops in adolescence according to Piaget. Piaget's stages of cognitive development represent a specific set of differences in the way people think. The term *formal* is used because at this stage the adolescent is able to consider the *possible*, and is able to reason in an abstract way. (Craig, 1986; Lloyd, 1985; Manaster, 1989; Matteson, 1975).

A second characteristic of formal operations is the ability to use hypothetico-deductive method. The formal operational person can consider hypotheses which may or may not be true and consider what may follow if they were true in the absence of empirical data (Manaster, 1989).

A third characteristic is that formal operations are second-order operations. The person with formal operations has the 'ability verbally to manipulate relationships between ideas (second-order operations) in the absence of recently prior or concurrently available concrete-empirical props (first-order operations)' (Manaster, 1989. p. 38).

A fourth characteristic of formal operations is that adolescents can engage in combinatorial thought, which means they are able to consider the effect of more than

two variables operating at the same time. Combinatorial thinking is required in systematic hypothesis testing when dealing with complex problems (Lloyd, 1985; Manaster, 1989; McCandless, 1970).

A fifth characteristic of formal operations is the ability to think about thoughts (meta-thinking), (Craig, 1986; Lloyd, 1985; Manaster, 1989; Matteson, 1975; McCandless; 1970). This enables the adolescent to evaluate the contents of their own thoughts as well as those of others. This implies that the adolescent is now able to challenge certain opinions and ways of doing things, including that of the adults and that they can co-construct the meaning of sexuality. One value of this developing teenager in the formal operations stage is the value to look beyond the here and now (Rickel, 1989). This means that the teenager has some insight into her/his acts and omissions. Thus, it can be implied that such a teenager is aware of the possible consequences of engaging in unprotected sex, including pregnancy and sexually transmitted diseases. Therefore, becoming pregnant can be seen as the 'choice' of the teenager.

A large majority of research worth noting suggests that young people develop cognitive competence- the ability to reason logically- some time during adolescence. This convincing evidence proposes that some young people arrive at cognitive competence at the beginning of adolescence whilst others are a good deal older (Rodman, Lewis, & Griffith, 1984). The ideal (for society) would be for teenagers to restrain themselves from sexual activity until they are completely mature to handle

the consequences in totality: physically, emotionally, and psychologically (Matteson, 1975). In practice however, most teenagers do become pregnant even though such a pregnancy may mean an end to a rosy future. They exercise their right to choose.

Looking at the high rate of HIV infections among adults in recent times one can safely argue that risk taking behaviour such as engaging in unprotected sex is also prevalent in adults. In spite of having achieved matured levels of cognitive functioning, periods of high stress and anxiety are likely to cause teenagers to revert to earlier, more concrete forms of information processing (Rickel, 1989). This is the case in only some of the teenagers. One of this earlier ways of concrete information processing is *egocentricity*. It refers to self-centeredness. It is a state where one is inconsiderate and careless of the feelings of others. Morgan, King & Robinson (1979, p. 365), refers to egocentrism as 'the inability of preoperational children to take the point of view of another person. They think that their conception of the world is the only one possible, and that everyone else sees things the same way they do.' This is the kind of behavior that is seen in teenagers when they engage in unprotected sexual activities without considering the result that these activities may have on them, their families, and the community at large.

According to Elkind (1967), teenage thought is characteristically egocentric and he speaks about *adolescent egocentrism*. They think and believe that everything revolves around them. The ability to think about their thoughts makes this possible (Craig, 1986; Lloyd, 1985; Manaster, 1989). Elkind cited in McCandless (1970, p.

246), calls it the '*conquest of thought*'. Adolescent egocentricity has several consequences. The first is labeled the *imaginary audience* (Craig, 1986; Lloyd, 1985; Manaster, 1989). They act as if they are being watched all the time by an audience. Now that they can think about their own thoughts as well as the thoughts of others, they continually act on the reactions of their imaginary audiences. This is expressed in their unwarranted self criticism.

A second result of adolescent egocentrism is *personal fable*. The personal fable is defined as 'a story which the adolescent tells him/herself which is not true' (Lloyd, 1985, p. 85). In this personal fable, the adolescent thinks that his/her thoughts are new and unique. This sense of being innovative makes the adolescent to be intolerable of others. They differ with their parents and find fault with them. According to Erickson cited in Manaster (1989), this conflict with parents is part of the adolescent's search for his or her identity. The adults in the society should try and help to co-create the reality of the adolescents instead of being judgmental towards them. Considering their biological changes, they have a high sex drive and because of their high expectations they frequently find faults with their partners (McCandless, 1970).

Another product of adolescent egocentrism is the surfacing of the *idealistic reformer*. Not only do the adolescent want to adopt adult roles but he or she also want to transform the world to meet their needs disregarding the needs of others (Lloyd, 1985). It is this separated, isolated feeling from believing that their suffering is unique

that may hamper them from listening to advices from adults. Elkind (1967) advances in his articulations that say teenagers see themselves as immortal and invulnerable (part of their personal fable). They believe they are immune to such consequences as automobile accidents, death or becoming pregnant. Futile statements such as '*I never really thought it would happen to her*' are common when teenage fathers describe an unplanned pregnancy with their female partners. Such supernatural thinking provokes teenagers- especially younger teenagers- to convince themselves that they are somehow special and exempt from the conditions under which others must abide (Craig, 1986; Lloyd, 1985; Manaster, 1989; Robinson, 1988). This calls for more adult intervention and to take up the responsibility to guide teenagers in order to avoid teenage pregnancy. It is critical to note that there is no definite congruency nor fixed ages at which this formal operational stage can be achieved. Adolescent egocentrism begins to recede by the age of 15 or 16 as they begin to replace their imaginary audiences with real audiences (Craig, 1986; Lloyd, 1985).

2.7.4 Teenagers: Differences in cognitive maturity

The ages of 11 to 15 are the early part of adolescence. This is significant because it is the beginning of the formal operations period. During this period, thought processes develop into mature adult like patterns, with specific traits that allow for adult accomplishments in thinking (Piaget, 1966). One cannot utter this without mentioning the noteworthy reminders of which are of the importance of being alert that *not all* individuals achieve this adult like thinking capability at the same time. It is therefore necessary for health care givers and society at large not to expect the same

level of maturity from all teenagers of the same age. According to Dlamini and van der Merwe (2002), the teenager recognizes reality but it becomes only a subset of many other possibilities. The teenager is therefore seen as extremely idealistic, is constantly challenging current norms and values, opposes authority, and considers the way things ought to or could be. This teenager attitude constantly brings them into disrepute with members of their society. Society needs insight into the cognitive development of the teenager in order to help the teenager to make meaningful decisions (Craig, 1986; Lloyd, 1985; Manaster, 1989).

Voydanoff and Donnelly (1990) use the cognitive development perspective to comment on teenage sexuality, pregnancy and childbearing. They attribute these outcomes to under-developed cognitive skills. Thus the teenager is unable to comprehend the repercussions of their sexual behaviour (Voydanoff & Donnelly, 1990). Teenagers also have a psychosocial development process to conquer.

2.7.5 Teenagers: Psychosocial development

Erickson, cited in (Lloyd, 1985; Manaster, 1989; Matteson, 1975) describes eight stages of psychosexual development in human beings of which the most important one for teenagers is the development of an identity. According to Erickson, the crises of teenagers is to find and answer to the question 'who am I' in order to provide themselves with an identity (Craig, 1986; Lloyd, 1985; Manaster, 1989; Matteson, 1975; Morgan, 1979; Moshman, 2005; McCandless, 1970). Identity is related to the individual's unique development and his or her link with the unique values of the

people the teenager sees as his own (Lloyd, 1985; Morgan, 1979). According to Erickson, the nature of one's culture also determines the particular manner in which various developmental crises are resolved. During the teenage years, the new cognitive powers of formal operational thought allow the teenager to analyze his/her role as sister, brother, student, group member and restructure the roles to form a new identity (Craig, 1986; Morgan, King & Robinson, 1979). The teenager seeks basic values and attitudes that cut across these various roles. It is in most cases a process that does not occur easily and requires trying on many roles and dedicated experimentation with ideas and sets of behaviours (Lloyd, 1985; Morgan, 1979). Ultimately, the teenagers 'uniqueness' and how he or she relates to other people, family members, peers, or institutions are integrated into a unified whole (Craig, 1986; Manaster, 1989; Morgan, King & Robinson, 1979). Other social beings also play an important role in the making or breaking of the teenager in his /her identity.

Erickson sees this search for identity during adolescence as a period of *psychosocial moratorium* for adolescents (Craig, 1986; Lloyd, 1985; Manaster, 1989; McCandless, 1970). Teenagers also go through an array of emotions. A brief discussion of their emotional development will provided next.

2.7.6 Teenagers: Emotional development

Morgan, King and Robinson, (1979, p. 640), describe emotion as 'a subjective feeling state, often accompanied by facial and bodily expressions, and having arousing and motivation properties.' Emotional development in teenagers is quite eye-catching due

to the fact that they experience a growing sense of awareness of their feelings. Their rapid physical growth seems to influence the intensity of their emotions. Their newly acquired cognitive skills enable them to think about their feelings and their new social roles force the teenagers to cope with new and different situations which can result in frustration and or other emotions (Lloyd, 1985). Teenagers experience emotions such as anger, joy, happiness, love affection, guilt, fear, anxiety, loneliness, depression and grief.

As a part of their personality development in adolescence, teenagers have to learn to be aware of their emotions and learn how and when to express such emotions in a way that is acceptable by society. Lloyd (1985) suggests that the most difficult emotion to regulate effectively for teenagers is probably sexual impulses. Thus, according to society, teenagers have to work harder to integrate their sexual impulses in order to have 'sexual behaviour' that society approves of, in terms of the socially constructed morals and values. Information on sexually related matters such as the use of contraceptives can be of help for the teenagers. A drastically small fraction of teenagers have adequate knowledge and understanding of sexual matters such as contraception and reproduction.

2.7.7 Teenagers: Contraception and Reproduction

Basic knowledge about contraception and reproduction is relatively common depending on the area where the teenager resides. The geographical location and cultural nature of the teenager has a direct connection with the knowledge offered to

the teenager on reproductive issues. Multi-cultural and open urban cultures are disputably more open than certain cohesive, closed rural cultural communities. What is disturbing is that in spite of the levels of information available regarding reproductive issues some teenage girls underestimate their ability to become pregnant (Peacock, 1982). This is not only ignorance on the side of the teenagers but also a lack of acceptable service on the part of the health sector providing contraceptives to teenagers (Magwentshu, 2000; Wood et al., 1998). This could mean that the reproductive health services in our country are not equally distributed to all sectors of the population. Studies by Ehlers & Maja (2001) undertaken at the George Mukhari Hospital in Ga-Rankuwa in the North West Province exposed unsettling results and reports that large numbers of teenagers become sexually active by the age 13.

More unsettling revelations were uncovered that showed that yearly, approximately 4 000 babies are born to mothers younger than fourteen years old. These studies comment on the futility of providing sex education at the age of 16 because they claimed that it is too late for the majority of teenagers in South Africa. A lack of knowledge about contraceptives and fertility is likely to result in teenage pregnancy. Most teenagers learn about contraception from their peers' scrappy knowledge about contraception. Other teenagers hold unsubstantiated faith in the reliability of their chosen birth control method whilst others believe they are putting themselves at virtually no risk of a pregnancy if they use rhythm (rhythm is withdrawal of the penis from the vagina during sexual intercourse shortly before ejaculation. The use of this

method has high frustration levels and it requires a high motivation level and cooperation from the male sexual partner) as a contraceptive method (Abramhamse, Morrison & Waite, 1988; Lloyd, 1985). Contraception is usually not even considered at first intercourse amongst younger teenagers.

First intercourse is less likely to be accompanied by the use of contraception the younger the teenagers are during its occurrence (Crouch, 2002). Allied to this statement is the projected reality that the youth involved is less likely to seek prompt assistance in the choice of a contraceptive method (Montgomery, 2003). The perplexing irony is that even when these younger teenagers implement a contraceptive method, (unlike older teenagers and young adults) they hardly use it without fail or effectively (Zabin & Hayward, 1993). The problem is aggravated by the younger teenagers who seem to fear judgment from their parents and nurses if they present themselves for family planning at such a tender age (Wood et al., 1998). This has the possibility of being interpreted as being sexually active or come across as though they are intending to become sexually active at such a young age. Contrary to this generalized opinion, is the opinion of the researcher who sees it as the ideal opportunity to start implementing sex-education and contraception methods when a teenager presents herself early for family planning services. The results of the health service provider capitalizing on this opportunity is said to arm the teenager with knowledge of contraception and reproduction.

A modest relationship to contraceptive use is showed as the product of measuring the knowledge of reproduction and contraception by exposure to sex - education courses (Manaster, 1989). Simplified, the women who have taken sex - education courses are somewhat more likely to use contraception once they are sexually active (Voydanoff & Donnelly, 1990). This increases their understanding of the relationship between coitus, contraception, and conception.

2.7.8 Teenagers: Knowledge of Contraception

Insufficient knowledge regarding the relationship between coitus, conception and contraception contributes to teenage pregnancies being reported in the rest of South Africa as they currently are (Ehlers & Maja, 2001). The insufficient knowledge is not as a result of the cognitive development of the teenagers but due to a lack of information presented to the teenagers. In a study by Ehlers and Maja (2001), fifty pregnant teenagers were asked about emergency contraception and the majority (thirty-five) of the respondents did not know. Only twelve knew about the existence of emergency contraceptives and a total of ten knew that pills could be taken to prevent pregnancies after unprotected sex. In spite of knowing about emergency contraceptives, none of these twelve respondents had attempted to use these contraceptive interventions. Without adjusting the focus of this study, it is attitudes such as these that call for attention (provision of health education with regards to contraception) as they are tremendously distressing in the contextualized face of the high prevalence of HIV/ AIDS amongst the youth. Large numbers of teenagers are ignorant about or hold erroneous beliefs about the use of contraceptives.

It is generally argued within communities that adhere to the Afro-centric cultural world-views that parents do not provide sexual information to their teenage children irrespective of a positive parent-child communication. Socially it means that parents are not involved in the co-construction of meaning and reality for their teenagers with regard to sexual matters. Teenagers rely largely on sexual information that they get from their peers including information regarding contraception (Manaster, 1989; Matteson, 1975; Morgan, King & Robinson, 1979). This could be the reason why most teenagers are so ill informed as far as contraceptives are concerned. The teenagers could just be putting their personal fables into practice. In their personal fables, the teenagers think that their thoughts are new and unique. This sense of being innovative makes the teenagers follow their own minds and respond to sexual matters in ways they deem fit. An authentic need to teach teenagers about emergency contraceptives and to make these services accessible to teenagers is revealed by this information. Access to contraceptives may be difficult for young teenagers (Mapanga, 1997; Wood et al., 1998).

Sadler and Daley (2002) argue that a pregnancy scare or a report of a negative pregnancy test alone is not sufficient motivation for using contraception. Pregnant teenagers are also empowered with the life-or-death decision of whether they would like to carry their pregnancies to term. In the event of a pregnant teenager deciding not to continue with her pregnancy, termination of pregnancy can be an option.

2.7.9 Teenagers: Termination of pregnancy

Termination of pregnancy, also known as abortion, is defined as the separation and expulsion of the contents of the uterus of a pregnant woman by means of surgical or medical means so that the baby is not born alive (MacMillan, 2002). Yet, it would be injustice to disregard the South African contextualized back street abortions which disregard medical or surgical prescriptions. These back street abortions dispute the core definition that was mentioned first. For they often defy prescribed health requirements and sterilizations to induce termination of pregnancy. As a result, the content of the uterus is expelled.

Termination of pregnancy is being used in many countries worldwide as a way of dealing with unplanned and unwanted pregnancies. Other countries use it as a birth control method. This termination of pregnancy may be carried out within the first 12 weeks of pregnancy at the request of the pregnant woman. From the 13th up to the 20th week of the gestational period, the medical practitioner after consulting with the pregnant woman will recommend termination of pregnancy under the following conditions:

Continuing the pregnancy will pose a risk to the woman's physical or mental health or the possibility that the fetus will have defects at birth. The pregnancy is a result of rape or incest and the continuation of the pregnancy will affect the woman adversely socially and economically. After the 20th week of gestation termination of pregnancy will be done after a medical practitioner in consultation with another medical

practitioner decide that the continued pregnancy will endanger the woman's life or have severe fetal defects or pose a risk of injury to the fetus (Thobejane 2001).

Teenagers may not recognize or acknowledge pregnancy without delay and thus limit their access to safe abortion or early prenatal care. High levels of secrecy and denial of the pregnancy may occur (Blake & Beard, 1999; Montgomery, 2003). This is usually out of fear of strong negative reactions from their family. Teenagers tend to have abortions later in pregnancy than older women. Alarming realizations that re-emphasize the severity of this crisis include notions that concur that nearly half of all abortions after twelve weeks are seen in teenagers. Their tendencies to deny, postpone, or have difficulty obtaining an abortion is linked with longer gestation (Zabin & Hayward, 1993). This delay often results in many teenagers being forced to carry their unwanted pregnancies to term.

2.8 Conclusion

Without dwelling on the points that were critically discussed in depth in the bulk of this chapter, it is evident that the teenage period can be a traumatic time for teenagers. For this is the period of making choices and various controversial decisions that tend to challenge societal norms and expectations as well as the teenagers' developmental phases. Cognitive, psychosocial, and emotional challenges present themselves in various forms to teenagers. It is not only challenging to be a teenager, but adding pregnancy to that put further strain on family members, community and the health providers. All systems are impacted upon by teenage pregnancies.

The economical productiveness of a noteworthy percent of these pregnant teenagers calls for concern. Many are not economically productive and will thus rely on the state for the provision of social grants and psychological support systems. The opportunities of going back to school to further their education are usually rare. Those who engage with these pregnant teenagers are instantly weighed down with the imperative task of helping them to be fully functioning members of the community especially the nurses. The nurses meet up with these pregnant teenagers at their most vulnerable moment in time. They can win the trust of these teenagers and in so doing, make it easy for these teenagers to confide in the nurses.

Each time we make an observation in our experiential world, we choose an epistemological stance from which the observation is made. Out of our accrued life experiences, we can often predict whether our adopting a particular position for observation will or will not permit certain kinds of observations to be made.

In the following chapter, a social constructionist epistemology will be used as a theoretical approach. It will serve as an alternative way of viewing, describing, and understanding the process of teenage pregnancy.

CHAPTER 3

THEORETICAL FRAMEWORK

3.1 Introduction

This chapter focuses on the social constructionist perspective as a conceptual epistemological framework that is followed in this study. Before emphasizing the philosophical basis of the social constructionist epistemology, it is imperative to define the term epistemology. Epistemology is defined by Morgan, King and Robinson (1979. p. 358) as 'the study of knowledge and knowing'. Lemon (2003. p. 112) refers to epistemology as 'logic of knowledge' and a 'way of knowing'. Auerswald (1985. p. 1) defines it as 'the study or a theory of the nature and grounds of knowledge'. Speed (1991) refers to epistemology as a theory used by humankind to comprehend knowledge and that which is fathomable.

Epistemology is all about how people or systems of people know things and how they create their own realities (Evans, 2004). Keeney (1983) sees epistemology as the study of the necessary limits and other characteristics of the process of knowing, thinking, and deciding. Judging from these definitions epistemology is the study of how we know what we know and the meaning(s) we attach to what we know. The two main broad epistemologies which are referred to in this study are modernism and the postmodernism.

3.1 The epistemology of modernism

Modernism according to Neimeyer (1998) and Becvar and Becvar (1996), is a broad concept around many areas of social life. Modernists believe in the existence of universal truths and language as faithful, unbiased, predictable, and understandable. Modernism brings with it a belief in a knowable world (Gergen, 1985). Clearly from the above assertion, modernist thinking is linear in its approach and practice.

The notion of linear causality is seen as the direct influence one object or system has on the other. According to Fish (1990. p. 25), linear thinking implies 'a system that is absolutely constrained and completely isolated.' Where two or more objects are interacting, other factors that may affect the interaction are not considered. The complexity of the situation is not appreciated. Such systems are based on a very simple limited notion of relationship, which is reductionistic in nature.

According to Fourie (1996), reductionism refers to the traditional view that objects need to be reduced to their basic components in order to make it easier to study and understand them. It is believed that the understanding of the whole can be achieved by the analysis of the reduced components. The observer is the expert and the observed is seen as separate from the observer. The social constructionist perspective however nullifies this reductionistic approach. In contrast to this way of thinking is social constructionist, which takes into account both the observer and the observed.

3.3 Postmodernist epistemology

According to Gross and Humphreys (1997), postmodern thought does not denote a coherent theory or a set of ideas but a heterogeneous collection of thinkers. Postmodern implies 'an emphasis on differences and continual changes of perspectives, an avoidance of dichotomies (seeing things in *either / or* terms) and reification (presenting abstract concepts as if they are *things* with a concrete existence)', (Gross & Humphreys, 1997. p. 4). Postmodernism makes allowance for the co-existence of a variety of ways of life that are situation dependent (Burr, 1995). Postmodernism challenges the Modernist's view of universal and objective knowledge (Becvar & Becvar, 1996). It ascribes to the view that human relations are structured in language (rather than purely described by it). The idea that people construct life experiences in part through language is central to social constructionist thought (Anderson & Goolishian, 1998; Coale, 1992).

3.4 Social Constructionist

For the purpose of this study the researcher is using a social constructionist epistemology. Social constructions are about the way knowledge is constructed by, for, and between members of a discursively mediated community (Neimeyer, 1998; Evans, 2004). In sharp contrast to the worldview of modernism, social constructionist does not believe in an objectively knowable universe. Social constructionist is referred to as a sociological description of knowledge (Berger & Luckman, 1996; Burr, 1995; Gergen, 1985; Hruby, 2001). According to Rapmund (1996) constructionist is the claim and viewpoint that the content of our consciousness, and

how we relate to others, is what we learned from our culture and society. Social constructionist acknowledges multiple socially constructed realities and not the existence of a single 'truth'. Therefore, any point of view of all participants is equally valid and has a place in a particular context.

In this study therefore, the view points of the participants will be considered without placing any social judgments on them. Socially constructed meaning is often taken at face value by members of a community as 'fact, reality, common sense, or otherwise inarguably foundational' (Hruby, 2001. p. 51). Neimeyer (1998) sees social constructionist as a way of making room for alternative social realities, which in turn creates possibilities for new meanings or realities.

In practice this means that how we relate to others is taught by our culture and society. This is what we have learned from others around us. It is basically not our own initiative. Speed (1991) states that we socially construct reality by the meanings we share and agree upon through the usage of language. Our beliefs about the world are socially invented and in the context of this study, the view that pregnant teenagers are socially deviant is socially constructed. We cannot know reality and can only have views of reality. Burger and Luckman cited in Speed (1991) give an example of measuring riches in the context of the Western culture by the kind of possessions you have like the house you live in or the car you are driving. Cultures other than the Western culture may have an entirely different way of measuring riches. What is important to note about culture is that it is learned and transmitted

from one person to another. Acknowledging that culture is not innate makes it possible to fathom that whilst teenage pregnancy may be a problem in some cultures, it is a sign of fertility and wealth in other cultures. Language thus serves as a means to communicate the agreed upon meanings around the complex issue of teenage pregnancy.

Social constructionists according, Anderson and Goolishian (1992), say that our togetherness is largely through language and our understanding of each other is by means of how we describe ourselves and what we say about others and ourselves. These are in essence narratives between and among people. Social constructionists also look at normative narratives. Normative narratives are those customary stories that become relatively stable organizational features also referred to as 'cultural scripts' (Daiute & Lightfoot, 2004). It is against these narratives that people measure themselves and any behavior that does not fit such narratives is regarded as socially deviant (Becvar & Becvar, 1993). Within the context of the current study, the notion of seeing pregnant teenagers as 'bad' is a socially constructed reality and by no means an absolute 'truth'. The pregnant teenagers' personal stories are frequently denied in favour of the current dominant stories, and hence their situations are seen as a form of pathology. Therefore in dealing with pregnant teenagers in the context of this study, the researcher for example looks out for the non-dominant stories of the pregnant teenagers as these non-dominant stories may bring about change. In this way, realities about reproductive health and reproductive health services for

teenagers can be 'deconstructed' and new meanings or realities can be co-created by the researcher and the participant (Coale, 1994).

Social constructionists agree that not all stories are equally valid as some stories 'are disrespectful of difference, gender, ethnicity, race, or religion' (Doan, 1997, p. 130). In the context of this study, the cultural practices of the participants are taken into consideration and they are not being judged by their race, religion or ethnicity. Social constructionists are cautious about isolated truths as these remote truths tend to be disempowering, silence and marginalize those whose stories fail to fit. Room is made for individual expressions and opinions even if such opinions may differ from the norm. A different opinion will be according to the individual's belief system.

Social constructionists support the notion that people behave according to their beliefs rather than their rigid backgrounds of culture or personalities. Hence according to social constructionists, it is possible for alternative meanings to exist and thus people can construct themselves in ways that are more meaningful and effective to them (Dickerson & Zimmerman, 1996).

3.5 Conclusion

The social constructionist implies a process of building different meanings and understandings of the world. In applying a social constructionist approach in the context of this study, it is possible to gain an understanding of how service providers together with pregnant teenagers/ clients co-create notions about reproductive health

and how these shape reproductive health services within the public sector. Validating the pregnant teenagers' ecstasy, difficulties, strong point(s), effort to learn, and other developmental issues that the pregnant teenager may be grappling with can be of benefit to the pregnant teenager. From the social constructionist way of thinking, teenage pregnancy shows the reality of teenagers, as there is no such thing as 'absolute reality'.

CHAPTER 4

RESEARCH METHODOLOGY

4.1 Introduction

In this chapter, the research methodology will be discussed. The qualitative research approach followed by an outline of the sampling criteria, the research design as well as the method of data collection and the background of the clinic where the study took place will be discussed.

4.2 Qualitative Research

A qualitative research approach is employed for the purpose of this study due to its emphasis on the importance of the social context. Qualitative research is equated with a new way of thinking about the world. The aim is to understand the subjective world of the participants. Qualitative research approaches assist the researcher to gain more insight on the phenomenon under study, especially in this context where the phenomenon cannot be quantified (for instance how pregnant teenagers experience the behaviour of nurses). Neuman (1997), states that qualitative researchers emphasize the importance of social context for understanding the social world. In a social context, language is a common vehicle through which ideas and thoughts are communicated.

According to Nicholas (2003), qualitative methods deal primarily with linguistic data. Linguistic data is concerned with illuminating constructed meanings from the experiences of human beings within their surroundings. Social realities are viewed as

created by the participants in a specific social context. In this study the pregnant teenagers as the participants will be required to construct their own realities. Their realities will not be constructed by observers. The construction of such realities is based on the participant's frame of reference. The researcher should be aware of the possible influence he or she may have on the participants. The researcher should have self-awareness and strive at all times not to contaminate the research data. Allan (1991), states that this can be achieved by the researcher having more flexible involvement with the participants. The other suggestions to achieve this are through being aware of the possible negative implications on real lives from the published documents. Being aware of the researcher's own prejudgments, stereotypes and definite subjectivity from personal experience will lead to more objective academic writing.

Qualitative modes of enquiry are open and reflexive allowing for discovery and for decisions to change course or reconstruct one's reality. The participants can reconstruct their realities thus allowing for a possibility of change and new beginnings (Nicholas, 2003). Qualitative research is usually equated with a new way of thinking about the world. It however covers a wide range of approaches some of which may still embrace some of the assumptions of the Cartesian-Newtonian philosophy (reductionism or atomism, linear causality, and neutral objectivity). Qualitative research requires the researcher to step out of the role of 'expert' (Becvar & Becvar, 1996). In this study, the participants will be allowed to give their accounts of events

without fearing to be judged by the researcher. The researcher does not purport to know everything in the subjective world of the participants.

Social constructionist guides the researcher to look at the world in a specific way with the aim of understanding the subjective world of the participants (Anderson & Goolishian, 1988). Mabena (2002) describes qualitative research methods as aiming to get a more in-depth understanding of human behaviour and not a search for facts or absolute truth. Kvale (1992) sees the research process not as a mapping of some objective social reality. Research involves a co-constitution of the objects investigated, with a negotiation and interaction with the very objects studied. De Vos (1998) regards reality as subjective in qualitative research. Clearly, from a qualitative research perspective, the researcher does not enter the research process as a 'knower'.

The researcher is not the 'expert' in qualitative research (Becvar & Becvar, 1996). The researcher is seen as part of the process. What the researcher sees, his or her interpretations and meaning formation in reality construction are thus as valid as any other version of reality. According to Owen, (1992), qualitative research deals with experience as a whole and not parts of that experience and aim at understanding the experience of the participants. Hence the participants in this study will be allowed to share and represent their full experiences of their natural world. Their full experiences of the world for them will be able to express their feelings and experiences without any reservations. This they will be allowed to do in their everyday setting.

Qualitative research is more natural, holistic and inductive (Kelly, 1999; De Vos, 1998). 'Qualitative research methods allow the researcher to study selected issues in depth, openness and detail as they identify and attempt to understand the categories of information that emerge from the data' (Terre Blanche & Durrheim, 1999, p 42).

Durrheim (1999) further states that the assessment of mind-set is primarily concerned with the focus on particular social and physical objects, including persons or groups. This is of relevance because it entails the feelings or experiences of the individual or group (Owen, 1992; Terre Blanche & Durrheim, 1999) which should be considered within an ethical framework.

4.3 Ethical considerations

As previously mentioned, informed consent, absence of deception, and the right_of the participant to decline or discontinue with the research project along with confidentiality and debriefing where necessary, are of the outmost ethical considerations to be stressed out and adhered to (Nicholas, 2003; Willig, 2001). Informed consent was obtained from the participants (the group in question) and written permission was obtained from the head of the antenatal care clinic to conduct research. For the sake of confidentiality, the real names of the participants were concealed and they are referred to as participants. The participants were informed of their right to withdraw from the research. The participants were also not deceived in any way or promised something in return.

4.4 Research design

Mouton (2001, p. 55) defines research design 'as a blueprint of how you intend conducting your research'. Terre Blanche and Durrheim (1999, p. 483), refers to research design as 'a strategic framework or plan that guides research activity to ensure that sound conclusions are reached'. The two definitions helped the researcher to map out all procedures necessary for this research. Because this research is mainly narrative in approach, a brief description of a narrative will be provided.

4.4.1 Narrative

Herman (2003) defines a narrative as an ordered depiction of a series of events. Cobb (1993) observed that a narrative transcends orthodox representations of action and discourse with the main purpose of retelling a story. Sabrin (1986), refers to a narrative as threading together a set of events or experiences in a temporal sequence in order to make sense of them. A distinct feature of the narrative approach to research that is relevant to this writing, was the gathering of information from the participants by the researcher. The researcher went to their setting, the clinic, and listened to their stories at their surrounding. Rappaport (1993) points out that 'narrative' and 'stories' are used interchangeably when referring to past events or experiences.

From these definitions it is apparent that narratives have certain structural features and that they serve a variety of functions. The structural features present a series of contextualised events (Rappaport, 1993). Stories may be told for different reasons for example to teach a lesson or make a point. In this study, stories are elicited from participants to impart meaning about their personal worlds. Stories make possible the understanding of human experience from the viewpoint of a person in a social context (Rappaport, 1993). They serve 'to order experience, give coherence and meaning to events and provide a sense of history and of the future' (Rappaport, 1993. p. 240). In this study, the participants tell their stories to the researcher. The researcher makes meaning out of the stories by deconstructing and then reconstructing them again into meaningful narratives about their experiences of reproductive health services.

Narrative approach is one of the most efficient ways of packaging our perceptions of time, which in turn significantly promotes our sense of individual identity (Nair, 2003). Narratives are 'an indispensable communicative and cognitive tool for self-fashioning across cultures' (Nair, 2003, p. 31). According to Rappaport (1993), the narrative stance is appealing for several reasons. Almost everyone seems to be able to tell a personal story. Furthermore, the telling of personal stories does not need any specialized kind of education and training.

Telling stories seems to be persuasive in their effect on people. The story teller, with the use of language and gestures, is able to give an account of his or her reality. Story telling is an active process from both the 'teller and the listener' (Rappaport,

1993. p. 253). Both the listener and the teller share interest in what is being said. The listener should however be aware not to influence the teller while telling her or his story. For the purpose of this study, the narrative stance was deemed to be the best suited method of data collection, for it allowed the participants to air their unrestricted experiences with the nurses responsible for their antenatal care.

The aim of this study is to have a contextual understanding of experience of how pregnant teenagers construct reproductive health services in the public health sector. In this study the pregnant teenagers will be facilitated to share their personal experiences with the researcher by means of a semi-structured interview.

4.5 Data analysis

A narrative analysis of the data was done. Narrative analysis is a variety of orientations to interpreting varieties of discourses, including narrative texts (Daiute & Lightfoot, 2004). The narrative analysis was appealing because its interpretive tools are designed to examine people's lives holistically and offered opportunities for understanding narratives as expressive behaviour.

Narrative analysis was a mode of enquiry based in narrative as a genre and a discourse. It relied on *themes* drawn from literary theory to provide explanations of interpreted lives (Daiute & Lightfoot, 2004). As Daiute and Lightfoot (2004) stipulate, the analysis explained psychological phenomena as meanings that were ordered

from some theoretical perspective. This made it possible for themes to be extracted from the participant's story.

4.6 Participant selection

A population is a complete set of objects or persons which is distinguished by a set of criteria which are of interest and relevant to the researcher's studies (Magwentshu, 2000; Nicholas, 2003; De Vos, 1998; Neuman, 1997).

4.6.1 Sampling

Sampling involves decisions to be made about which people should be selected from a population in order to participate in the study. (De Vos, 1998; Neuman, 1997). The sample should be representative of the population of interest from which the data will be gathered (Terre Blanche & Durrheim, 1999).

For the purpose of this study, the sampling criteria included: i) A public health clinic in the Gauteng Province that provides antenatal care. The Gauteng province was selected because though being the smallest amongst the nine provinces in South Africa (Statistics SA, 2001), it has the highest number of households that have access to various services and facilities, including health services (Statistics SA, 2005). ii) The participants will be pregnant teenagers visiting the clinic who are between the ages of 12 and 20 years. The participants should be willing to participate in the study with the view of sharing their experiences with the researcher. iii) The participants must have visited the clinic at least three times or more in order to be

able to share their experiences with the researcher. v) The pregnant teenager could be a primigravida (pregnant with her first child) or multiparous (pregnant more than once).

4.6.2 Sampling approach

4.6.2.1 Accidental sampling

For the purpose of this study accidental sampling was used. De Vos (1998) describes accidental sampling as the inclusion into the sample of any case that comes across the path of the researcher that has relevance to the research topic. Gabor (1993) cited in De Vos (1998), call this type of sample a convenient or availability sample and add that the respondents are usually those who are nearest and most easily available. Such cases are taken until the researcher is satisfied about the size of sample that he or she wants. The convenience sampling method is often criticized because the findings from the convenience sample cannot be generalized to the whole population (Marshall & Rossman, 1995; Neuman, 1997). In this study, pregnant teenagers who visited the clinic and who were willing to be part of the research were asked to take part in this research.

4.6.3 The sample size

The sample size comprised of six pregnant teenagers, five of whom were 18 years old and one was 19. In the context of this study being a qualitative approach, the aim is to obtain an in-depth understanding of the phenomenon under study and not to generalize the findings of this study (Neuman, 1997). All these teenagers had three

or more antenatal care visits to the clinic. They could all express themselves verbally and all these teenagers were fluent in Setswana and understood English. A discussion that dissects the data collection suited to the qualitative narrative approach will follow.

4.6.4 Data collection

Before the data could be collected according to the appropriate qualitative narrative approaches, it is first necessary to identify what is meant by the term 'data'. Magwentshu (2000) refers to it as being the information collected in the duration of the study. Data can also be a collection of raw material from a group of people or an individual in the form of texts or images, (Terre Blanche & Durrheim, 1999).

The methods of data collection in this study consisted of individual in depth, semi-structured interviews and observations. Audiotapes were used as a medium of collecting data. The audiotapes as well as the transcripts of the interviews are available from the researcher if required.

4.7 Research procedure

4.7.1 Semi-structured interviews

In this study, semi-structured interviews were used to collect data from the six participants. According to De Vos (1998), face-to-face interviews are a worldwide method used in systematic enquiry. By using this kind of interview, the interviewer is able to extract information from the interviewee. A major advantage of the interview is

its adaptability. The interviewer can follow up ideas, probe responses and investigate motives and feelings (Bell, 1999).

Face-to-face interviews help us to understand the mysterious worlds of individuals, families or communities at large. The way in which a response is made (the tone of voice, facial expressions, hesitation, physical actions, etc.) can provide information that would otherwise not be revealed in a written response. These individual interviews also serve as a meaning-making process (Bell, 1999).

4.7.2 Observation of behaviour and interaction

William and Vine (1999) cited in Blake and Beard (1999), report about a recent study where adolescents between the ages of 13 and 20 described a process of using the experience of pregnancy and parenting as an instrument for growth. The pregnancy experience also provided the teenager with an opportunity for improving or building positive relationships and receiving support from family members. In recent times where education and having a profession is seen as an achievement, being a pregnant teenager can strain the relationship with members of the family. Peer support groups can also provide a valuable form of emotional support.

4.8 Research context

The study was conducted in a clinic in the Gauteng Province. It is a polyclinic and it runs daily. This health clinic is situated in Klipgat, which is about 50km north of Pretoria.

4.8.1 Services rendered by the clinic

The clinic caters for minor ailments, antenatal, intranatal and postnatal care, and obtaining consent for choice on termination of pregnancy (the procedure for termination of pregnancy is done at a hospital nearby), psychiatric services, family planning, HIV counseling, and tuberculosis care.

The clinic provides antenatal care services also to the researcher's target sample namely, pregnant teenagers. The clinic staff does not distinguish between pregnant teenagers and pregnant women.

4.8.2 Daily client attendance

The clinic caters for an average of 120 clients daily. This number includes maternity clients.

4.8.2.1 Clinic routine

4.8.2.1.1 Preaching and prayer

At seven o'clock in the morning the day staff takes over from the night staff. Then a preaching and prayer by a minister of religion start the proceedings for the day. Three ministers of religion are responsible for this daily sermon, with each minister preaching on a different day. The patients, nursing staff, and the labourers are part of this sermon. The approach of these sermons is very modernistic in nature with clear cut margins of right and wrong.

4.8.2.1.2 Health talk and health forum members

One of the professional nurses gives a health talk to the rest of the team. Any topic of interest is prepared and the health talk is structured in such a way that it is very much interactive. Community members who are also health forum members get an opportunity of talking to the clients informing them about their rights as clients.

4.8.3 Staffing

The clinic has 13 staff members, which consists of ten professional nurses, one enrolled nurse and two nursing assistants. Two staff members are on leave. Four staff members will be on night duty, while seven staff members will be on day duty. Of the seven day duty staff, two or three will be day off. Hence the clinic will effectively run on a staff of four to five members at any given time during the day. This will be the number of staff that caters for the clients that visit the clinic daily. From the qualitative nature of this study, the researcher will be able to observe the interactions between the nurses and pregnant teenagers at any time.

4.8.4 Qualifications of the staff

Five out of the ten professional nurses are qualified in general nursing, midwifery and psychiatric nursing. However, contrary to the widely held notion, having psychiatric nursing does not imply that these nurses qualify to conduct psychotherapy. This means that the nurses are mostly best suited to handle the medical aspects of the pregnant teenagers and not emotional aspect of the pregnant teenagers.

The unit manager has the following qualifications: Diploma in General nursing; midwifery; community nursing; nursing administration and psychiatric nursing; and a Certificate in clinical health assessment, treatment and care. The unit manager also has a license for dispensing treatment. Given the qualifications of the staff it shows that none of the staff members are qualified to conduct psychotherapy with the pregnant teenagers.

4.8.5 The researcher's observations of the clinic's activities

The nurses work hard and they seem to be involved in the difficulties presented by the pregnant teenagers. They respond in an empathic way to the teenagers' problems.

4.8.5.1 Patients' rights charter

A patients' rights charter is mounted in the clients' waiting rooms. This charter is written in English in a community that is predominantly Setswana speaking. The health forum members translated this verbally to the clients as they explained to them what the primary purpose of this charter is.

4.8.5.2 Nurse – client relationship

The interaction between the nurses and the clients is supposed to be of mutual respect. The nurses are firm but friendly. The nurses seem to be very client centred

and are patient enough to explain to their clients why they do certain things in order to avoid misunderstandings from their clients.

4.8.5.3 Facilities at this clinic

4.8.5.3.1 Equipment

The staff members at this clinic still use manual recordings to go about their daily records. There is not a single computer in the clinic and their equipment is very basic. All wall charts are hand written. There is a television in the postnatal room and the clients in this room are permitted to watch programs on this television. Given the bear minimum of facilities, the nurses at this clinic still seem to have the patience and eagerness to continue with their daily routines at work.

4.8.5.3.2 Transport

The clinic does not have its own means of transport. In the case of an emergency (mostly maternity clients) the nursing personnel use their own cars to transport the clients to the hospital. They are not being reimbursed for these services. Within the context of this study, such circumstances are likely to have an influence in the behaviour of the nurses in their line of duty.

4.8.5.3.3 Achievements

The clinic boasts with two awards for the year 2004 in the Gauteng Province. They were the best clinic in caring for psychiatric clients and the best clinic in caring for clients diagnosed with tuberculosis. Although the staff members at this clinic seem overworked, they however still manage to be patient and polite with the pregnant teenagers. A semi-structured interview with the pregnant teenagers will probably reveal the actual relationship between the pregnant teenagers and the nurses.

4.9 Conclusion

In this chapter the research design and sampling methods were discussed. A background of the clinic staff and clinic routine where the study took place was given. Semi structured, face-to-face interviews was used. Six pregnant teenagers took part in this study.

CHAPTER 5

PRESENTATION OF RESULTS

5.1 Introduction

In this chapter a narrative analysis of the research data is presented. Narrative analysis makes room for different ways of conceptualizing the storied nature of human development. Narratives are specific discourse forms which occur as epitomes of cultural values and personal subjectivity. Narrative analysis, according to Daiute and Lightfoot (2004), is the process that involves explaining psychological phenomena as meanings that are ordered from some theoretical perspective. Narrative analysis makes it possible for themes to be extracted from the participant's story.

Background information of each participant will be given. This will be followed by a presentation of the themes that have emerged from the interview data. Each participant's information is discussed in terms of demographic characteristics, family background, and personal experiences with nursing personnel during antenatal visits to the clinic. Subsequently, all the themes from different participants will be grouped into categories of themes. As discussed in the methodology chapter, the term participant will be used in the place of real names to ensure confidentiality.

5.2 Description of the participants

All participants were from working class families. Most had reported to having siblings and all of them were from the same area. Participants were alternating secondary school at the time they became pregnant. None of the participants were married at the time of the interview. Nor were any participants employed at the time of the interview. What follows is a condensed description of each participant.

5.2.1 Participant 1 (P1)

5.2.1.1 Demographic characteristics

Participant 1 (P1) was an eighteen-year-old black pregnant teenager who was in grade 11. This was her first pregnancy and she was not married. She however seemed positive about this pregnancy and was planning on going back to school after the delivery of her baby. Her first visit to the clinic was when she was seven months pregnant. When asked about reporting to the clinic for antenatal care at such a late stage in her pregnancy, the participant said that she feared the negative response of the nurses to her being pregnant.

P1 was a soccer player at school and she was also playing soccer for a small team after school hours. She was paid for this. According to the participant, she hoped to become a professional soccer player in future.

5.2.1.2 Family Background

The participant is the eldest of four children. Her mother was unemployed and her father was a laborer doing odd jobs. According to the participant, her father's income was not sufficient to sustain the family. The participant said that her mother was very disappointed about her pregnancy and to make matters worse, her father was blaming her mother for this pregnancy. Her pregnancy caused a lot of friction between her parents. Her boyfriend denied the pregnancy and she had little emotional and financial support from her parents.

5.2.2 Participant 2 (P2)

5.2.2.1 Demographic characteristic

The participant was an eighteen-year-old unmarried pregnant teenager who was doing Grade 9 at the time she fell pregnant. This was her first pregnancy and she was unemployed. This was her fourth visit to the clinic. The participant resides in Klipgat and was within walking distance from the clinic.

5.2.2.2 Family background

The participant is the third of four children. She comes from a single-parent home. According to the participant, her mother was very disappointed with this pregnancy. The participant says that her pregnancy was unplanned.

5.2.3 Participant 3 (P3)

5.2.3.1 Demographic characteristics

P3 was an eighteen-year-old pregnant teenager in her ninth month of pregnancy. The participant passed Grade 11 and was both unemployed and unmarried. This pregnant teenager had visited the clinic about ten times for this pregnancy.

5.2.3.2 Family background

This participant is the second of four children. Both her parents were labourers. The participant was staying at Klipgat and was also within walking distance from the clinic. Both the parents of the participant would have liked her to go back to school after the birth of the baby.

5.2.4 Participant 4 (P4)

5.2.4.1 Demographic characteristics

This participant was an eighteen-year-old unmarried pregnant teenager. She was in Grade 10. This was her first pregnancy and she was in her sixth month of pregnancy. The participant resided in Klipgat and it was also within walking distance from the clinic. She was unemployed. This was her fourth visit to the clinic.

5.2.4.2 Family background

The participant is the only child of a single parent. Her mother is a part-time worker and she has no contact with her father. The participant says that she actually planned

this pregnancy in order to gain mature or adult status and this decision infuriated her mother. According to the participant, her mother has also decided that she must not see her boyfriend again because she [the mother] said he was a 'bad person'. Her mother also said that her pregnancy was the result of mixing with bad people.

5.2.5 Participant 5 (P5)

5.2.5.1 Demographic characteristics

This participant was a nineteen year old unmarried teenager pregnant with her second child. She resided in Klipgat. She was unemployed. This participant was in Grade 12 prior to the pregnancy.

5.2.5.2 Family background

This participant is the second of four children. Her elder brother was married and her two younger sisters were at school. Her father was employed in a factory at Rosslyn whilst her mother was a domestic worker. This participant planned to get pregnant and was hoping to marry the father of her unborn baby as he is also the father of her first baby. Her first baby was born at Ga-Rankuwa Hospital and was then three years old.

5.2.6 Participant 6 (P6)

5.2.6.1 Demographic characteristics

This participant was an eighteen year old teenager, pregnant with her second child. Her first baby was two years old. She was in Grade 10. This participant was unemployed.

5.2.6.2 Family background

This participant is the first of two children. Her younger brother was doing Grade 5. Her mother was a domestic worker and her father was unemployed. This participant had not planned this pregnancy. She was currently receiving a social grant for her first baby. Her parents were not happy with her being pregnant again.

5.3 Status of the pregnancies

P (1), P (2), P (3) and P (6) had not planned their pregnancies. The psychological implications of the actions of these teenagers could be to satisfy their curiosity about their sexuality and their drive to explore was part of their risk taking behaviour as teenagers. A fifth characteristic of formal operations is the ability to think about thoughts (meta-thinking).

P (4) and P (5) seemed to be able to challenge certain opinions and ways of doing things through their evaluation of their own thoughts and those of others. They, like the adults co-constructed the meaning of sexuality. They possessed the value to look beyond the here and now. This refers to the teenagers' insight into their acts and omissions. Thus, it can be implied that such teenagers are aware of the possible

consequences of engaging in unprotected sex, including pregnancy and sexually transmitted diseases. Therefore, becoming pregnant could have been a 'choice' made by the teenagers. P (4) intended to become pregnant in order to gain independence from her mother. P (5) hoped to get married to the father of her unborn child.

5.4 Themes extracted from the narratives

None of the participants in this study reported any negative treatment from the health care service providers (the nurses) at the clinic. Several reoccurring themes emerged from the narratives of the pregnant teenagers. Noteworthy themes to be discussed include acceptance, respect, communication, privacy, dedication and professionalism, interest and care, staff shortage, information, trust, consideration and understanding.

5.4.1 Acceptance

Acceptance is the underlying belief and attitude that is worthy of self-respect and the corresponding attitude of respect for others' capability to be self-responsible (Long, 1996). Acceptance in this regard means respecting other peoples' right to their own unique individualities and perspectives including the right to make their own choices regarding their own lives. Psychologically, the pregnant teenager experiences self worth and reduces the feelings of guilt and self-blame when acceptance is accorded to her.

The participant experienced the behaviour of the nurses as accepting her unconditionally. P (1) expressed herself as follows: *'The care is quite good since my first visit to the clinic. I'm satisfied with how they are treating me. I am not seen by the same person whenever I come here for treatment, but whoever sees me treats me well'*. P (1) seemed relaxed as she expressed her praises and there was calmness in her voice. She did not feel judged and saw herself as any other client in need of antenatal care.

P (2) described her visit to the clinic as enjoyable and problem-free. She seemed relaxed as she spoke about her visits to the clinic. This is what she had to say about how she experienced her first visit to the clinic. *'Quite well. The nurses here treat people very well. I was not nervous on my first visit'*.

P (3) seemed to have experienced the nurses of the clinic as accepting. It also seemed that this acceptance made it possible for her to address some of her needs as a pregnant teenager. *'The nurse was friendly towards me. I am referring to the matron (the chief nurse of the unit). She always speaks well with everybody. She takes time to explain the procedures to you. She even asked me about my plans after the delivery of the baby. I feel she really cares for people. I always first look for her when I come here, especially when I have a few things to ask'*.

P (4) also experienced the nurses as accepting. She was convinced that the chief nurse cared about her future plans and cautiously helped her realize her mistake when she implemented her family planning method.

P (5) had her first baby in a hospital nearby and she compared the service she received from that hospital to the service that she was currently receiving from this antenatal care clinic. She experienced acceptance from the nurses.

P (6) had her first baby at this clinic and she seemed to be experiencing acceptance from the nurses. *'I feel good. They do not shout at me or seem to be impatient with me'*.

5.4.2 Respect

Respect means the acknowledgement of and positive regard for individuals' ability for self-responsibility (Long, 1996). Distinction between *person* and *behaviour* and *circumstances* is fundamental to respect. It means prizing the individuality of clients and supporting their search for self (Egan, 1990). In the case of the pregnant teenager, the behaviour (being a parent) must be distinguished from the inherent worth as an individual. Respect means trying to understand your client (in this instance the pregnant teenager) rather than to judge him/her. For pregnant teenagers, being accorded respect improved their psychological well being as it made them feel understood by nurses.

The participants felt that the nurses at this clinic were treating them with respect. P (1) says *'everybody treats me with respect. No one ever said something hurting to me'*.

Concurring with this was P (3) who experienced the nurses as being dedicated to their work regardless of the amount of work that they were faced with. *'I have not experienced improper behaviour towards me. They [the nurses] are on their feet the whole day and I have never seen them being mean towards me or any other pregnant teenager. I have already referred a few of my friends and other pregnant teenagers who are staying in this area to the clinic'*. None of the participants complained of disrespect from the nurses.

5.4.3 Communication

Communication is a meaningful process that is conveyed within a series of behaviours (Hassibi & Breuer, 1980). Morgan, King and Robinson, (1979, p.192) comment on the meaningful signals that communication has on other organisms that influence behaviour. Long (1996) gives a definition that comments on the relational aspects of communication stating that it involves two or more people. Communication can be verbal or non-verbal and maintains the viewpoint that it is not possible for one not to communicate. Verbal communication takes place through the use of language. Non-verbal communication takes place through the use of signs, symbols, and gestures. Language is the most universal system of communication in which word symbols are used in various combinations to convey meaning (Morgan, King &

Robin, 1979). Long (1996) identifies the goal of communication within helping relationships as facilitating growth through self-understanding. Effective communication promotes psychological well being for pregnant teenagers as it promotes self understanding.

The participants experienced informative and clear communication with the nurses as a result of the clinic routine. As a result, it was never very necessary for P (1) to be turned back home for not having kept time or coming to the clinic on a wrong day. *'I was told before what time to arrive here at the clinic by the nurses. They also put notices all around the place with regards to clinic times. I think defying that will be disrespectful. I was never sent back'*.

This participant P (4) experienced the nurses with regards to clinic times and procedures as good communicators. She seemed to have enjoyed and understood most of the procedures that were performed on her. *When they take blood they will tell me how many bottles of blood they are taking and what they will be used for'*.

5.4.4 Privacy

Baron and Byrne (1991. p. 262) define privacy as 'the desire to prevent others from knowing everything that one says and does at present (or has said and done in the past or will say and do in the future)'. Long (1996) identifies privacy in terms of being an individual amongst a group. De Vos (1998) takes this even further by stating that privacy refers to an isolated something that is not meant to be shared by the public.

Thus privacy entails being able to share your concerns with someone relevant and not involving anyone else who is not relevant to those concerns.

The participants seemed satisfied with the degree of privacy provided by the nursing staff. The clinic nursing staff provided sufficient structure and explanation of procedures to be performed on P (1). *'The nurses explained to me what they are going to do to me before hand. They also do it in private away from ears and eyes of other people'*. From a psychological point of view, being given privacy makes one feel valued and taken seriously.

P (2) enjoyed privacy during her visit to the clinic. Even when she went through a busy routine, they still granted privacy to this participant. *'They took me to a private room and there I felt free when they were busy with me'*.

P (3), P (4), P (5) and P (6) also seemed to have had privacy during their consultation at this clinic. Regardless of the enormous numbers of clients visiting the clinic for health care, the nurses managed to give privacy to these participants.

5.4.5 Dedication and professionalism

Hornby (1974, p.227) defines dedication as 'to give up, devote one's time and energy to a noble cause or purpose'. Dedication is the ability to show devotion and keenness in what one is doing.

One participant felt that irregardless of the other challenges that the nurses had to face, the nurses worked hard and were committed to their wellbeing. P (4) confirmed that *'they work hard, but are not impatient with us. The people (clients) are many and the nurses are few.'* The psychological effects of this recognition led to the pregnant teenager feeling safe and secured. The client voiced that she felt that she was in caring and capable hands.

5.4.6 Care and interest

Thoughtfulness and consideration are amongst some of the words used by Hornby (1974) to define care. From a psychological perspective the pregnant teenager felt that her presence at the clinic was not seen as just another client to attend to and the pregnant teenager had less anxiety, tension, worries and concerns.

The participants seemed to enjoy care from the nurses. According to the participants, the nurses showed total commitment to their jobs. P (1) said that *'they are good. They keep on checking me and I feel they are interested in my well-being. It is not the same nurse who is treating me each time. All of them are fine and they never shout at me.'*

P (2) seemed satisfied with the care and treatment that she received at this clinic even to the extent of referring other pregnant teenagers to the clinic. She confirmed that she was content. *'The care is good here. I can say that I am happy and pleased. I can advice another pregnant teenager to come to this clinic for help.'*

P (3) seemed to have experienced care from the nurses. Besides being pregnant, this teenager also had other health related difficulties. P (3) said that *'besides this pregnancy, I am also troubled by tonsils. These nurses also treated me for my tonsils.'* This participant seemed to have experienced total care from nurses.

5.4.7 Staff shortage

All the participants felt that in spite of the hard work and dedication of the nurses, the clinic was still seriously understaffed. When asked how the service could be improved at this clinic for pregnant teenagers, P (6) expressed the need for more nursing staff. According to the participant, the waiting period to be served at this clinic was just too long. She suggests that *'the nurses should be increased in this clinic. There are too many people (clients) coming for help at this clinic. Most of the time the nurses have to attend to patients giving birth and the rest of the patients are still waiting.'*

When asked about anything that she thought is of concern in this clinic, P (3) stated that too few nurses were a serious concern. *'According to my evaluation of things, I think the clinic can do with more nurses. The present staff is few and hardworking. The clients are far too many for the nurses. I would like to write to Zola (Zola is an SABC television program that helps individuals or organizations to overcome difficulties) and inform him about the shortage of nursing staff at this clinic, perhaps we can get more nurses to help out on this backlog at this clinic. These nurses run*

around too much. They are overworked.' According to the participant, this would evaluate the conditions at the clinic including the care of pregnant teenagers.

P (2) seemed satisfied with the care and treatment that she received at the clinic. She however expressed concern about the working conditions at the clinic that affected her as a pregnant teenager. *'It will be better to have more nurses to work in this clinic; the people (clients) here at the clinic become impatient when the nurses are so few.'*

5.4.8 Information

These participants P (1), P (2), P (3) received information regarding pregnancy test, HIV counseling and information on prevention of sexually transmitted disease from the nurses.

P (4) received information on pregnancy test, HIV counseling and the process of child birth from the nurses.

These participants P (5) and P (6) received information on HIV counseling, the process of child birth, exercises and healthy eating during pregnancy from the nurses.

5.4.9 Trust

P (2) seemed to have had minimal verbal communication between her and the nurses. The participant did not ask much about any nursing procedures that were

performed on her. When asked about the reason why she did not ask the nursing staff about the procedures that they performed on her she answered '*I trusted what they were going to do to me. They looked like they know what they are doing.*' The nurses were perceived as efficient in their tasks. Even without saying much, they had succeeded in building a good relationship of trust with this participant.

5.4.10 Consideration

Several participants experienced the nurses' behaviour as being considerate. What was noteworthy was the praises about the way the nurses treated the participants. P (3) said that '*the nurses are sharp (trouble free). They serve me well. They even start with the pregnant clients first and none of them ever told me that I am not supposed to be here being pregnant.*' It appeared that this participant also experienced the nurses as being accepting of her as a pregnant teenager.

5.4.11 Understanding

The participants experienced some understanding from the nurses at the clinic. Care and concern from the nurses seemed to be greatly appreciated and enjoyed by the participants who did not feel blamed. One participant (P 4) also experienced understanding from the nurses on more than one occasion. After an HIV pre-test counseling session, the participant was required to take blood for HIV testing. She asked the nurses to take blood for the HIV test when she was with her boyfriend. She was impressed that the nurses understood. This participant is more likely to confide in the nurses than discuss any serious related matter with her mother.

5.5 Conclusion

Pregnancy is a stressful event for adult women and may even be more stressful for teenagers because they have very little life experiences. The nurses demonstrated the ability to create an environment that reduces the levels of anxiety, tension, worry, uncertainty and insecurity for the pregnant teenagers.

A non-judgmental stance and easy to understand instructions are necessary for the care of pregnant teenagers. Themes such as understanding, dedication, patience, respect, and interest are evident in the interactions between the nurses and the pregnant teenagers. Pregnant teenagers often have fewer life experiences than adult pregnant women hence they have a greater need for empathy. Deducing from the experiences that the pregnant teenagers had with the nurses, one can see that it has enormous psychological benefits for them. Contrary to the literature review about how nurses are treating pregnant teenagers, the results of this research project were different. The experiences that these pregnant teenagers had with them are different and very positive to them. Therefore one cannot generalize the manner in which nurses treat pregnant teenagers.

CHAPTER 6

CONCLUSION

6.1 Introduction

In the previous chapter focused on the narrative analysis of the research data. In this chapter will interpret the findings and discuss them in relation to effective reproductive health care services.

6.2 The impact of pregnancy on the teenagers

Pregnancy is a physically, emotionally and socially stressful time in any expectant female's life (Canuso, 2000). As such teenage pregnancies may also be associated with health and social problems. The impact is pervasive and is likely to affect the physical, psychosocial, and cognitive development of the teenager. The participants in this study showed congruence with the adolescent developmental theories, namely, the cognitive, emotional, biological and psychosocial development. The data confirm that biologically most teenagers were ready to engage in sexual activities. Psychosocially they were also ready to take on a new identity of becoming a mother.

In order to take on their roles as pregnant teenagers, they need suitably tailored support from the health care workers in order to reduce their anxiety and fear (Parson, 2003) as well as better equipment of what lies ahead. Participant 4 confirmed such anxiety in the interview, saying she *'didn't have a clue on how to care for a baby. The nurses told me a few things. I don't know much about pregnancy. But*

coming here helped me learn more. They also told me about the labour (child birth) process- what to expect and what to do during labour.'

In order for the health care workers to relevantly assist the pregnant teenagers, they have to be aware of their own values and beliefs about the issues of teenage pregnancies and at times put their own prejudgments aside for the wellbeing of the pregnant teenagers. A practical illustration is when one of the participants had told the nurses that her pregnancy was actually planned. P (4) explains that *'the nurse did not seem surprised. She asked me about the father of the baby and the amount of support I have at home. I thought the nurse was going to shout at me.'* In this study the health care workers are of help to the pregnant teenagers who are trying to negotiate their space into the adult world.

Even though the physical needs of pregnant teenagers are equivalent to those of pregnant adult women, pregnant teenagers have additional exceptional needs (Montgomery, 2003). Pregnant teenagers usually have very limited life experiences as compared to adult women. Hence they are in need of more widespread teaching in order for them to cope with life changes that they will encounter during pregnancy.

6.3 The need for respect by the pregnant teenagers

The research indicated that nurses seem to respect the position that the pregnant teenagers find themselves to be in. Even in the context of overcrowding and staff shortages, the pregnant teenagers were still treated with respect. These health care

workers assist the pregnant teenagers to negotiate space for them in life and by finding their new identities. In general, the participants seemed to have felt respected and not condemned by the nurses in spite of their premarital sexual activities that led to the teenage pregnancies. The health care workers seem to be instrumental in the smooth transition of these pregnant teenagers to motherhood. Their challenge is to assist the pregnant teenagers to achieve the best possible outcomes for themselves and their unborn infants. In order to meet this outcome, part of the challenge will be to provide cognitive support in a form of information, knowledge and or advice to the pregnant teenager. This kind of cognitive support will enable these pregnant teenagers to make informed decisions with regard to their pregnancies.

6.4 Provision of cognitive support

The cognitive support provided by the nurses at this clinic was in a form of knowledge, information and advice given to the pregnant teenagers. Best of all is the unconditional acceptance and behaviour that the nurses displayed in their provision of cognitive support to the pregnant teenagers. All the pregnant teenagers interviewed expressed satisfaction with the cognitive support that they received from the nurses from this clinic and the manner in which it was provided to them.

The cognitive support provided by the nurses at the clinic to the pregnant teenagers was in the form of talks on topics such as HIV, pregnancy, termination of pregnancy, childbirth, and advice on social grants. The nurses encouraged those pregnant teenagers expressing the wish to continue with their studies at school after the

delivery of their babies. The cognitive support given by the nurses to the pregnant teenagers improved the emotional well being of the pregnant teenagers.

As already stressed out, it is vital to be alert that curiosity and the drive to explore are at its peak within the lives of the pregnant teenagers. Yet there can be considerable differences in the maturity levels and abilities of teenagers in their various stages of development. Chronological age does not always match up to the development level of the teenager (Drake, 1996).

The nurses first determined the point at which each individual pregnant teenager was without first judging the actual event of being pregnant. Ultimately, the teenagers 'uniqueness' and how she/he relates to other people, family members, peers, or institutions are integrated into a unified whole. The health workers can be of immense assistance in enabling the pregnant teenager to experience her uniqueness. From a social constructionist point of view this is a nonjudgmental approach. It is this very approach that elicits the reoccurring themes within the pregnant teenagers' narratives which were discussed in the previous chapter. These themes are of acceptance, respect, dedication and professionalism, amongst others. To these health workers, it is not that which is considered right and acceptable according to their values and beliefs that count, but that which is meaningful to the pregnant teenager. One of the pregnant teenagers interviewed said that she chose the role of parenthood in order to gain mature status much to the disapproval of her own parents. To this her parents reacted with shock, anger and repugnance- something that she did not experience

from the health workers at the clinic. One can then conclude that these pregnant teenagers can use this health facility as a source of help and support, something that they do not get at their respective homes. Participant 4 confirmed this when she said that she did not *'know much about pregnancy... I think coming here will help me learn more.'*

This is also a period where the teenagers in this stage want to make choices about what they want to do with their lives. This in itself is an enormous emotional undertaking for a teenager and being pregnant and faced with such decisions does not make it any easier. The teenager is therefore seen as extremely idealistic, is constantly challenging the norms and values, opposes authority, and considers the way things ought to or could be. Therefore pregnancy for these teenagers at this point will be seen by the teenagers as how things 'ought to be'. This teenagers' attitude constantly brings them into disrepute with members of their society. Society needs insight into the cognitive development of the teenager in order to help the teenager to make meaningful decisions- for both the teenager and society.

Jacobson (1986) defines emotional support as behaviours that foster feelings of comfort, admiration, respect and love and the reassurance that there will be others to provide care and security. Drake (1996) proposed a relevant argument to consider which proposes that the priorities of boys and girls differ when it comes to sexual identity. The girls are more interested in passion loving relationships with boys

whereas the boys are more interested in sexual pleasures than maintaining a loving and lasting relationship.

6.5 Understanding the individual needs of pregnant teenagers

The health workers at the clinic seem to understand the priorities of pregnant teenagers at this stage. P (4) wanted the involvement of her unborn child's father in some of her prenatal activities. She stated that she *'asked them to take blood for HIV when I and my boyfriend are together here. I do not want to take a test for HIV alone. They agreed. They said it was a good thing that I and my boyfriend should get tested.'* The health workers seem to encompass that which is meaningful to the pregnant teenager at this stage, which is her partner.

This does not seem to be the case at the homes of these pregnant teenagers. Some of the participants stated that they experienced conflict with their parents regarding their boyfriends. The parents may forbid the pregnant teenager to see her boyfriend again and this may lead to rebellion, resentment, and anger in the pregnant teenager. As in the case of P (4) who stated that her *'mother said that I must not see my boyfriend again because according to her he is a bad person. She says that my pregnancy is the result of mixing with bad people.'* In this instance the parents overlooked the need for the teenager to form relationships with members from the opposite sex. This is one of the needs for the teenager to establish his or her own identity. Such behaviour from parents may strain relationships between them and their pregnant teenagers as well as the communication between them.

The health workers at this clinic seem to have the ability to stay unruffled, patient, respectful of the choices of the pregnant teenagers and nonjudgmental, hence the cooperation of these pregnant teenagers with the nurses at the clinic. This gives a message to the pregnant teenagers that at least some understand their ways of thinking and of doing things. Responses from participant 1 reinforce this in her saying that the nurses *'work hard, but are not impatient with us.'* Participant 4 concurs in her statement that *'the nurse was friendly towards me. I am referring to the matron (the chief nurse of the unit). She always speaks well with everybody. She takes time to explain the procedures to you. She even asked me about my plans after the delivery of the baby. I feel she really cares for people. I always first look for her when I come here, especially when I have a few things to ask.'*

The health workers at this clinic respect the feelings of the pregnant teenagers and even make an effort to be of assistance to them where possible. Their rapid physical growth seems to influence the intensity of their emotions. Their newly acquired cognitive skills enable them to think about their feelings and their new social roles force the teenager to cope with new and different situations which can result in frustration and or other emotions. Teenagers experience emotions such as anger, fear, anxiety, loneliness, depression and grief. The pregnant teenagers do not feel blamed by the nursing staff for being pregnant.

According to Savage (1996), acting positively toward pregnant teenagers builds their self-esteem and confidence. It also gives them a feeling of being in control. P (4) told the nurse that she had actually planned this pregnancy and was surprised that the nurse did not shout at her as she had expected. This illustrates that the nurses do not regard the actions of these pregnant teenagers as deviant. This is positive for the psychological well being of the pregnant teenagers. The actions of the nurses in this study seem to help the pregnant teenagers not to feel guilty and valueless. They are even attended to before other clients at the clinic. P (3) goes on to say that *'the nurses are sharp (trouble free). They serve me well. They even start with the pregnant clients first and none of them ever told me that I am not supposed to be here being a pregnant teenager.'* This means that these pregnant teenagers experience the service at this clinic as pregnant teen friendly. It takes nurses who are nonjudgmental to be able to serve pregnant teenagers like this. Further more, all of the pregnant teenagers who participated in the interview felt confident enough that other teenagers would listen to their opinions. P (3) reinforces that *'I have already referred a few of my friends and other pregnant teenagers who are staying in this area to the clinic.'*

In general, most of the nurses' questions were asked from a *curious* and not knowing position. This seemed to encourage the pregnant teenagers to talk about their cognitive experiences. The nurses also praised the teenagers for their knowledge even if it was merely superficial, shallow insight. Praising the pregnant teenagers for their meager knowledge allowed the teenagers to reconstruct their perception of

themselves of being cognitively inadequate and arguably gave them *new meaning* into their abilities to learn and cope with pregnancy. According to Shamai (2003), social constructionist thinking refers to knowledge as a product of all kinds of social relations. Thus knowledge about teenage pregnancy can be achieved by reading literature, watching television programs featuring teenage pregnancy, or even talking to other people who had previously experienced teenage pregnancy. Equipping the pregnant teenagers cognitively improves their psychological well being and encourages them to do well socially.

Stigmatization is a common fear that often occurs among teenagers who become pregnant. This frequently goes with negative consequences such as losing friends, expulsion from home or school, or being rejected by most members of the society in a culture that practices chastity before marriage (Montgomery, 2003). Thus the pregnant teenagers' not conforming to the culture of society (which is the collective meaning), is seen as a weakness. This means that the pregnant teenager does not only have the problem of negotiating their space in life at health facilities, but also at home and school and other spheres of their social lives.

It is arguable from the narratives of these pregnant teenagers, their interaction with the health workers at the clinic assisted them to take stock of their individual meaning of strength and weakness. This is through the participant's comments on the enlightening conversations they had with the nurses. The steadiness between

weakness and strength allow the pregnant teenagers to rephrase their perception of pregnancy beyond a view of weakness and strength.

From a social constructionist view, it is possible to claim that when the collective meaning loses its social power, the construction of the individual's reality and relationships can be changed accordingly (Gergen, 1985). This gives the pregnant teenager the opportunity and the flexibility to see situations once perceived as strong to be weak and vice versa (Shamai, 2003). This was also an opportunity for the health workers to bring the pregnant teenager to the understanding that it takes strength to admit some weakness.

According to Anderson and Goolishian (1992), this way of doing things allows the client a place of being the expert in dealing with feelings of weakness and also allows for new options to dialogue. The nurse also explored the emotional issues that the pregnant teenager grapples with.

Montgomery (2003) states that in the event of an unintended pregnancy, teenagers may experience intense distress in coming to a decision with regards to the pregnancy. The teenagers may grapple with feelings of guilt, depression, denial, feelings of being trapped, feeling inadequate or just being under pressure. The nurse explored the feelings of the pregnant teenager. All questions are asked out of curiosity and to find out more about the pregnant teenager's current emotional state.

6.6 Limitations of the study

The limitations of the study are identified and their implications critically discussed.

The very first limitation to note is that the study was done at only one clinic. It is therefore advisable to carry out similar studies in other clinics. Semi – structured interviews were used which could have channelled the narratives of the teenagers into specific directions. Only six participants were part of the study. Although this number is acceptable for qualitative research, it still serves as a limitation because the information gathered, though valuable, cannot be taken as a global norm. But rather as a catalyst, setting the platform for further studies to spring out of it.

The geographical position of the clinic serves as a limitation because it is situated in a rural area and thus serves a predominantly homogeneous community who are more often than not, of the same race and similar [economic] class. Thus all the participants were as expected, from only one racial group – black pregnant teenagers. This is a limitation because the findings give accurate accounts of the experiences of pregnant teenagers, but within the specific context of a predominantly black working class community. The themes that arose from the pregnant teenagers' reflections from their experiences are extensions of their constructed realities and experiences. They are influenced by their race, identity as teenagers and the economical factors that they face as teenagers from mainly working-class homes. The overriding limitation in this qualitative research, is said to be the researcher's influence which Shamai (2003) argues is impossible to eliminate completely. As a means of minimising the

researcher's influence, the researcher strove to remain objective through clearly distinguishing the facts and opinions within the study. Going to the participants' clinic and interviewing them where they are comfortable as opposed to conducting the interviews in an office far away from the clinic was less threatening to the clients. The multi-lingual researcher responded to the participants in their language of choice verbally freeing them to express themselves and consciously limiting the researchers' own influence even more.

6.6 Recommendations

The following recommendations can be made following the findings of this study: Nurses should be familiar with the developmental stages of teenagers. This can be useful in their behaviour towards pregnant teenagers. They should be aware of their own cultural values and beliefs and not allow their values and beliefs to interfere with efficient patient care. Promoting the development of a more effective relationship with the pregnant teenager is significant and important. A relationship of trust is essential for the co-operation of pregnant teenagers and nurses. Pregnant teenagers ought to be praised for beginning prenatal care especially in the first trimester of pregnancy and encouraged to be regular with their prenatal visits. Provision of emotional support to pregnant teenagers by health care workers is essential, as this will help the teenagers to feel in control of their situations and it serves as a potential buffer for stress during pregnancy.

If a pregnant teenager brings along a friend or a relative for support, that support person should be included in the education of the pregnant teenager as a sign of respect for the teenager. Empathy and understanding to the plight of pregnant teenagers is essential. Health care workers should be aware that pregnant teenagers may have less experience than the adult pregnant woman and will therefore need additional health education and guidance. The role of the nurse is to focus on the problem at hand and assist the pregnant teenager to maintain her focus on the here and now. Pregnant teenagers usually respond better to honesty, respect, and being treated as young adults who are capable of taking part in decision-making and should thus be involved in matters regarding their pregnancies.

Sufficient staffing of health clinics can give nurses more time to interact with pregnant teenagers and other problems such as drugs, physical or emotional abuse can be dealt with if present. There is a need for further research on this aspect in more clinics across a number of provinces in South Africa.

Pregnant teenagers in the reproductive health care context are frequently denied confidentiality and their parents or guardians are usually informed about the decisions that they make with regard to their pregnancies. Such decisions may include termination of pregnancy. There is a desperate need for more practical measures to be put in place to ensure the implementation of confidentiality in the government reproductive health care institutions. This will enhance the user's confidence in the

reproductive health care service, as the teenager will feel that care and consideration is given to her sexuality.

6.8 Conclusion

Dealing effectively with pregnant teenagers is a continuous challenge for the health care providers particularly for the nurses. Effective interaction with pregnant teenagers requires an understanding of their cognitive, psychosocial and emotional development. It is important to realize that pregnant teenagers may move through their developmental tasks at different rates. A social constructionist approach from the nurses in this study allowed for the pregnant teenager to be an active partner in decision making about her care during pregnancy. Both the nurses and the pregnant teenagers seem to have engaged in a meaningful relationship as far as teenage pregnancy is concerned. Furthermore, the approach of the nurses seemed to be different in that they went along to do that which was meaningful to the pregnant teenagers.

This partnership promotes increased cooperation between the pregnant teenagers and the nurses. A non-judgemental stance by the nurses towards pregnant teenagers increases the pregnant teenagers' chances of getting health care that is relevant to their needs at a specific point in time. One participant in the study expressed appreciation at being asked about her plans after pregnancy. In a study by Blake and Beard (1999), it was found that if a pregnant teenager receives support during pregnancy, then adaptation to the phenomenon of pregnancy can occur including the

realisation that pregnancy was not the end of the world. The pregnant teenager can still be persuaded to readapt to their studies.

It certainly takes a special kind of clinic to accord each pregnant teenager such importance and respect. This is one of the themes that was voiced by one of the participants 'they are good... all of them are fine and they never shout at me.' A respectful approach, knowing the clients' right to make decisions and take action- no matter the nurses' personal opinion- is an important step in forming a good working relationship with any client, including pregnant teenagers (Shaefer & Emerling, 1997). The study showed that non-judgemental care and simple instructions for caring for the pregnant teenagers can promote better understanding and cooperation between nurses and the pregnant teenagers.

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APPENDIX 1

PERMISSION LETTER TO THE CLINIC MANAGEMENT

Enquiries : L. A. Nkosi
Telephone: (012) 549 1526

P. O Box 58604
KAREN PARK

0118

02 June 2004

To: The unit manager

Ikhutseng clinic

PERMISSION TO CONDUCT RESEARCH WITH REGARDS TO HEALTH SERVICES FOR PREGNANT TEENAGERS

I intend to conduct a research project entitled *a contextual study of nurses' behaviour towards pregnant teenagers: a social constructionist approach* in compliance with the requirements for a Masters in clinical psychology with the University of South Africa.

The purpose of the study is to assess the interaction of nurses with pregnant teenagers with regards to the following:

- Whether the clinic is friendly to pregnant teenagers
- Whether the clinic gives information to pregnant teenagers with regards to termination of pregnancy
- Is the clinic able to cater for needs such as privacy and confidentiality with regards to pregnant teenagers?

For the purpose of this study a qualitative research design will be used and the participants will be required to take part in a semi-structured interview. A random sampling will be used.

Should permission to do this research be granted, the respondents in this research will be required to give informed consent and will reserve the right to withdraw their consent at any stage during the research process. The identities of the respondents will be protected and no names will be used in this study.

The research results will be made available to this clinic on request. I am available for further clarification with regards to this research project.

Yours faithfully

L. A. Nkosi (Mrs)

APPENDIX 2

PERMISSION LETTER FROM THE CLINIC MANAGEMENT

Enquiries : V.M. Seeletse (Mrs)
Telephone : (012) 7079057

The Unit Manager
Ikhutseng Clinic
Private Bag X 509
Mabopane
0190
22 July 2004



Ms L.A. Nkosi
P.O. Box 58604
Karenpark
0118

RESEARCH IN THE ADOLESCENT REPRODUCTIVE HEALTH

Permission is hereby granted for you to conduct your research with pregnant teenagers at the above-mentioned clinic.

We wish you well in your study.

Thank you

V.M. Seeletse (Mrs)
Unit Manager