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PROMOTING THE HEALTH AND WELLBEING OF TEENAGE MOTHERS IN MOPANI DISTRICT, LIMPOPO PROVINCE

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DECLARATION

I, Beauty Ruth Hlongwane,

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declare that the thesis:

"PROMOTING THE HEALTH AND WELLBEING OF TEENAGE MOTHERS IN MOPANI DISTRICT, LIMPOPO PROVINCE"

is my original work and that all sources that have been used or quoted have been indicated and acknowledged by means of complete references in the text and bibliography, and that this work has not been submitted for any other degree at any other institution.

_____ _____

Beauty Ruth Hlongwane **Date**

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Praising God for my willpower, wisdom, protection and guidance in achieving this goal by lifting me up in times of storms, sorrow and difficulties and showing me somewhere, there is always light.

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This study is dedicated to the following people who gave me courage when I became weak; took my hand and guided me when I got lost; and whose love and care helped me to stand steadfast when all I wanted to do was to fall.

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ABSTRACT

PROMOTING THE HEALTH AND WELLBEING OF TEENAGE MOTHERS IN MOPANI DISTRICT, LIMPOPO PROVINCE

Health promotion in rural villages provides an important opportunity for registered nurses not only to address the curative and preventive side of healthcare, but also the wellbeing of teenage mothers to ensure their continued development and education. The Limpopo Provincial Government indicates significantly high rates of unwanted pregnancies among unmarried teenage girls from as young as 10 and 11 years due to lack of knowledge about sexuality, contraceptives, negative attitudes of staff, poverty and family breakdown. The researcher observed that once they are teenage mothers, the majority did not return to school to complete their education. She was concerned about the dismal future faced by so many young girls whose human rights, autonomous decision making and the privilege of having a childhood life were forcefully taken away from them through early motherhood. This became the driving force for the researcher to obtain empirical evidence confirming there is an urgent need to promote the health and wellbeing of teenage mothers in the Mopani District, Limpopo, South Africa.

The aim of the study was to develop guidelines to promote the health and wellbeing of teenage mothers in rural villages in the Mopani District in Limpopo. This study comprised of 2 phases.

The specific objectives of Phase 1 were to explore and describe challenges experienced by registered nurses regarding the promotion of health and wellbeing of teenage mothers and to describe barriers experienced by teenage mothers in returning to school post-delivery.

In the first phase, a qualitative study Data analysis was conducted according to Tesch's method (in Creswell 2009:186) as described below.

In the first phase, a qualitative study rooted in the conceptual revised health promotion model of Pender was done with 15 registered nurses and 15 teenage mothers in two of the poorest villages in Mopani District. The data obtained from this empirical phase was

transcribed verbatim by the researcher in consultation with an independent coder which led to the seven themes that emerged.

The results of phase 1 of the study displayed challenges of health care service provision by registered nurses, during antenatal, labour, and post-natal care including follow up. Lack of support for child care and need for child support grant was exhibited. Post-natal barriers to access contraceptives and to return to school were shown. However, a plan of action was also suggested by participants. A literature control verified the findings in context.

The conclusions drawn from the findings of the empirical phase were used to draft a set of preliminary guidelines for promoting the health and wellbeing of teenage mothers including their return to school in Mopani District.

In the second phase, the integration of study findings in relation to Pender's model formed the basis which guided the formulation and development of drafting preliminary guidelines.

The specific objective of Phase 2 was to develop guidelines to promote the health and wellbeing of teenage mothers in rural villages in Mopani District, Limpopo.

In this phase, the Delphi technique was employed, utilising purposefully selected experts from different disciplines and different provinces who had experience in health promotion among teenage girls and teenage mothers. Consensus was reached among the experts and the development of seven guidelines for promoting the health and wellbeing of teenage mothers in the selected setting and in other rural settings was done as well.

The guidelines developed could be the resources for promoting teenagers' health and wellbeing, their interaction and integration with families, schools and communities, and achievement of the development goals of the province and the country as well as contribute to knowledge and education through curriculum development in Nursing Science. If the situation fails to change, school drop-out will not decline. On the other hand, registered nurses can and should follow a health promotion strategy that supports healthy teenage development that is sensitive to the situation of teenage mothers in rural villages in order to promote their health and wellbeing in a manner that transforms their environment and increases their educational opportunities and life chances.

The study objectives were successfully achieved. Ethical considerations and trustworthiness were adhered to throughout the study process. A pilot study was conducted before each phase to validate instruments used. It was recommended that a review of the seven guidelines be done on a regular basis to ensure that they reflect current decisions and are

continuously aligned to policies to enhance the health and wellbeing of young teenage mothers and to motivate them to attend school to ensure they have a better future as women and as mothers.

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7.3	LIST OF ACRONYMS/ ABBREVIATIONS

LIST OF ABBREVIATIONS AND ACRONYMS

ABBREVIATION	MEANING
ANC	Antenatal care
ABBREVIATION	**MEANING**
ARV	Antiretroviral
CSG	Child Support Grant
DoH	National Department of Health
DoHE	National Department of Higher Education
HPM	Pender's revised health promotion model
ID	Identity Document
HRSA	Health Resources and Services Administration
IDP	Mopani District Integrated Development Plan
IMR	Infant mortality rate
IRH	Ibis Reproductive Health
ISHP	Integrated School Health Policy
MDG	Millennium Development Goals
MDM	Mopani District Municipality
MDMIDP	Mopani District Municipality Integrated Development Plan
NACHC	National Association of Community Health Centres
NAFCI	National Adolescent Friendly Clinic Initiative programme

NASRH&R	National Adolescence Sexual and Reproductive Health and Rights Framework Strategy
PHC	Primary Healthcare
PMTCT	Prevention of Mother-to-child transmission
RNAO	Registered Nurses Association of Ontario
SANC	South African Nursing Council
SDG	Sustainable Development Goals
StatsSA	Statistics South Africa
STIs	Sexually Transmitted Infections
UN	United Nations
UNECA	United Nations Economic Commission for Africa
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNMISS	United Nations Mission in South Sudan
VLBW	Very Low Birth Weight
WHO	World Health Organization

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CHAPTER 1

INTRODUCTION AND ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Pregnancy in girls aged 10 to 21 remains a prevailing challenge to educators, governments and health workers globally. For the girl child who has prospects of building a better future through obtaining an education, finding proper employment and earning a steady income, an unplanned pregnancy can derail all of these dreams and ideals. In fact, the United Nations Population Fund (UNFPA) asserts the impact of a childhood pregnancy can "reverberate throughout her life and carry over to the next generation" (UNFPA 2013:97). Elaborating on the negative consequences of early motherhood, the United Nations (UN) explains in its World Health Organization (WHO) Millennium Development Goals (MDG) Report 2014 early childbearing is associated with extreme and even life-threatening health risks to the young mother as well as her infant and his or her life years up to age five. For a girl child, the transformation from childhood through adolescence into adult and motherhood defines and influences her future world on all levels; the inevitably negative consequence for communities, society and the world at large of the extraordinary high level of teenage pregnancies is the intergenerational transmission of poverty (MDG Report 2014:31).

Doctor Babatunde Osotimehin, United Nations Under-Secretary-General and Executive Director of UNFPA, states that "it is time for the international community to face the reality of teenage pregnancy and motherhood, instead of viewing the girl as the problem and changing her behaviour as the solution, governments, communities, families and schools should see poverty, gender inequality, discrimination, lack of access to services, and negative views about girls and women as the real challenges" (UNFPA 2013:ii). The human and humane needs of this vulnerable and seemingly forgotten group of young mothers are immense.

Every day, 20 000 teenagers below 18 years give birth in developing countries. In regions such as West and Central Africa, Latin America and the Caribbean, teenage births are still rising – the under 15-year-old births account for 2 million of the annual total of 7.3 million new teenage mothers (UNFPA 2013:4-5). According to Sedgh, Finer, Bankole, Eilers and Singh (2015:224), the number of teenage pregnancies continues to rise globally. These researchers obtained data from the vital statistics reports of 21 developed and developing countries on the pregnancy incidence among 15 to 19 years old girls as well as young girls between 10 to 14 years. The results inform pregnancy rates of teenagers between 15 to 19 years old were highest in Mexico and sub-Saharan Africa which are both developing regions (Sedgh, et al 2015:223). High teenage childbearing was observed in 2015 in sub-Saharan Africa at 116 births per 1 000 teenage girls (MDG Report 2015a:42). In South Africa, Statistics South Africa (StatsSA) reports 5,3% of females in the age group 14 to 19 years were pregnant during 2014 (before the 2015 survey). “The prevalence of pregnancy increased with age, rising from 0,6% for females aged 14 years, to 9,7% for females aged 19 years.” (StatsSA 2015:24).

Across the developing world, millions of girl children live in societies and communities where squalid living conditions, illiteracy and inherited age-old traditions, values and beliefs render them exceptionally vulnerable to different types of exploitation and abuse including forced marriage and childbearing while still children themselves (Engebretsen 2012:2). Sadly, it is often times the girl-child who is at the highest risk of being a victim of early motherhood which brings great risk to her health and can have lasting damaging effects on her overall welfare. The girl child Engebretsen (2012) refers to, are girls from 10 and above who have not yet reached puberty. Any person between 10 and 19 years old is defined by the United Nations as an adolescent (teenager), but the Convention on the Rights of the Child stipulates that anyone 18 years old and younger is considered a child (UNFPA 2013:vii).

The immense needs and basic human rights of a whole generation of girls from 10 to 14 and older has somehow been overlooked by “national health, education and development institutions, often because these girls are in forced marriages and are prevented from attending school or accessing sexual and reproductive health services” (UNFPA 2013:iii). In its 2016 State of World Population Report, UNFPA (2016:32,66) reports in many low- and middle-income impoverished countries where gender-based norms and values are still practised according to inherited traditions, 10-year-old girls are deemed old enough to be married even if marriage and/or pregnancy is not the girl child’s or older teenage girl’s choice. Once married, many are submitted to forced sex, early childbearing, and an impoverished lifestyle. The challenge of exposure to contactable diseases like sexually

transmitted infections (STIs) and HIV increases if the teenager is ignorant about safe sexual practices and not in control of her own reproductive health.

Teenage girls can no longer be allowed to have their dreams, potential and survival destroyed by being brought up to simply exist voiceless in the shadows of a shack, hut or house. Unbelievably, internationally no single legal standard exists that converges upon the protection of the human rights of girls despite the fact that they "as females and as young people, face dual and intersecting challenges to their rights" (UNFPA 2016:39). These rights include, among others, a teenage mother's right to a proper education (UNFPA 2016:26); her right to safe motherhood (i.e. safe obstetric healthcare before, during and after birth) in accordance with the youth-friendly healthcare characteristics outlined by the World Health Organization (WHO) (2009a:2-3); and her right to make her own choices about fertility control (i.e. reproductive health and contraception) (Fatalla 1999:2).

However, as asserted by UNFPA (2016:39,42), the road to empowerment, autonomy and independence for a teenage mother is littered with personal, familial, cultural, educational and health-related difficulties, obstacles, problems, and hardship – and even more so if the mother is only a child herself. As a girl child, it is highly unlikely for her to know she has rights. On the other hand, if old enough and being aware of her rights, knowing how to assert them may in any case be beyond her comprehension and decision-making power. Whether in developed or developing countries, parents, husbands, partners, the community and society at large often ignore pregnant teenagers' human rights owing to the broader forces of normative and gendered perceptions of a female's submissive, inferior position in the household and society (UNFPA 2016:39,42). Yet, it is time to acknowledge that young teenage girls have human rights just as everybody else. However, a critical shortcoming is that data on 10 to 14 year-old girls and their pregnancy status are scarce. What is needed for governments, communities and families to help such young girls to prevent falling pregnant or support those who have already become pregnant or given birth, is an unprejudiced and definite deeper understanding of "the determinants of pregnancies among this group, their challenges and vulnerabilities, the impact on their lives" (UNFPA 2013:14-5).

With the change from the MDGs to the 17 new SDGs for 2030, the focal point has moved to a more inclusive, collective and expanding global development agenda with more attention "on a broader set of social determinants and, importantly, a specific sensitivity to equity, which could have a substantial effect on health" (Scott, Schaay, Schneider and Sanders 2017:77). These authors understand social determinants to be "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness" (WHO social determinants of health, as cited in Scott, et al (2017:78), operate on four

levels: global, national, sector-specific, and local, and therefore “a set of different actions, operating at different levels, is required to address the social determinants” (Scott, et al 2017:79). The Primary Health Care PHC) was identified by the National Department of Health in South Africa as a means of bringing development and improvement in people’s lives (Scott, et al 2017:77).

Fleming, O’Driscoll, Becker and Spitzer (2015:742) state a girl child’s right to educational attainment is often compromised by her pregnancy since she is “more likely than her non-pregnant peers to have lower educational attainment, to drop out of school, and to have lower socioeconomic status and lower social capital”. UNFPA (2016:2) agrees the biggest challenge faced by pregnant teenage girls is the negative impact it can have on their educational status. Concerning the educational status of females in South Africa, statistics for functional illiteracy (people with no schooling or who have not completed Grade 7) show “with the exception of women in the *age group 20–39* [own emphasis] women remain more likely to be functionally illiterate *across all age groups* [own emphasis]” (StatsSA 2015:18). In the age group 7 to 18 years males and females cited reasons for not attending schools as having no money (22,5%), poor academic performance (20,3%) and family commitments (9,4%). These ‘family commitments’ are specified by StatsSA as “getting married, minding children and pregnancy” with the added comment “it is noticeable that females were much more likely to offer these as reasons than males (18,1% compared to 0,4%) (StatsSA 2015:11). It is posited if gender was taken into account in the ‘poor academic performance’ result, ‘female’ would have scored quite high since teenage pregnancy and motherhood often lead to poor academic performance and eventually total school dropout.

The young mother cannot cope with the double workload (being a mother and learner) and does not have a support system or enough financial resources to support herself and the child while also attending school. Agarwal (2012:1) provides evidence that in real life many young mothers do decide to return to school after giving birth; however, most of them were unable to cope with rejection by fellow students, they performed poorly in class leading to repeating the same grade or drop out of school. Also, in the Unites States of America (USA) it was found that teenage mothers who returned to school achieved lower grade averages; they were more absent from school and had trouble completing their work (Briggs, Brownell and Roos 2007:65). The WHO mentions adult women who had children at an early age experience their opportunities for socioeconomic improvement curtailed, particularly because as teenage mothers they could not continue studying and, if as adults they need to work, they may find it difficult to combine family and work responsibilities (WHO 2013:5).

Fortunately, there is also a positive side to this situation. The Registered Nurses Association of Ontario (RNAO) (2010:14) states in spite of the emotional stress and physical difficulty teenage mothers endure during pregnancy and when eventually giving birth at such an early age, some teenage mothers are able to manage and cope with their hardship in positive and uplifting ways which may also strengthen their ability to respond to future adversities as a young mother with similar perseverance and courage. The RNAO also indicates that resiliency and an absolute resolve to better their lives as well as that of their child drive many young teenage mothers to 'one day' reach their full potential – it is this inner self-belief and strength that support them to successfully achieve the transition into adulthood. However, the conditions for their successful transition rely on providing them with the broadest possible support from a multidisciplinary team of stakeholders including nurses, educators, their families and the community at large.

A concerted effort must be made by governments, policymakers, healthcare and educational departments, communities and individuals to improve teenage mothers' health and wellbeing. According to the WHO's Global Strategy for Women's, Children's and Adolescents' Health 2016-2030 (2016:91), the community should become engaged in learning programmes to increase their understanding of the health behaviours of teenagers and learn how to support the latter. Undeniably, health and education are powerful vehicles for promoting male and female teenagers' health, wellbeing and economic growth as UNFPA (2016:48) declares and further asserts that investments in strengthening the human capital and agency of teenage girls can "yield enormous social and economic returns, to individuals, their families, communities and nations" (UNFPA 2013:97). Therefore, in the time leading up to 2030, an urgent goal of the UN via the Sustainable Development Goals (SDGs) 2030 was to ensure that binding commitments made by governments, policymakers, international organisations, civil society, families and religious leaders to focus on the overall health and wellbeing of "children (aged 6 to 14 years) and youth (aged 15 to 24 years), especially girls, to ensure that all young people can complete secondary education and make an effective transition from school to skills to the labour market" (Sachs 2012:2209). The Millennium Development Goals Report (MDG 2015a:42) advocates for aims to intensify delayed childbearing and prevent unwanted pregnancies among vulnerable age groups by increasing the opportunities to school-going which will lead to better employment opportunities, an improved standard of living, autonomous decision making and overall independence. Such efforts will further improve maternal and child health, contribute to reduce poverty, and promote gender equality.

In 2010, former President Jacob Zuma committed the South African government to reinstate health programmes in public schools. This decisive step was in line with the primary

healthcare (PHC) approach which embodies all elements of healthcare, with specific emphasis on preventive and promotive healthcare that addresses the immediate health problems that constitute barriers to learning for learners (Integrated School Health Policy (ISHP) 2012:7). The goal was to improve the general health of school-going children including pregnant teenagers or teenage mothers attending school. The ISHP emphasises that school health nurses must be responsible for the provision of health care to all students in their communities (ISHP 2012:7). This policy supports the National Policy on HIV and AIDS for learners and educators by encouraging educators to be responsible for providing sexuality and life skills education while parents and guardians are also encouraged to provide their children with sex education (ISHP 2012:35). Another intervention aimed at specifically promoting the general health of school-going pregnant teenagers and teenage mothers in the country is the Guidelines for Maternity Care in South Africa 2016. These are guidelines recommending prevention of mother-to-child transmission (PMTCT) to be part of an expanded package of care for the mother-infant and their family to prevent transmission of HIV. The guidelines regarding antenatal care is an attempt to ensure the best possible pregnancy outcome for mothers and babies through proper screening, assessing risks, treating identified problems, providing information to pregnant women and preparing them physically and psychological for childbirth and motherhood (Guidelines for Maternity Care 2016:20).

Further to the reinstatement of health programmes, the RNAO (2010:28) recommends for nurses to work in partnership with the youth and to collaborate with a variety of community partners when endeavouring to develop health guidelines that focus on particular youth-specific health problems and serve to enhance healthy teenage development (RNAO 2010:37). Comprehensive sexuality education may improve learners' knowledge, self-esteem, changing attitudes and social norms; comprehensive sexuality education could be the building agency to prevent teenage pregnancy by delaying sexual debut (UNFPA 2016:66). According to Viero, Farias, Farraz, Simöes, Martins and Ceretta (2015:485), it is important for health professionals to motivate teenagers to become active subjects of their own care, using health education strategies that aim at health promotion involving parents and family members. In South Africa, improved access to and utilisation of comprehensive sexual and reproductive healthcare for teenagers would significantly improve a range of health outcomes.

This study deals with teenage pregnancies that strike one of the most helpless groups of modern society teenage girls (some as young as 10 years old) living in poverty in remote areas of developing countries where they lack choices and opportunities in life, have limited or no access to sexual and reproductive healthcare, including contraceptive information and

services, lives in constant hunger and is poorly educated. The current situation of young teenage mothers in two remote, impoverished rural villages, Muyexe and Homu 14C with its squatter camp at the southernmost tip of the African continent is representative of the situation of 580 million teenage girls in the world of whom four out of five live in developing countries (UNFPA 2013:iii). Health promotion in rural villages in Limpopo province provides an important opportunity for registered nurses not only to address the curative and preventive side of healthcare, but also the wellbeing of teenage mothers to ensure their continued development and education (Rangiah 2012:49).

The current researcher's interest to investigate the health and wellbeing of teenage mothers in a remote area stems from her distress when she observed that the needs of the girl behind the mother was not recognised, respected or responded to. She reflected on why, despite major developments and improvements in the South African healthcare system over the last two decades, it has been unable to meet the distinct needs of particularly teenage mothers living in impoverished, rural and low-income areas where they face many critical health risks. The coverage of antenatal care, assisted birth and post-natal care are particularly important in the case of teenage maternal care; yet, it does not seem to be adequately utilised by teenage mothers in remote communities such as the current study setting. Moreover, the high incidence of teenage pregnancy she observed in two rural villages in the Mopani district attest to the need for reorienting health promotion service providers to focus on the promotion of health and wellbeing of teenagers as well as reducing their rate of school dropout.

Limpopo, one of the nine provinces in South Africa, shows a very high rate of teenage pregnancies. Maphoti (2014:10) reports in 2014 that out of the five Districts in Limpopo, Mopani District had the highest pregnancy rate of 29% while the lowest was Waterberg with a rate of 7.6%. First pregnancy of 90.8% is experienced at 16 years and above whereas 9.2% is younger than 16 years; 71% are unwanted pregnancies. The Limpopo Provincial Government (2012:6) indicates significant high rates of pregnancies among black and coloured teenagers where 57.8% of teenage mothers had unwanted pregnancies and were not married. Mothiba and Maputle (2012:4) posit that in the Capricorn District of Limpopo, teenage girls fall pregnant as a result of insufficient knowledge about sex and contraceptives as well as negative attitudes of staff, poverty and family breakdown. However, some teenagers have knowledge but are reluctant to use contraception for fear of complications such as side effects and parental detection. Many never return to school after giving birth. A high incidence of teenage pregnancy in remote villages and areas similar to those in the Mopani District in Limpopo has been noticed in many rural villages dotted around the South African landscape. Therefore, there was a need to develop guidelines for the promotion of

the health and wellbeing of teenage mothers in remote rural areas and for support encouraging them to return to school.

1.2 PROBLEM STATEMENT

Early pregnancy brings great risks to the health and wellbeing of teenage girls. It also deprives a national economy of the benefits of better educated young women who enter the workforce as opposed to them staying at home to rear children.

As indicated in South Africa's Millennium Development Goals (MDG) Country Report 2015, the education of girls has had a positive multiplier effect on progress across all development areas; however, the greatest improvement occurred in primary schools as a result of achieving gender parity (MDG Report 2015b:29). Teenage pregnancy unfortunately still inhibits girls' progress in education and their future plans. The two main reasons for this is that teenage mothers attend school irregularly and mothering instil pressures which result in poor performance and school dropout (Malahlela 2012:55). Because of their incomplete schooling, teenage mothers struggle to find employment and support themselves while bringing up their infants. This may contribute to risky behaviour such as substance abuse, criminal conduct, sexual abuse, coercion, peer group pressure and suicide (Lee 2009a:33). The stance of Ware (2013:24) is that teenage pregnancy is driven by how boys and girls behave in relation to sexual taboos, poverty, poor access to contraceptives, abortion and the apparent judgemental attitudes they perceive of the health providers.

Teenage mothers experience a deficit in parental capacity, autonomy and self-reliance. There is an increased vulnerability due to their dependence on others for support and care of their children (Malahlela and Chireshe 2013:145). Growing up and living in such a constraining environment, teenage mothers nonetheless still need support to promote their health and wellbeing. They also need to be encouraged to return to school and complete their education (Chang'ach 2012:37) because as mothers of young babies they have a multitude demands to meet; caring for babies whether healthy or when sick and sleep deprivation make them not perform well at school (Willan 2013:45). Therefore, teenage mothers need to be supported by parents, family members, the school and the community to accomplish successful transition into adulthood for the attainment of economic self-sufficiency and for engagement in healthy family and community relationships (RNAO 2012:6).

In South Africa, the National Department of Health (DoH 2012:18) implements a number of interventions to improve the state of maternal and child health as well as sexual and reproductive health services. The challenge is that the interventions are mostly centred on

clinical level – health worker training and strengthening of health systems. Ndlebe (2011:13) noted that teenagers were not satisfied with the health services they received at clinics and neither were some aware of their sexual and reproductive health rights. These factors contribute to unplanned teenage pregnancies. The National Department of Higher Education (DoHE) view teenage pregnancy and HIV as a problem that should be concurrently addressed. The more teenage pregnancy the more the spread of HIV infection meaning that the same programmes should be applied for both problems (Panday, Makiwane, Ranchod and Letsoalo 2009:60).

An enabling policy environment has been created to remove barriers to teenage mothers' education. The South African Schools Act (No. 84 of 1996) forbids discrimination in schools in cases of pregnancy and childbirth. However, as indicated by Nkani and Bhana (2016:1), the right to schooling for learner-parents do not automatically translate into better schooling access, more positive school experiences or support as they face obstacles in accessing schools which compromise their educational aspirations. The DoHE recommends the universal implementation of sex education programmes that promote abstinence and safe sex (Panday, et al 2009:26). However, many teenagers who become pregnant fail to return to school post-delivery as a result of the lack of support (Rangiah 2012:38). The DoH points out that a lack of integration at different spheres of government and different levels of care remain a challenge. As a result, there is poor access and poor quality of care, especially in under-resourced rural areas (DoH 2012:18).

Teenagers experience a judgemental approach and punitive responses to pregnancy (Bhana, Clowe, Morrel and Shefer 2008:82). As confirmed by Shefer, Bhana, and Morrell (2013:4), the responses of schools to and experience of learners of parenting and pregnancy indicate it is powerfully gendered as teenage fathers do not take responsibility for the child. The attitudes of clinic staff are often the reason why young people refrain from going to clinics for healthcare as the DoH 2012(13) on National Contraception and Fertility Planning Policy and Service Delivery guidelines reports that only around one third of clinics provide contraceptive options to those seeking contraceptives. In addition, clinic opening hours, waiting time at clinics, concerns around confidentiality, and limited staff knowledge hinder the use of health services by teenagers. In a study by Alli, Maharaj and Vadwa (2012:2), the youth reported fear of the reaction of the healthcare workers at the clinics when they divulge that they were involved in sexual behaviour. Fear of stigmatisation was reported if personal information was not kept confidential.

The Youth and Adolescent Health Policy outlines a range of strategies to address health priorities, including promoting a safe and supportive environment, providing information,

building skills, providing counselling and improving health services (ISHP 2012:31). Further, in South Africa family planning is considered to be the responsibility of a woman. Teenagers are not yet emotionally mature or self-assured enough to make a concrete decision on contraceptive choices and many lack information about access to modern forms of contraception. The National Adolescent Sexual and Reproductive Health and Rights Framework Strategy (NASRHRFS) 2014-19:33) indicates that teenagers need to be equipped with a sense of inner belief, self- and mutual respect and understanding towards their own sexuality including building the skill and capacity to be assertive and exercise self-agency. They also need to make choices to negotiate, make informed decisions about their sexual reproductive health, and to report cases when their sexual rights are infringed or violated.

The researcher suspected that enhancing healthy teenage development may be a particularly challenging endeavour in the resource-poor communities in the Muyexe and Homu 14C villages where the limited infrastructure, an ethnic culture that is not liable to easily be changed, and poor service delivery as a result of limited staff presented great obstacles to a more open-minded approach to teenage motherhood and educational opportunities. Yet, the researcher was acutely aware that there was a definite need for health promotion that is responsive to the situation and environment of teenage mothers in rural villages. It was the researcher's deepest wish to contribute towards guaranteeing these mothers' proper healthcare, equal educational opportunities, reproductive health and choice, and equal job opportunities. The researcher knew well that the influence of registered nurses and their engagement with teenagers and their communities are critically important to change the current situation in the village environment, but was committed to attend to the plight of teenage mothers. The researcher was also convinced that through health promotion, teenage mothers would experience improved health, enhanced functional ability and better quality of life at all stages of their development and transition into adulthood.

1.3 RATIONALE

The problem of teenage pregnancy is noted as the number one reason why female youths drop out of schools (Social Survey 2012:34). According to Malahlela (2012:56), they come to school late, play truancy and sometimes drop out of school. In South Africa, according to Department of Social Development (2014:3), teenage mothers rarely complete high school; they are more likely to be poor adults and rely on being assisted by the state, which also affect their children to suffer the same throughout their lives as adults. Compared to other districts in Limpopo, the incidence of teenage motherhood continues to be disproportionately high in the Mopani District. The district comprises five local municipalities, namely, Greater

Tzaneen, Greater Letaba, Greater Giyani, Ba-Phalaborwa and Maruleng (Mopani District Municipality 2007/8:14). About 90.8% teenagers experience first-time motherhood at 16 years; below 16 years the percentage of teenage pregnancies are 9.2% and of these 71% are unwanted pregnancies (Mopani District Integrated Development Plan [IDP] 2011/14:19).

Living and working in the community, the researcher observed that a large number of teenage girls were pregnant or had babies. The teenage mothers were reported to experience a range of health problems including protein induced hypertension, pre-eclampsia, post-partum haemorrhage, giving birth to premature babies and deliveries through Caesarean section. Teenagers and teenage mothers were found to be sexually abused and the cases were not reported. Most of the teenagers became pregnant while at school and failed to return to school after delivery. During the accompaniment of students who explored the connection between family health and school health, the researcher observed that programmes employed by school health nurses in the schools in the area did not include reproductive and sexual health services.

Education, going to school, schooling – whichever term one uses, socialising with peers, extending one's knowledge and learning new skills and aptitudes in a disciplined and controlled environment such as a school plays a critical role in teenagers' overall health, wellbeing and development into a responsible adult (RNAO 2010:27). The researcher deemed it important for registered nurses to understand all aspects of school health in the rural villages and to work in collaboration with all stakeholders to adequately promote the health and wellbeing of teenagers; specifically, that of teenage mothers.

Ramulumo and Pitsoe (2013:756) report 57 female students at Mavalani Secondary School outside Giyani in Limpopo became pregnant in 2011. The youngest was only 13 years old. These observations made the researcher to have an interest in exploring the problems related to teenage pregnancy. Oyedele, Wrights and Maja (2013:106) found teenagers living in Soshanguve, a township in Gauteng, South Africa, have limited choices to prevent pregnancies as only condoms were encouraged to be used during sexual relationship. Condoms were available but teenagers were not taught how to use it. These researchers also suggest that a different departure point in nurses' counselling of teenagers may provide alternative outcomes to teenage motherhood. This current study built on the work of Oyedele, et al. and sought to develop what Oyedele, et al (2013:107) refer to as "a different departure point" for primary healthcare and, more specifically, for nurses dealing with teenagers in the two rural villages, Muyexe village and Homu 14C village (together with a squatter camp) located in the Greater Giyani Municipality in the Mopani District in Limpopo, South Africa.

There seems to be no clear understanding of the challenges associated with the current health strategies employed by education providers to enhance healthy teenage development and to promote the health and wellbeing of teenage mothers. If these challenges in rural villages continue to be ignored or not understood, failure to change the situation of school dropout, ostracism leading to an unsupportive family or community which leaves vulnerable teenage mothers to virtually carve out an existence for themselves and their infants in any way possible, and a rise in an impoverished, illiterate and disadvantaged next generation will be the inevitable consequences. On the other hand, one must never forget that nursing is a noble profession. Bound by an inner desire to care, cure and alleviate human suffering, emotionally intelligent registered nurses who possess the skills, knowledge and will to promote the health and wellbeing of teenage mothers in a manner that the latter experience as genuine, respectful and caring, will inevitably render positive outcomes for both sides. It could transform the locale and setting from one of disengagement to an understanding and supportive milieu, increase educational opportunities and eventuate life chances for teenage mothers who, in fact, are indeed also mothers who give birth to a future nation (UNFPA 2016:46).

Best practice guidelines are available for enhancing healthy adolescent development (RNAO 2010:7). However, there is a need to further develop these guidelines to be applicable specifically to promoting the health and wellbeing of teenage mothers in rural villages. In this study, the guidelines were developed to transform the current environment in the selected villages from a high incidence of teenage pregnancy and school dropout to an environment that supports healthy teenage development through health promotion and education.

1.4 RESEARCH QUESTION

The study sought to answer the three guiding research questions stated below.

- What are the challenges experienced by the registered nurses in regards to the promotion of health and wellbeing of the teenage mothers?
- What are the barriers experienced by teenage mothers in regards to return to school after delivery of their babies?
- How can guidelines to promote the health and wellbeing of teenage mothers in rural villages of the Mopani District in Limpopo be developed?

1.5 AIM AND OBJECTIVES OF THE STUDY

The aim of the study was:

- To develop guidelines to promote the health and wellbeing of teenage mothers in rural villages in the Mopani District in Limpopo.

The study was conducted in two phases. The specific objectives of each phase are noted below.

Specific objectives of Phase 1 were to:

- Explore and describe the challenges experienced by registered nurses regarding the promotion of health and wellbeing of teenage mothers.
- Explore and describe the barriers experienced by teenage mothers to return to school after delivery of their babies.

Specific objective of Phase 2 was to:

- Develop guidelines to promote the health and wellbeing of teenage mothers in rural villages in the Mopani District in Limpopo.

1.6 SIGNIFICANCE OF THE STUDY

The findings of the study together with the guidelines may contribute to the development of an appropriate and coordinated health promotion strategy in the rural villages of the Mopani District with the focus on creating a supportive environment for healthy teenagers, both boys and girls, so that they know how to prevent teenage pregnancy. In cases where teenagers already have one child, to prevent a second unplanned pregnancy by involving all local stakeholders (registered nurses, local school educators, religious institutions and teenage mothers and their families) in a concerted effort to promote the health and wellbeing of such teenage mothers even more decisively. In Mopani District with its high incidence of teenage pregnancy, being sensitive to the local context is especially necessary when involving local stakeholders to work towards the transformation of the environment of teenage mothers to promote their health and wellbeing. The guidelines developed could be the resources for promoting teenagers' health and wellbeing, their interaction and integration with families, schools and communities, and achievement of the development goals of the province and the country. The guidelines may also contribute to knowledge and education through curriculum development in Nursing Science.

1.7 CONCEPTUAL CLARIFICATION

Rural area

Ngomane (2012:10) defines 'a rural area' as a sparsely populated space where people mostly depend on paring and natural resources for their livelihood. The villages and townships are scattered all over. 'Rurality' refers to the way of life; the cultural state of mind of the inhabitants which revolves around family life, land, livestock, small farming enterprises, and the use of natural resources. This study was conducted in rural areas in the north-eastern part of Limpopo, one of nine provinces in South Africa, which is geographically bordered in the north by Zimbabwe and in the east by Mozambique. The Mopani District spans a total area of 2 242 183 ha (22 421.83km^2), with 15 urban areas (towns and townships) and 325 small villages (Mopani District IDP 2007/8:19).

Health

Referring to health, Pender's (2011:3) view pertains to "inherent and acquired human potential through goal directed behaviour, competent self-care and satisfying relationships with others while adjustments are made as needed to maintain structural integrity and harmony with relevant environments". While Wills (2014: 4) view health as a positive or wellness approach which reflect the ability to do something and not focusing on the absence of disease or illness only. Pender (2011:3) refers to health as a developing life experience. In this study, 'health' refers to a teenage mother who was not suffering from an illness or disease and who had various sources of support from parents and family members at home after delivery of the baby.

Wellbeing

'Wellbeing' is defined as an integral part of health reflecting a person's quality of life and the various factors which influence it over the course of his or her life. According to the Concise Oxford English dictionary (2006:1638), it implies "the state of being comfortable, healthy, or happy". The concept 'wellbeing' encompasses the concepts of positive mental health which assist to make a person realise his or her own ability to cope with the normal stresses of everyday life thereby enabling the person to make a contribution to the community (Health Ireland 2013-25:9). In this study 'wellbeing' pertains to young female teenagers' overall physical and mental welfare (that is, they feel happy, comfortable and experience a sense of 'being fine') during pregnancy, delivery and in the post-natal period.

Registered nurse

A 'registered nurse' is a person who graduated from a nursing college or university where she or he was educated and trained to care for sick and injured people. Registered nurses usually work in health facilities like hospitals, clinics and doctors' consulting rooms (Hamdan and Kawafhah 2015:337). In accordance with the South African Council Nursing Act (No. 33 of 2005), all nursing graduates have to be registered with the South African Nursing Council (SANC) according to their clinical nursing qualification before they may practice as registered professional nurses (SANC 2005:63) In this study 'registered nurses' implies nurses who are registered with the SANC as a nurse, midwife and various clinical specialists such as primary healthcare provider and obstetrics nurse who provide general nursing care and midwifery to all childbearing age groups.

Health promotion

The concept 'health promotion' involves the process of enabling people to increase control over their health and to improve their health. It is a comprehensive social and political process which focuses on the appearance and experience of a person, perceptions and suffering, and the results of their behaviour (RNAO 2010:13). In this study, health promotion is understood as including the physical, psychological and social wellbeing of teenage mothers and the actions directed towards improving their social, developmental and economic conditions. The study also recognises the importance of participation in sustaining health promotion action as recommended by the WHO (2008), cited by Hamdan and Kawafhah 2015:334), which includes creating supportive environments, strengthening community action, developing personal skills, reorienting health services, and moving into the future. The WHO further notes that people must be provided with appropriate information in order to develop healthiness. It further advises that registered nurses are skilled health professionals who are available to introduce information in the form of health instruction, thereby developing a systematic problem-solving approach to improve and develop strategies to promote good health of individuals (Hamdan and Kawafhah 2015:334).

Teenage mothers

Maphoti (2011:18) refers to 'teenage mothers' as young girls who become pregnant before the age of 20; thus, who have children early in their reproductive cycles and are physically, socially, psychologically and emotionally immature to be a mother. Adolescence (a synonym of 'teenager') is defined by the United Nation Population Fund (UNFPA) along with the WHO and the United Nations Children's Fund (UNICEF) as young children between the ages 10–19 (WHO 2010:2). UNFPA (2013:ii) breaks up this age category further by classifying early

adolescence as youths between 10–14 and late adolescence as between 15–19. The National Adolescent Sexual and Reproductive and Rights Framework Strategy (ASRH&R) 2015:17) aligns 'teenage mothers' with the aforementioned 10–19 categories as well as embracing the breakdown of this category. In this study, teenage mothers who participated in the study were between 18 and 21 years as recommended by the Research Ethics Committee of the University of Pretoria.

1.8 RESEARCH PARADIGM AND PHILOSOPHICAL ASSUMPTIONS

A paradigm is a worldview; it is a general perspective on the complexities of the real world we live in (Polit and Beck 2012:11). Christensen, Johnson and Turner (2011:10), noted a paradigm as a framework of thoughts or beliefs by which reality is interpreted and also reflect responses to basic philosophical questions.

The chosen research design for this study fell within the naturalistic paradigm, also known as the constructivist paradigm, which is based on the belief that reality is not a fixed entity, but is a construction of the input of peoples' participation in a research study. The naturalistic paradigm takes the position of contingency. If there are multiple interpretations of reality which exist in people's minds, then there is no process by which the ultimate truth of the construction can be determined. In this study, multiple interpretations of the reality of registered nurses and teenage mothers were made. Polit and Beck (2012:12) further assumes that knowledge is maximised when the distance between the inquirer and those under study is minimised in naturalistic paradigm. In this study, a self-report inquiry was done. Polit and Beck (2012:742) define self-report as a method of collecting data that involves a direct verbal report of information by the person who is being studied.

The rationale for choosing this method was that the voices and interpretation of the study participants were crucial to gain understanding of the phenomenon of interest and subjective interactions were the primary way to access them. The findings were the product of the interaction and inputs between the researcher and the participants in a qualitative study which is in line with naturalistic inquiry.

In the next section, the philosophical assumptions relevant to this study are described. Philosophical assumptions are "embedded in thinking and behaviour and therefore influence the development and implementation of the research process" whereas assumptions refer to "basic principles that are accepted as being true based on logic or reason without a proof" which is adherent to positivism. Positivism assumes that nature is basically ordered and regular and that an objective reality exists independent of human observation (Polit and Beck 2012:12).

Ontological assumptions

Following the naturalistic paradigm, the relevant question to be answered is, 'What is the nature of reality?' Polit and Beck (2008:14) agree that the nature of reality in the ontological assumption is multiple, subjective and is mentally constructed by people who construct their own reality by associating certain meanings with certain events. The inquirer assumes that different realities exist for different people, and that meaning is constructed by people about people and through people and the way these people interact with the world around them (Polit and Beck 2012:11). With regard to the current study, the ontological assumption the researcher made regarding the teenage mothers was that they constructed meaning from the rurality of their environment; likewise, registered nurses, educators and families constructed their own meaning of teenage motherhood. It was therefore important to investigate the meanings constructed by different participants in order to develop guidelines for the implementation of health promotion strategies, programmes and practices.

Epistemological assumptions

Botma, Greef, Mulaudzi and Wright (2010:40) define epistemology as the branch of philosophy that focuses on the nature of knowledge and evidence generated from that knowledge. Epistemology is the knowledge about reality; it suggests asking the rhetorical question, 'how we come to know reality' and is related to the inquirer's relationship to the people being investigated. The findings of the inquiry are therefore the creation of an interactive process since the process explains the actual developments during the data collection and analysis processes of the study (Polit and Beck 2012:11,13). The current researcher built an understanding of the recent practices, programmes and strategies of registered nurses and nurse educators in their response to teenage motherhood.

Theoretical assumptions

The study was guided by the revised health promotion model (HPM) of Pender (2006:50), cited in as it focused on health promoting behaviours by using the concepts of 'health' and 'wellbeing' to find answers to the research question (George 2011:546). The model entails activations directed towards developing guidelines to enhance teenage mothers' health and wellbeing in their local rural environment. The model fits well within the naturalistic paradigm as substantiated below as well as the diagram that shows Pender's revised Health promotion model.

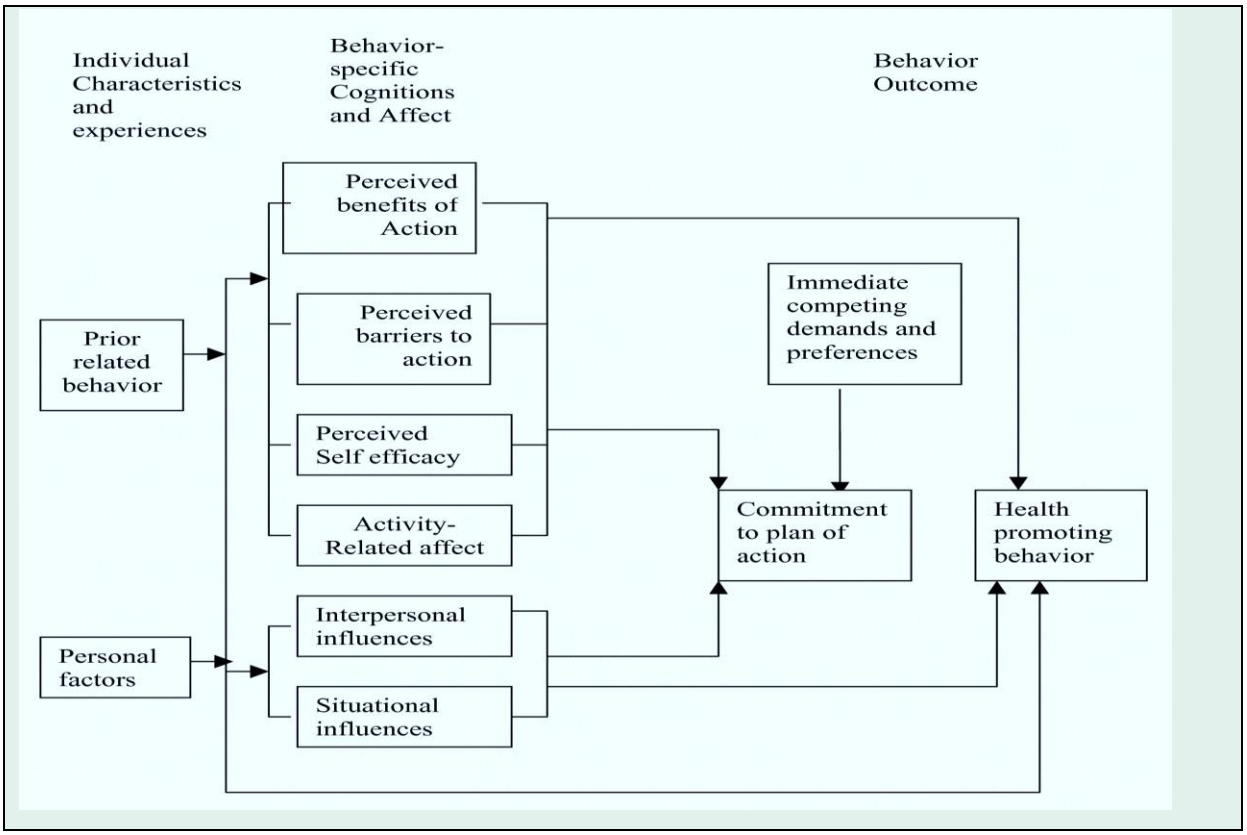

Figure 1.1: Pender's Health Promotion Model

This Model was revised in 2002 by Pender, Murdaugh and Parson George (2011:546). They also noted the revised HPM which consist of seven assumptions. These assumptions were used in this study by the researcher as were relevant to the study. The Pender's assumptions are as follows:

The first assumption: Pender (2011:3) stated that "Individuals seek to create conditions of living through which they can express their unique human health potential". The researcher viewed this assumption relevant to the study as teenage mothers may be given the opportunity for open communication in their own environment which exclude adult pregnant women if they can trust health service providers (RNAO 2015:24).

The second assumption: Pender (2011:3) stated that "Individuals have the capacity for reflective self-awareness, including assessment of their own competencies" After the teenage mothers dropped out from school, they were still willing to return to school after assessing their own competencies and believed they can make it when an opportunity can occur. However, they faced a delay in returning to school as they were expected to raise their babies prior returning (Thobejane 2015:274).

Third assumption: Pender (2011:3) indicated that “Individuals value growth in directions viewed as positive and attempt to achieve a personally acceptable balance between change and stability”. Through health education and challenges experienced by teenage mothers, the researchers believes these could implant positive attitudes and make teenage mothers value their return to school (Fasoranti, et al 2015:225).

Fourth assumption: Pender (2011:3) stated that “Individuals seek to actively regulate their own behaviour”. Indeed, if the teenagers could be well informed about contraceptives, they may have positive attitudes and regulate own behaviour, thus reducing the rate of pregnancies.

Fifth assumption: Pender (2011:3) also reflected that “Individuals in all their bio-psychosocial complexity interact with the environment, progressively transforming the environment as well as being transformed over time”. Teenage mothers being aware of the environment, in which they were affected, may stimulate them to change and improve their own health and behaviours (Shahroodi, Amin-Shokravi, Haidarnia and Nooghabi 2013:58).

Sixth assumption: Pender further stated that “health professionals, such as nurses, constitute a part of the interpersonal environment which exerts influence on people through their lifespan”. The researcher believes that if teenage mothers are encouraged and provided with the support they need, this may change their health behaviours and improve their health (Nkani and Bhana 2016:2).

Seventh assumption: Pender stated that “Self-initiated reconfiguration of the person-environment interactive patterns is essential to changing behaviour”. The peer group influence of teenage mothers in their environment may bring something that they have initiated by themselves (George 2011:546).

In this study, it was argued that, healthcare providers such as registered nurses can improve programmes to improve teenage mother’s health and develop strategies to promote wellbeing for all female teenagers as they constitute part of the interpersonal environment which could exert influence on the latter’s lifespan.

1.9 CONCEPTUAL FRAMEWORK

A conceptual framework is a set of highly abstract and related constructs which broadly explain phenomena of interest, express assumptions and reflect philosophical bearing (Grove, Burns and Gray 2013:689). The current study was rooted in a specified conceptual

model, namely the revised health promotion model of Pender (2006) of which an overview is given in the next section.

1.9.1 Overview of the model

Nola J. Pender, emeritus professor at the nursing school of the University of Michigan in the USA, published her health promotion model in 1982. She revised it in 1996 to be a complementary counterpart to models of health promotion. Foregrounding health as a positive dynamic state rather than simply the absence of disease, the revised model is directed at increasing a person's wellbeing (Guedes, Moreira, Cavalcante, Araujo and Ximenes 2009:774; George 2011:545). This health promotion model (HPM) describes the multidimensional nature of persons as they interact within their environment to pursue health. The authors Hamdan and Kawafha (2015:346) indicate that factors derived from the HPM predominantly centre on a person's lifestyle such as psychological health, social and cultural aspects as well as biological factors. Subsequently, according to Pender's health promotion model, pursuing health is a unique approach to attain good health and maintain a satisfying, balanced lifestyle (Hamdan and Kawafha 2015:346).

As indicted by Pender (2011:3), Pender's health promotion model focuses on three major concepts of health promotion, namely:

- individual characteristics and experiences
- behaviour-specific cognitive and affect
- behaviour outcome

RNAO (2010:13) defines health promotion as the process of enabling people to increase control over and promote improvement of their health by increasing their level of wellbeing and self-actualisation or by including health education, identification and reduction of health risks for selected individuals and populations. The RNAO also indicates that this could be achieved through empowerment advocacy, preventative healthcare and health policy development. The researcher in this study believed that these could go beyond healthy lifestyle to wellbeing. The stance of McQueen and De Salazar (2011:ii,195) is that when embedded in the provision of information on health as well as the provision of education on health and the enhancement of life skills, health promotion supports personal and social development. These authors state approaching health promotion in this way increases the options available to people to exercise more control over their own health, their own environment, and assists them in making choices more conducive to their own health. The redistribution of power over one's health and wellbeing therefore requires prioritising a

health promotion process suitable for personal and societal empowerment and development (RNAO 2010:13). Pender's health promotion model – which focuses on empowering the person and augmenting the environment in pursuit of sustainable health – was found an appropriate conceptual framework for the development of guidelines to promote and maintain the health and wellbeing of teenage mothers in the study setting. Next, consideration is given to the three major concepts of Pender's health promotion model.

- The first major concept is the "individual characteristics and experiences or combination of them which varies with the behaviours under consideration". The combination of individual characteristics and experiences is unique to each person. Guedes, et al (2009:773) stated that it comprises prior related behaviours which are important as the individual's previous habits related to the search for health is linked to the idea that personal factor and experiences affect the actions of nurses. Therefore, in nursing, previous experience is the standard condition that influences intervention or may interfere directly in individual behaviour in order to promote health and personal factors is described as biological, psychological and sociocultural (George 2011:548).

- The second concept according to Pender's model is "behaviour-specific, cognitive and affect which consists of perceived benefits of action, perceived barriers of action, perceived self-efficacy, activity related affect, interpersonal influences and situational influences", commitment to plan of action, and immediate competing demand (Brouwers, Kho Browman, Cluzeeau, Feder, Fervers, et al 2013:38).

- The third major concept is described by Pender (2011:4) as "the behavioural outcome or health promoting behaviour that is the desired behavioural end point or outcome of health decision making and preparation for action".

All these concepts may contribute to health promotion behaviour as well as enhance functional ability and better quality of life at all stages of development (Pender 2011:4). These behaviours should result in improved health. More details of this model will be discussed in Chapter 4.

1.9.2 Alignment of Pender's revised model with naturalistic study design

In line with the selected study design, the rationale for choosing the model was to assist nurses in understanding the major determinants of health behaviours as a basis for behavioural counselling to promote a healthy lifestyle. At a young age Pender believed that

"the goal of nursing was to help people care for themselves" (Sakraida 2010: 434). The naturalistic design of this study emphasised the inherent complexity of humans, their ability to shape and create their own experiences, and the idea that truth is a composite of realities (Botma, et al. 2010:50). Naturalistic studies are heavily focused on understanding the human experience as it is lived; understanding is usually derived through the careful collection and analysis of qualitative materials that are narrative and subjective (Polit and Beck 2012:14).

Aligning Pender's revised model with the naturalistic study design helped in the provision of new insight on the promotion of health and wellbeing. According to the Ottawa Charter of Health Promotion (1999/2017:1), models help researchers to determine the phenomenon under study and this process enables people to increase control over and improve their health. This is seen as a resource for everyday life. Pender's model helped the current researcher to develop guidelines to promote the health and wellbeing of teenage mothers and their return to school. Her impression behind the model is assisting teenage mothers as well as teenagers to change their lifestyles and progress toward a state of ideal health. In this study, the researcher seeks a way of finding a means to attract teenagers to change unhealthy habits for healthy ones.

Responsible decision making was made based on this model. The HPM provides steps with which a person can pursue better or ideal health following constructivist paradigm that hold in multiple interpretation of reality (Polit and Beck 2010:724). De Vos, et al (2011:7) viewed constructivist researchers emphasised the dynamic, holistic and individual aspects of human life and attempt to capture those aspects in their entirety within the context of those who are experiencing them. The current participants became actively involved in all the phases of the process of data collection to seek understanding of the world in which they lived.

The researcher views teenagers as holistic beings who are growing and still developing. Their experiences regarding pregnancy, giving birth and during their return to school need to be understood. They also needed to be empowered with knowledge of reproductive health. The researcher viewed the health promotion model as relevant to the study as it aimed to present ways of changing teenage mothers' approach to health promotion by giving them the power to make choices that would benefit their health, wellbeing, development and resiliency. More reasons were provided in Chapter 2.

1.10 RESEARCH DESIGN AND METHODOLOGY

The study was divided into two phases. Phase 1 comprised of the empirical phase and Phase 2 involved the development of guidelines.

PHASE 1: EMPIRICAL PHASE

A qualitative descriptive exploratory design was followed (Polit and Beck 2012:739). The population was all registered nurses employed in the community hospital, primary healthcare centre (PHC), clinics and visiting points. All pregnant teenagers and teenage mothers who visited the selected healthcare institutions were included as population.

For this study, two institutions in two villages at Greater Giyani Municipality in the Mopani District in Limpopo were purposively selected. The institutions were situated at Muyexe village and Homu 14C. The latter has a squatter camp adding to the population. The Mopani District Integrated Development Plan 2011-2016 (IDP 2011/2016:13-4) informs that Giyani is the only town in this northern area of the Mopani District. The economy consists of both formal (shopping centres for retail development; municipal services and transport also offer employment opportunities) and informal activities (which are mostly small-scale agriculture like maize and vegetables). According to the Provincial "War-room on poverty 2009" (2009:37), the following has been identified as the most poverty-stricken communities in the Greater Giyani Municipality: Muyexe (population of 2 356), Gaula (population of 2 684), Khakhala (population of 2 314) and Muyexe North (population of 893). The villages span a total of 8 247 residents as per 2003 data. There is only 48.2% of the population who are economically active. Giyani has a large number of scattered rural settlement which are un-accessible due to poor road conditions resulting in less economic development. Greater Giyani Municipality has an average number of 2 639 people per settlement (Mopani District IDP 2011/2016:64)

Mopani District IDP (2013/2014:122) reported that there is only one specialised hospital, 1 district hospital, 24 health centres, clinics and gateway clinics, mobile clinics for the visiting points. Some of the institutions functions for 24 hours but are understaffed and have insufficient work materials and medication. There is a problem of poor water supply. One clinic caters for about 9 526 people and transport is a great problem.

Purposively selected participants for the study sample included registered nurses, who were purposively chosen from the healthcare worker corps providing health services, and pregnant teenagers as well as teenage mothers who resided in the two villages which were also purposively selected. The researcher visited the villages during accompaniment of students to do family studies and environmental health. The researcher shares the language of Xitsonga with the population for better understanding of each other. Having knowledge of the population allowed the researcher to hand-pick the cases to be involved in sampling.

The study enabled participants to share their experiences on the challenges regarding the promotion of health and wellbeing of teenage mothers and barriers experienced by teenage mothers to return to school after delivery of their babies. Data was collected from the various categories of participants by means of interview guides. In-depth interviews were completed with the participants. Having face-to-face conversations ensured flexibility during the interview process; it also enhanced free interaction between the researcher and the participants. All interviews were audio recorded with the consent of the participants. Transcripts of interviews that were recorded in Xitsonga, were translated by the researcher who was a Mutsonga as she had an opportunity of understanding Xitsonga as well as English.

Verbatim transcriptions of the audiotapes were done to ensure accuracy of transcriptions and that they genuinely reflected the experiences of the participants. The transcribed data was organised and kept separately in different data sets (Creswell 2009:186). The Tesch's method of analysis was utilised to generate themes, subthemes and categories. Some conclusions were drawn. For more details of the research method refer to Chapter 3.

PHASE 2: DEVELOPMENT OF GUIDELINES

Guidelines are systematically developed document designed to help healthcare for specific circumstances, making an agreement about healthcare and assist policymakers with informed decision to improve quality, appropriateness and cost-effectiveness (Brouwers, et al 2013:1). In this study, the objective of Phase 2 was to develop guidelines based on the findings of the analysed data of the empirical phase and Pender's health promotion model to promote health. The population comprised of experts in various health sectors. The sample included nurse educators, nurses who are registered as a nurse, midwives, obstetricians and advanced midwives, who dealt with mother and child health or reproductive health and who had at least five years of experience in the field of nursing.

The Delphi technique was used in this phase to gather data (Linstone and Turoff 1975:3). With this technique, the opinions of a group of experts within their domain of expertise were obtained without them meeting physically; anonymity is thus guaranteed. It was a systematic forecasting method that involved structured interaction among a group of experts on the subject. The Delphi Technique was conducted using experts who answered the questions and gave justification for their answers, providing the opportunity between rounds for changes and revisions (Burns and Grove 2005:407). In this study, a series of questionnaires were used to aggregate experts' opinions and built on the responses received to reach consensus on the guidelines for registered nurses (De Villiers, De Villiers and Kent

2005:639; Hsu and Sandford 2007:2). Adherence to criteria such as validity, reliability, clarity, applicability, and acceptability ensured trustworthiness in Phase 2 of the study.

Round 1: The first questionnaire survey allowed the group of expert participants to privately express their opinion on each guideline. These opinions were then incorporated into the guidelines.

Round 2: The revised set of guidelines was then circulated again to allow participants to rank their agreement with these guidelines.

Rounds 3 The results of Round 2 were summarised and some discrepancies were found to exist between reviewers, the questionnaire were circulated to all participants with a revised version of the questionnaires. The questionnaires were then circulated for the third round of rankings. Otherwise, the final rankings were summarised and assessed for the degree of consensus. During the third round, that is where the consensus was reached. Feedback was given to the participants and their participation was acknowledged.

The data was analysed in an intelligible, interpretable form to make inferences from the suggestions. The process was repeated continuously until consensus was reached on the quality and content of the guidelines (Habibi, Sarafrazi and Izadyar 2014:12). A detailed discussion of the guideline development is presented in Chapter 4.

1.11 ETHICAL CONSIDERATIONS

Polit and Beck (2012:727) define ethics as the system of moral values that is concerned with the degree to which research procedures adhere to the professional, legal and social obligations to the study participant. This study also considered the regulatory prescripts of South Africa by asking permission from relevant authorities to conduct the study. According to De Vos, et al (2011:114), ethics implies preferences that influence the behaviour in human relations conforming to a code of principles, the rules of conduct, the responsibility of the researcher, and the standards of conduct given to the profession generating evidence based on the findings of data. Codes of ethics are the ethical rules and principles drafted by professional associations that govern scholarly research in the various disciplines (Creswell 2009:227). The current study was essential to generate a sound evidence-based practice for nurses. The code of conduct provides guidelines for protecting the rights of human subjects in biological and behavioural research; therefore, the researcher and the reviewers of research have an ethical responsibility to protect the rights of human research participants (Grove, et al 2013:159). The following principles of ethics were upheld in this study: beneficence, respect for human dignity and justice.

Beneficence

Beneficence imposes a duty on the researcher to minimise harm and maximise benefits described by Polit and Beck (2012:152). This principle covers multiple dimensions: the right to freedom from harm and discomfort, the right to protection from exploitation, respect for human dignity including the right to self-determination and the right to full disclosure. It requires a researcher to do good and not to harm (Grove, et al 2013:174).

- **The right to freedom from harm and discomfort**

The responsibility of the researcher is to minimise harm from the participants by asking permission and explaining expectations prior data collection (Polit and Beck 2012:152). In this study, the researcher ensured that the participants were not subjected to unnecessary risks associated with physical and psychological harm. Every participant was fully informed about the impact of the investigation as a way of offering an opportunity to withdraw without prejudice if she wished to do so. To prevent participants from psychological harm, the researcher made a point of eliminating vulnerable participants whom she believed would be too emotional to be interviewed. To exclude this kind of emotions, the researcher used an age criterion for participants to be between 18- and 21-years-old and also did not include anybody from child-headed households in the selection of participants (De Vos, et al 2011:115). Local schools and families of teenage mothers were also excluded. The reason for these exclusions stemmed from the recommendation made by the Research Ethics Committee of the University of Pretoria that the researcher should not focus on groups which included schools, governing bodies, educators and families but that the focus should be on the health institutions and their clients only. Sensitive questions were not asked during the face-to-face interviews with the participants to prevent possible psychological harm.

- **The right to protection from exploitation**

This implies that the participants in the study should not be exposed in any disadvantageous position (Polit and Beck 2012:153). Discomfort and harm can be physical, psychological, social and/or economic in nature and should be prevented at all cost (LoBiondo-Wood and Haber 2010:253; Grove, et al 2013:174). In this study participants were informed that confidentiality would be maintained as information obtained would not be used against them. They were further informed that follow-up questions may be done during and after analysing the data to verify and validate the data. Participants gave their contact numbers as an indication of their agreement to participate.

Respect for human dignity

This principle includes the right to self-determination and the right to full disclosure.

- **The right to self-determination**

Human beings should be treated independently without forcing them to do anything. Prospective participants decided to take part voluntarily in the study other than declining participation (Polit and Beck 2012:154). Regarding self-determination, Grove, et al. (2013:164) assert that humans are free to control their destinies. Participants in the current study received information on the study before their participation, and their consent was obtained before involving them in the study. They were assured that their participation was voluntary and they could decide whether they wanted to share information or not. Since they were not coerced to participate but made the choice willingly, they were informed that it was their right to withdraw from the study at any time without stating a reason (Grove, et al. 2013:164). The researcher provided each participant with all the necessary and required information to help them make an informed decision on participating in the study or decline participation. All information related to the reasons for the study, the study process, their role therein and so forth was made available on an information leaflet. All are discussed below:

- **The right to full disclosure**

Polit and Beck (2012:154) define full disclosure as meaning that the researcher has fully described the nature of the study to the participant, the person's right to refuse to participate, the researcher's responsibilities, and the risks and benefits involved in participation. The researcher of the current study provided all the information about the nature of the study to the participants to ensure that they made an informed decision. The researcher also explained to every participant that no answer would be judged as right or wrong because all answers were acceptable and valued.

The principle of justice

This principle of justice encompasses the participant's right to fair treatment and the right to privacy (Polit and Beck 2012:154).

- **Right to fair treatment**

Based on the principle of justice, people should be treated fairly. LoBiondo-Wood and Haber (2010:25) include fair treatment during the selection of participants for reasons directly related to the problem studied and fair distribution of risks and benefits regardless of age,

race or socioeconomic status. Participant selection was based on study requirements and not on the vulnerability of the group. All participants as well as the persons who refused to take part in this study were treated fairly, equally and not forced to participate. The privacy of the participants was maintained at all times and no names were mentioned in any of the interviews or materials containing collected data; hence, anonymity and confidentiality were guaranteed. Teenage mothers who were under the age of 18 were also not included for the interviews. Local schools and families of teenage mothers were also excluded as for reasons mentioned under the heading (Grove, et al 2013).

- **Right to freedom from harm**

Measures taken exclude vulnerable persons. The intent of this study was to benefit the teenage mothers' health and wellbeing thereby invigorating and motivating them to return to school. After ensuring that every participant understood the information with regard to the study that the researcher had explained, the researcher requested each participant to sign an informed consent form before beginning with the interview. All the participants signed this form (Refer to Annexure E).

Consent and approval from the Faculty of Health Sciences Research Ethics Committee University of Pretoria (Refer to Annexure A), Department of Health Ethics Committee Limpopo Province, Polokwane (Refer to Annexure B), Giyani District office (Refer to Annexure C) and the Chief Executive Officer of the Giyani District hospital were obtained (Refer to Annexure D).

- **Right to privacy**

Polit and Beck (2012:156) define the right to privacy as the freedom of an individual to determine the time, extent and general circumstances under which private information is shared or withheld from others. In this current study, these occurred during data collection when invasive questions that may result in loss of dignity, embarrassment and mental distress were avoided by the researcher (LoBiondo-Wood and Haber 2010:252). The participants in this study were informed that confidentiality would be maintained. Permission to conduct the study was also obtained from the Ethics Committee of the Limpopo Provincial Office as well as the Limpopo Department of Health. The permission granted was submitted to the Board of Directors of the hospital of each of the two selected hospitals and the primary healthcare centre senior managers where data was collected.

1.12 ORGANISATION OF THE STUDY

The study report was organised as follows:

Chapter 1: Introduction and orientation to the study
Chapter 2: Research design and methodology
Chapter 3: Data analysis, discussion of findings and literature control
Chapter 4: Discussion of empirical findings of research with reference to Pender's revised health promotion model
Chapter 5: Development of guidelines for promoting health and wellbeing of teenage mothers in Mopani District, Limpopo
Chapter 6: Review of the findings, validation and description of the guidelines with applicable recommendations, limitations, implications and conclusions

1.13 CONCLUSION

The aim of this study was to develop guidelines to promote the health and wellbeing of teenage mothers in rural villages in the Mopani District in Limpopo, one of the nine provinces in South Africa. In this chapter, the reason for conducting this study was introduced and some national and international information on the promotion of health and wellbeing among teenage mothers were provided. The research question, aim and objectives and significance of the study were noted. Key concepts related to the study were clarified. The research paradigm and ontology and epistemology as the philosophical assumptions relevant to the study were described. Theoretical assumptions were explained guided by Pender's revised health promotion model (HPM). The conceptual framework was used to explain the phenomenon of interest. It was shared that the study was conducted in two phases. It was noted that Phase 1 was the empirical study and the Delphi technique used in Phase 2 was briefly explained. Ethical considerations adhered to in the study were thoroughly addressed and confirmed. The organisation of the report was stipulated. Chapter 2 comprises a comprehensive discussion of the methodology used in this study.

CHAPTER 2
RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

In Chapter 1 an overview of the challenges experienced by teenage mothers was given. The goal of this chapter is to provide an overview and rationale for the research methodology applied in the study. The research was conducted in two phases. The specific objectives of each phase are described next.

2.2 OBJECTIVES

The specific objectives of Phase 1 were to:

i. explore and describe the challenges experienced by registered nurses regarding the promotion of health and wellbeing of teenage mothers
ii. describe the barriers experienced by teenage mothers to return to school after the delivery of the baby

The specific objective of Phase 2 was to:

develop guidelines to promote the health and wellbeing of teenage mothers in rural villages in the Mopani District in Limpopo.

2.3 RESEARCH DESIGN AND METHOD

According to Polit and Beck (2012:733), research methods are steps, procedures and strategies for gathering and analysing data in a study. In this study, the research methodology referred to the research process and the logical sequence in which it was applied to support the study. The main focus of this study was to explore challenges experienced by nurses and teenage mothers on the latter's health and wellbeing.

Polit and Beck (2012:741) define the research design of the study the overall plan for addressing a research question, including specifications for enhancing the study's integrity.

The research design falls within the naturalistic paradigm where reality is not a fixed entity, but a construction of the individuals participating in the research. An exploratory and descriptive qualitative study was used with a specific population to understand the needs for, desired outcome of or views on appropriate interventions held by participants. The goal was to create guidelines for nurses to benefit the population. The researcher used an exploratory and descriptive qualitative study to identify the specific lack of knowledge that can be addressed only through seeking the viewpoints of people most affected; in the case of this study the affected people were teenage mothers (Grove, et al 2013:67). There were multiple interpretations of the reality by registered nurses and teenage mothers.

The qualitative method was selected as the most relevant research design for investigating the research topic. This method was chosen for its flexibility and for allowing the researcher to make a number of up-front decisions about the data collection. These two aspects assisted with developing a rich understanding of the phenomenon as it exists in the real world (Polit and Beck 2012:481; Creswell 2009:173). The evidence was subjective as it was based on the experiences and opinions of individuals. The emergence of the researcher's understanding was grounded in the responses of the participants to the research questions.

The research was conducted in two phases. Phase 1 constituted of the empirical phase – the researcher used interviews and observations to measure the real or factual world of participants. Phase 2 focused on the development of guidelines to promote the health and wellbeing of teenage mothers in Mopani District, Limpopo.

PHASE 1: EMPIRICAL PHASE

2.3.1 Research methods

A qualitative, exploratory and descriptive design was used to conduct this study.

- **Qualitative design**

Qualitative research is defined by Polit and Beck (2012:739) as the investigation of phenomena typically in an in-depth and holistic fashion through the collection of rich narrative materials using a flexible research design which is useful in nature to investigate little understood phenomena. In Creswell's (2009:4) opinion a qualitative design is a means of exploring and understanding the meaning individuals or groups ascribe to a social or human problem. The process of research involves emerging questions and procedures with data typically collected in the participants' setting. The researcher collected narrative

information from the participants through observation, description and documentation of the situation as it occurred.

- **Exploratory design**

Exploratory design is research conducted on a problem that has not been studied extensively. This specific design is used to shed more light on the various ways in which the phenomenon manifests and its underlying processes (Polit and Beck 2010:22). An exploratory design is used to increase knowledge among the study population; it is not intended for generalisation to the larger population, but to provide the basis for confirmatory studies. In the current study, the researcher used this method because of its flexibility and broad contingencies that posed decision opportunities planned in the study. The researcher explored the challenges experienced by registered nurses regarding the health and wellbeing of teenage mothers in the manner it manifested in the community where they lived. The researcher had little understanding of the phenomenon and she therefore undertook the study to gain insight into the situation as it existed in the specific community. The necessity to conduct this study arose because the researcher observed there was a scarcity of basic information on the phenomenon. She desired to get acquainted with the situation so as to formulate guidelines to promote the health and wellbeing of teenage mothers in the Mopani District in Limpopo (De Vos, et al. 2011:95).

- **Descriptive design**

The descriptive design is typically used in a research study of which its main objective is to provide accurate representation of the population and circumstances as they occur (Polit and Beck 2010:22). Descriptive research focuses on the careful description of people's experiences in their own environment. The purpose of using a descriptive design was to observe and listen carefully to the challenges experienced by teenage mothers during pregnancy, labour and post-delivery as well as the barriers they encounter when returning to school. Because the researcher investigated a phenomenon about which very little was known, she made use of thorough probing during the data collection process. By obtaining a comprehensive understanding of the characteristics of the real-life situation the teenage mothers had to endure, the researcher was enlightened to truthfully document the aspects of their situation as it naturally occurred. The acquired new knowledge and valuable insight gained served as the starting point for developing the guidelines.

2.3.2 Study context

The study context for the empirical study was the rural villages of Mopani District, in the Greater Giyani Municipality which was demarcated into 30 wards during the proposal but at the time of study it had 31 with 60 councillors. There were 10 traditional authority areas comprising 91 villages then and at time of study it comprised of 93 villages and one urban area (Mopani District Municipality [MDM] 2016/2017:31).

At the time of the study, Mopani District Municipality (2007/2008:41) reported that healthcare services in the Greater Giyani Municipality were rendered by:

- one district hospital
- two health centres
- 17 clinics
- 10 satellite clinics (one was recently officially opened as the Muyaxe Clinic)
- four mobile clinics.

The incidence of teenage pregnancy in the Greater Giyani Municipality is exceptionally high. In one of the secondary schools, 57 teenagers were reported pregnant in the first nine months of 2013 which lead to the rampage of leaners destroying property, accusing the principal for reporting the incident (Ramulumo and Pitsoe 2013:256).

2.4 DESCRIPTION OF THE POPULATION

Polit and Beck (2012:738) define the population as the entire set of individuals or objects having some common characteristics while sampling is referred to as the process of selecting a portion of population to represent the entire population. According to Mopani District Municipality Integrated Development Plan (MDMIDP) (2011-2016:79). Greater Giyani is the most polluted in the district with a lot of shacks and open fires caused by uncontrolled and unlicensed street vendors. There are three informal settlements with 1 134 dwellings that are without access to basic services like water, sanitation and waste removal. In this study, two villages were purposively selected in the Greater Giyani Municipality, namely Muyexe and Homu 14C village with its squatter camp known as Hluphekani. The reason for selecting these specific villages was that when the researcher did student accompaniment in the different villages, she observed the incidence of teenage pregnancy and teenage motherhood were extraordinarily high in these areas.

Muyexe is one of the rural villages in Giyani District which was identified and declared by President Jacob Zuma as one of poorest village in South Africa. It lacks basic services such as water, electricity, sanitation and proper housing (Bila 2013:3). There is one high school and one primary school. In both schools, the researcher saw a high number of pregnant teenage girls. The researcher further noted most of the teenage mothers never returned to school. These two observations motivated the researcher to explore and describe ways to support health promotion among teenage mothers and find ways of encouraging them to go back to school. Pregnant women living in Muyexe depended on the nearby village clinic for the delivery of their babies. Access to health services was poor and as a result of poor transportation, pregnant women about to give birth were bound to walk to the clinic in the nearby village whether by day or at night to give birth. This led to some teenage mothers giving birth at home without medical assistance. It used to be only a visiting point but, fortunately, during data collection, the visiting point Muyexe was upgraded and opened officially as a clinic in the village.

Homu 14C with its squatter camp known as [Hluphekani] was the other village purposively chosen for data collection. It is situated near the Giyani township. The village is overpopulated as a result of the nearby squatter camp. People live in extreme poverty because the unemployment rate is very high. Poor sanitation and waste products strewn all over make the environment unhygienic and unsanitary. There is no clinic and the villagers depend on a mobile clinic and the nearby health centre in Giyani township for healthcare services which leads to the continuous overpopulation of patients at the health centre in Giyani township.

Participants were purposively selected from two healthcare institutions: the district hospital, the health centre and the satellite clinics in Muyexe which was a drop-in then and the mobile clinic in Giyani township that the inhabitants of these two villages frequented. (Refer to Sections 2.3.3 and 2.4).

2.4.1 Population

The population in some research studies used as the ‘target population’ is the entire group of people or set of objects, events or substances sharing common characteristics and, provided that they meet the sample criteria, are considered for inclusion in a research study (Grove, et al 2013:703). In the current study, the population included all registered nurses employed by the community hospitals who worked in the maternity unit, the primary healthcare centre and chosen health clinics in the Greater Giyani Municipality in the Mopani District in Limpopo. All

teenage mothers in the two villages who met the criteria and visited these institutions constituted the population of choice.

2.4.2 Sampling

Sampling is the process in which the researcher selects certain percentages of the population to represent the entire population under study (Polit and Beck 2012:567). Sampling further refers to selecting groups of people, events, behaviours or other elements with which to conduct a study (Grove, et al 2013:703). In this study, purposive sampling – sometimes referred to as the judgemental sampling technique – was used as the sampling method to select participants. The researcher consciously selected participants whom she believed would provide information relevant to the central focus of the study. For participation in the study, the researcher identified registered nurses who met the selection criteria (refer to Section 2.3.3). Female and male registered nurses, who had three years' experience working as midwives in the maternity unit at the district hospital where they assisted with complicated deliveries and to which first-time pregnant teenagers presenting with complications were referred to for delivery, were selected also as participants. The sample further included registered nurses who worked in the PHC health centre and clinic at the local village visiting point before it became a clinic. All these clinics provide comprehensive health services in Greater Giyani Municipality, Limpopo. Pregnant teenagers as well as teenage mothers who were between the ages 18 to 21 and who lived in either Muyexe village or Homu 14C village were selected from each health institution.

The researcher consciously selected fifteen (15) registered nurses and fifteen (15) teenage mothers who met the criteria as participants. These individuals were the unit of analysis, irrespective of the institutional affiliation of the person (LoBiondo-Wood and Haber 2010:113). The participants were invited to participate in individual interviews which would be conducted in the clinic settings. The researcher visited the institutions a week before commencement of the interviews to meet with management and make arrangements for an interview room as well as with the registered nurses, pregnant teenagers and teenage mothers.

The manager of each clinic was met and permission letters were submitted from the Research Ethics Committee of the University of Pretoria and the Provincial Department of Health requesting permission to conduct the study. Permission was granted by both bodies. A free room was designated in every institution where the researcher would meet with the individual participants. Participants were readily available since the registered nurses were

working there and the teenagers visited the clinics for under-five-years' immunisations or antenatal care.

Using the content of the informed consent form as a guide, the researcher read and explained the reason for the study, the process and what the role of the participant would entail (Polit and Beck 2012:158). It was explained that participation was totally voluntary and the participants were assured it was permissible to terminate participation any time they chose to do so without prejudice and without stating a reason (Brink 2009:38). Anonymity and confidentiality were guaranteed as no names would be used or written down anywhere. Participants who were interested were given consent forms to complete. Questions were answered and additional information was added on request. Each participant's contact details (cellular or home telephone numbers) were written on their consent forms to enable the researcher to timeously confirm their availability on the interview date. The selection of participants continued until 15 suitable registered nurses and 15 teenage mothers who were willing to participate had been chosen and handed their signed consent forms (Grove, et al 2013:181).

Obtaining the participants' experiences of the topic under study was essential. As registered nurses and teenage mothers who had first-hand knowledge of the phenomenon, their verbal reports were decidedly valuable to promote the health and wellbeing of all teenage mothers in Limpopo.

2.4.3 Inclusion criteria

Male and female nurses were eligible for selection as participants in the study if they met the set inclusion criteria. They had to have had at least three years' experience of working as a registered nurse and midwife in any sphere. The researcher selected a health centre, two clinics, and a maternity unit at the District hospital in the rural villages of Greater Giyani Municipality, Mopani District. Teenage mothers aged between 18 and 21 who had previously attended local schools in the selected villages were eligible for selection. Participants had to be literate in either English or Xitsonga. The registered nurses as well as some of the teenage mothers used English. However, some preferred to speak in Xitsonga and were allowed to do so.

2.4.4 Exclusion criteria

Teenage mothers younger than 18 years were not included in the interviews. Focus groups that had been planned for local schools and families of teenage mothers were also excluded,

following the recommendation of the Research Ethics Committee of the University of Pretoria to collect data only at the clinics.

2.4.3 Data collection

Data collection is defined by Grove, et al (2013:691) as the precise, systematic gathering of information relevant to the research purpose or specific objectives, questions or hypothesis of the study. According to Polit and Beck (2012:725) it means gathering of information to address a research problem. Data collection in this study meant the process of gathering data from the chosen participants who met the selection criteria. Polit and Beck (2010:341) viewed semi-structured interviews as the instrument used to collect data. The researcher had a list of topics to cover rather than a specific series of questions to ask.

2.4.3.1 Pilot study

Prior to the actual data collection process, a pilot study was conducted. Polit and Beck (2012:106) describe a pilot study as a small trial run done in preparation for the main study; a pilot study is also known as a 'feasibility study'. Its purpose was to test the method to be used in the main study. By implication, a pilot study is done to test the feasibility of the proposed study and to detect whether flaws exist in the instrument and, if problems are encountered or flaws detected, it could be adjusted, corrected or changed before the main study is done (Polit and Beck 2012:106). Hence, a pilot study was conducted with three teenage mothers who were students on campus at the time and two registered nurses teaching midwifery at the same campus, namely the Limpopo College of Nursing (Giyani Campus).

All five participants followed the process of informed consent and confidentiality. The rationale was to test whether the semi-structured questions in the interview guide would be fully and easily understood by all participants. Secondly, the researcher wanted to make sure the prepared questions would render responses from the participants that contained the required, relevant information needed. If this was not the case, the questions would need to be adjusted or re-thought to assure that the data gathered in the main study would cultivate a deep understanding of the phenomenon. The pilot study further assisted the researcher with her interview skills, for example, when probing needed to be done (Brink 2009:167). The participants regarded the interview guide as quite clear and understandable. Therefore, nothing was changed on the interview guide after the pilot run. The participants in the pilot study were not part of the main study and their contribution was not considered or included in the data collection or analysis processes of the main study "refers to page 268, annexure F".

2.4.3.2 Setting

The individual interviews were conducted in institutional settings. Prior to the interviews, the researcher contacted every participant telephonically to confirm the date and time of her interview. The researcher chose the date and time bearing in mind that it had to be convenient for the participant. Thus, a day was chosen when the researcher knew the participant would either be at work or, in the case of a teenage mother or pregnant teenager, on a day she would be visiting the healthcare facility. The participants were invited for individual interviews which took place at the clinics and hospital settings. The researcher visited the institutions a week before commencement of interviews to meet with management in order to make some arrangements with registered nurses and teenage mothers. The researcher agreed with the participants about the time allocated for interviews and the venue.

Privacy was provided in the interview environment and interruptions from outside the room were prevented. Rapport was built through warmly greeting and welcoming the participants which made them feel at ease and comfortable. The nature and the process of the study such as the equipment used (an audio-recorder and field notes) were explained. It was emphasised once again that confidentiality would be maintained at all times. Information participants shared was voluntarily and were informed that they could terminate the interview at any time without giving a reason and without prejudice.

Consent forms were provided and completed a week before data collection commenced. During the interviews, data on health promotion and the wellbeing of teenage mothers was collected using broad questions. Probing was used to extract additional information on a participant's ideas or feelings or to explore a sub-topic that emerged further until saturation was reached. Grove, et al (2013:37) indicate that saturation of data occurs when additional sampling provides no new information and therefore only redundancy of previous data collected are left. Polit and Beck (2012:743) define data saturation as the collection of qualitative data to the point where a sense of closure is attained because new data yields redundant information.

The manager of each clinic was met and permission letters from the Research Ethics Committee (University of Pretoria) and from the Department of Health that allowed conducting a research were submitted. A free room was provided where the researcher met participants. Participants were readily available since they visited the clinics for under-five-year-old immunisations and antenatal care.

As regards the interviews, rapport was built through warm greetings and welcoming of the participants in order to put them at ease. The nature and the process of the study such as equipment to be used (field notes and an audio recorder) were explained as well as the research process. All clinics offered a free room to the researcher with three chairs, a table with some glasses and a jug of water. The content of the consent form was read and clarified. The participants were informed that participation was voluntary. They could terminate any time they felt like it. Those interested were given consent forms to complete and their cellular telephone numbers were written on their consent form to enable the researcher to reach them in case she had to clarify something recorded. Fifteen (15) participants who met the selection criteria had been selected.

Individuals arrived at the clinics as arranged a week before the actual interviews. Refreshments were served before commencement of each interview. The interviews were conducted in a private room in each nominated healthcare facility where only the researcher, field note writer and participant were present. The researcher made sure that the participants had a comfortable chair where she could relax in during the face-to-face interview. An experienced assistant researcher was advised to ensure that all equipment for collecting data had been checked to make sure it was in working order. Spare batteries were available in case an electricity problem occurred. A fresh bottle of water was placed on the table for participants to drink during the interviews.

Each participant was warmly welcomed and thanked her/him for her/his time and willingness to participate. This immediately built rapport between the researcher and the participant and put the latter at ease. The researcher closed the door to protect their privacy and explained the proceedings shortly to the participant. No participant objected to being recorded.

The researcher explained that while the participant would be sharing her experiences, she and the trained facilitator would take down some field notes so the participant should not be distracted by this. All cellular telephones were requested to be switched off, but the baby remained with the mother in the room. Fortunately, no disturbances were made by the babies during the interviews. Once again, the researcher emphasised that the participant would remain anonymous and that everything shared would remain confidential. The researcher also reminded the participant if the latter wanted to terminate the interview at any time, she was welcome to do so. Care was taken not to disrupt the delivery of healthcare services therefore a room in a quiet area of the clinic was chosen the interview (Grove, et al 2013:171).

2.4.3.3 Interviews

Data was collected from the two categories of participants (registered nurses and teenage mothers) by means of a pre-prepared semi-structured interview guide. Both English and Xitsonga were used during the interviews. The preference of each participant was taken into consideration for using these languages. To begin the interviews, the researcher asked a broad question regarding the promotion of health and wellbeing of teenage mothers from the interview guide which provided the researcher with a set of predetermined questions that were used as an appropriate instrument to engage participants. The broad, central question asked, was: “How can guidelines to promote health and wellbeing of teenage mothers in rural villages of Mopani District in Limpopo be developed?

Burns and Grove (2009:405) state consistency is maintained as the participants are asked to respond to the same questions during every face-to-face interview. The researcher used interview skills such as probing, reflecting, attentive listening, observation and clarifying (De Vos, et al 2011:356) to obtain in-depth information and gain a deeper understanding of the experiences of the registered nurses and teenage mothers on the health and wellbeing of teenage mothers in the study setting.

Probing encouraged participants to elaborate on the topic being discussed and increased the opportunities for further exploration until saturation is reached (Polit and Beck 2012:310). Probing further deepens the response of the participant to a question thereby increasing the richness of the data given. Reflection means showing or indicating or demonstrating that one understands a message (Oxford School Thesaurus 2012:464). The researcher repeated the participant’s ideas, thoughts and statements to ensure that the communicated messages or feelings were understood by both the researcher and the participant.

Attentive listening is the ability to absorb new information without bias and receiving information through various modalities, for example, by observing or sensing what the participant might mean and then following up on exploring exactly what is meant using probing questions (Yin 2009:70). The researcher’s good listening skills enabled her to encourage participants to talk more freely when she perceived the researcher was listening and understanding what she was sharing. The researcher also used clarifying as a technique to gain details about their experiences from the participants. For example, the researcher requested the participant to provide more details about what was shared to enable both the researcher and the participant to have the same understanding of what the latter meant.

A certain number allocated to every interview also had the same number appeared on the field notes. Thus, anonymity was ensured. A trained assistant handled disturbances by

ensuring cellular telephones were turned off and limited noise from the outside was ensured daily by displaying the sign, on the outside of the door that prevented the disturbances and that the audio-recorder was working and there were spare batteries.

The researcher facilitated the interviews, directed the discussions and wrote field notes while a trained assistant was in charge of the audio-recorder and handled disturbances. On the outside of the door was a sign that restricted noise. In case of a knock, the assistant would attend to it. The researcher listened intently to the participants without interrupting them. The researcher listened intently to the respondents without interruptions. The duration of each interview was 30 to 45 minutes per participant.

- **Individual interviews were conducted using semi-structured questions** with fifteen (15) registered nurses in the primary healthcare centre, clinics and a District hospital in order not to take them away from their service delivery points. Interview guides contained questions on how and what the registered nurses understood and perceived as the challenges experienced by teenage mothers and their barriers to return to school after birth. In-depth knowledge was acquired through probing participants.

- **Individual interviews were conducted using semi-structured questions** with fifteen (15) teenage mothers using interview guides containing questions to develop an understanding of the challenges experienced and the barriers for teenage mothers to return to school after delivery. Teenage mothers were interviewed at the clinic settings. In-depth interviews were conducted by probing teenage mothers between the ages 18 and 21 who lived in the two selected villages, Muyexe and Homu 14C, with its squatter camp. Data saturation was reached in both groups at the tenth individual interviews. Then researcher added extra five participants in both registered nurses and teenage mothers for verification and confirmation of saturation being reached.

2.4.3.4 Post-interview

In closing the interviews, the participants were asked whether they would mind being contacted again in the event that additional information might be needed to clarify something they had said or to verify what they had shared. All participants agreed to this arrangement. The researcher once again thanked participants for their cooperation, time and valuable input and the interview was terminated.

The field notes assisted the researcher to compile rich data since observations were made regarding the participants' body language (e.g. wringing of hands, slumping shoulders or shaking of the head), facial expressions or showing emotions, such as having tears in their eyes. Fortunately, no one cried, however one of the participant indicated that sharing information about some of the 'things' done by her father after discovery of the pregnancy was impossible to discuss. Her wish was respected. The researcher therefore acknowledged the concern and asked if the interview can still continue and she agreed to do so.

The researcher stored the audio-recorder and tapes in a safe place to prevent theft. Field notes regarding the interviews were written and stored as soon as possible after completing the interviews before the researcher could forget what had occurred during the specific interview session.

2.4.3.5 Delineation

The burden of pregnancy and parenthood seemed to be carried almost totally alone by teenage girls and not boys. There was overwhelming evidence implying that teenage girls suffer disproportionately in becoming and then fulfilling the role of a parent (Ibis Reproductive Health 2013:15). The study excluded boys, as well as boys and men who fathered the infants of the pregnant teenagers and teenage mothers. For ethical reasons, minor teenagers (attending or not attending school) were not selected for participation either. However, information on their situation was accessed through the inclusion of consenting teenage mothers over the age of 18 who were familiar with the former's situation because they had been younger than 18 when they became pregnant. (This is deduced from the fact that participating mothers brought their children to the clinic for under-five-year immunisations).

2.4.3.6 Language

The researcher speaks and understands the local language, Xitsonga, spoken in this sub-district. Twenty-nine (29) interviews were conducted in English and audio-recorded with the permission of the participants. Some participants were not fluent in English and therefore the researcher interviewed them clarifying in Xitsonga. Only one participant who communicated fully in Xitsonga. The verbatim transcription of the audio tape and field notes were done in preparation for data analysis by the researcher. Translation of the interviews, validation and back-translation process was followed in this case (Polit and Beck 2012:557). The interviewer encouraged the participants to talk freely about all topics in the interview guide and probed them where necessary. The information was gathered by talking directly to the participants and observing their possible physical behaviour, facial expression and signs of

upset within their context. The researcher ensured that any pre-conceived ideas that she might have had were put aside and she only focused on obtaining data from the participants' perspectives. All the participants were familiar with the environment (Polit and Beck 2012:533; Creswell 2009:181).

2.4.3.7 Data saturation

The principle of data saturation was followed (Grove et al 2013:371; LoBiondo-Wood and Haber 2010:236). Data was collected from ten registered nurses and ten teenage mothers. The researcher later added five registered nurses and five teenage mothers for more information and verification of saturation. When data obtained from the participants became repetitive, the researcher approached it as confirmation of what had already been shared; thus, the information shared by previous participants was deemed accurate. Probing of questions were then used to glean rich and supportive data on the subject or directed the participant to expand on possible new ideas, thoughts or perceptions mentioned. The researcher went back to some of the participants through use of telephone to confirm whether the findings accurately reflected their experiences and viewpoints where needed. The process was done until new data no longer emerged. Thus, saturation was reached.

2.5 DATA ANALYSIS

Grove, et al (2013:691) define data analysis as systematically conducted and synthesised to reduce and give meaning to data (Polit and Beck 2012:725). The purpose of data analysis in this study was to analyse the narrative information in an organised, but intuitive fashion, to provide structure to it, elicit meaning from it, and make sense from the collected data following Tesch's method of data analysis (Brink 2009:11).

The researcher transcribed the collected data from the audio-recordings verbatim. The one interview conducted in Xitsonga was translated into English by the researcher. The researcher then started reading the transcribed data again and again all the while searching for meaning and understanding. She made use of her field notes to give deeper meaning to the written transcribed data. By combining the transcribed words with information, she obtained from her field notes she wrote down all emerging ideas, comments, inferences made and connecting words in the margins. The field notes were further used to ensure that the transcriptions were accurate and that they validly reflected the interview experiences. The researcher carefully transcribed information to verify accuracy (Polit and Beck 2012:557).

In qualitative studies, researchers typically scrutinise data carefully and deliberately, often reading the data over and over in search of meaning and understanding until researchers become completely familiar with their data (Polit and Beck 2012:557). The researcher scrutinised the data carefully, read it repeatedly until the data was understood. The data collected from various categories were then organised and kept separately as different datasets during the first round of the interviews. Information was analysed per category, e.g. the information collected from registered nurses were kept together and analysed as a dataset as well as that of teenage mothers. Themes were developed from each categories of participants viz. registered nurses and teenage mothers (Polit and Beck 2010:466).

The basis for analysis consisted of transcripts, recordings, field notes, interviews and observations made during data collection. The researcher considered the words, contexts, internal consistency, frequency and extensiveness of comments made by the participants. Phrases and quotations from collected data led to the development of themes and categories and sub-categories until the point of data saturation (Grove, et al 2013:617).

The researcher entered the field data, interview data, observations, researcher's field notes and coded names so that chunks of data could be extracted and then reassembled into a new and informative configuration (Polit and Beck 2012:559). Descriptive wordings for the topics were checked and turned into categories. Related topics were grouped together to reduce the total list of themes and categories that showed interrelationships. Coding was done by developing themes, sub-themes and categories from the data. These were submitted to a specialist researcher for a second opinion. The researcher and coding specialist reached consensus about the themes. The process of data analysis is fully described in Chapter 3.

2.6 TRUSTWORTHINESS OF THE STUDY

The framework and criteria for developing the trustworthiness of qualitative inquiry as described by Lincoln and Guba (1985 cited by Polit and Beck 2010:492) were employed in this study. The rationale was to ensure the trustworthiness of the data collection and its interpretation. The criteria for credibility, dependability, confirmability and transferability were adhered to throughout the study.

2.6.1 Credibility

Credibility is defined by Polit and Beck (2012:585) as confidence in the truth of the data and interpretation thereof. The researcher ensured credibility through prolonged engagement which means the researcher invested in providing plenty of time during data collection to

have an in-depth understanding of the participating group under study, thereby enhancing credibility (Polit and Beck 2008:62). Persistent observation referred to a good researcher's intense focus on the aspects of a situation that are relevant to the phenomenon being studied (Polit and Beck 2012:548). In this study, persistent observations were conducted on how participants behaved in relation to the interview processes.

The researcher in this study displayed credibility when the findings reflected the reality of data collected (Tracy, 2013:235). The criterion used to select participants were relevant to the phenomenon. The researcher was also fully engaged in the data collection, writing of field notes, analysis of data, and discussion of the data. Follow-ups were done where information was not clear to the researcher as the participants' telephone numbers (cellular or home telephones) were kept for that purpose. Also, the researcher had spent 30 years as a midwife (a position she still holds) and therefore has in-depth knowledge and extensive clinical experience in this field of expertise. Credibility was also achieved in the second phase when the experts reached consensus regarding the development of guidelines (Loh, 2013:6).

2.6.2 Dependability

This displayed trustworthiness of information during the process of data collection which was confirmed by experts in the second phase of this study (Sikolia, Biros, Mason and Weiser 3013:4). The researcher conducted a pilot study to identify any problems that might have occurred during the main data collection process. Dependability in this study was ensured by providing a thick description of the research design and method to enable an audit of the research process and findings at the end of the study. Furthermore, the researcher and an objective research specialist (independent coder) reached consensus about the themes, sub-themes and categories developed. Field notes were also written and non-verbal communications were observed and verbal data was recorded (Creswell 2009:190).

2.6 3 Confirmability

Polit and Beck (2012:585) define confirmability as the objectivity and the potential for congruence between two or more people about the data's accuracy, relevance or meaning where the findings are reflecting the participant's voice. Data represented the information the participant verbally provided. The study findings were confirmed by doing a literature control on all identified themes, sub-themes and categories. The findings were aligned with the data throughout to ensure the interpretation of the data truthfully represented the participants' experiences without interference of researcher bias or elimination of data deemed to be supposedly irrelevant or unnecessary (Polit and Beck 2012:585). Confirmability was also

achieved via the involvement of experienced supervisors who reviewed the whole document findings to ensure it reflected the participant's voice and the conditions of the inquiry and did not contain researcher biases, motivations or perspectives.

2.6.4 Transferability

Transferability refers to the extent to which qualitative findings can be transferred to another setting or groups (Polit and Beck 2012:745). The researcher provided a thick description of the research design, methods and data discussion to ensure transferability. The researcher used purposive sampling to assure the sample provided a true reflection of the phenomenon under study. Field notes also contributed to the transferability of this study. The findings could be transferred and applicable to other settings or groups (De Vos, et al 2011:421; Polit and Beck 2010:492).

PHASE 2: GUIDELINES DEVELOPMENT

2.7 DEVELOPMENT AND VALIDATION OF THE GUIDELINES ON PROMOTING THE HEALTH AND WELLBEING OF TEENAGE MOTHERS IN MOPANI DISTRICT, LIMPOPO

2.7.1 Development of guidelines

Mahtani (2015:3) defines guidelines as "a systematically developed document" to help healthcare providers and patients to decide on appropriate healthcare for specific circumstances; it assists policymakers to make informed decisions about useful frameworks for healthcare, and enables individuals with diverse backgrounds to come to a workable agreement. In this study, the guidelines were systematically developed and participants were allowed to participate and make relevant and appropriate decisions. The researcher also developed guidelines to serve as a tool to assist healthcare providers to make important decisions relating to the promotion of the health and wellbeing of teenage mothers and their motivation to return to school after delivery of their babies. The current researcher used the Delphi technique in the study as an instrument to collect data. The main reason for using the Delphi technique was because the researcher wanted consensus from a group of experts whose opinions, knowledge and expertise were highly valued. The experts received a series of intensive questionnaires combined and streamlined during controlled feedback (Habibi, et al 2014:8). The population was all health professionals who had been involved with the healthcare of teenage girls for a substantial period of time and who was thus knowledgeable and experienced in this health area. Sampling involved purposefully choosing experts from various sections in the health sectors, universities and colleges. The experts remained

anonymous and did not know each other. Data was collected from these experts via emails in rounds until consensus was reached in the third round. The data was analysed statistically.

2.7.2 Methodology of guidelines development

The Delphi technique is a method of structuring effective communication among a group of experts during the decision-making process. It allows the group as a whole to deal with the themes under study (Habibi, et al 2014:8). This technique was used to gather opinions on the draft guidelines from a group of experts within their domain of expertise to acquire the most reliable consensus via a series of intensive questionnaires combined with controlled opinion feedback. The technique was able to pool intelligence and convergence of opinions from the responses received thus building consensus on the guidelines for registered nurses (Ab Latif, Mahamed, Dahlan and Mat Nor 2016:89) In this study, the complex problem was regarding the challenges experienced by teenage mothers and their need to return to school. Therefore, guidelines were found necessary to be developed in order to promote their health and wellbeing.

In this study, the Delphi technique was used to improve understanding of the problem, find solutions and to develop forecasts. By using this technique, the researcher was able to identify and prioritise criteria for the development of guidelines as a framework of reference. This was achieved by the use of formulated questionnaires that emanated from the outcome of the analysed data which was controlled with literature. Preliminary guidelines were formulated from the outcomes of the empirical study about the promotion of health and wellbeing of teenage mothers. The scope and objectives of the guidelines are fully discussed in Chapters 5 and 6.

2.7.3 Guiding attributes in this study for the development and validation of guidelines

These guiding attributes are discussed fully in Chapters 5 and 6. However, below are the guiding attributes and explanations in Table 2.1.

Table 2.1: Guiding attribute and explanations

CRITERIA	EXPLANATION
Validity	The guidelines had a strong research evidence based from participants themselves emanating from the empirical research results which assisted the healthcare professionals with making decisions about promotion of health and wellbeing of teenage mothers. In this study,

	validation of the instrument was done using the empirical findings of the study and validated by experts as participants. Multiple considerations of the tool were done (Kuechler and Vaishnavi 2011:128).
Reliability	It is the degree of consistency or dependability with which an instrument measures an attribute. The preliminary guidelines were evidence-based as the integrity of the current findings was evaluated using epistemological standards and, when applied in similar circumstances, similar results will be produced (Polit and Beck 2012:741).
Clarity of presentation	Jamaloodien (2014:21) indicates that the guideline should be easy and specific to the situation and population to which it will apply. The current guideline is clear, simple and unambiguous. This guideline will produce similar results if applied in similar circumstances. It is clearly written in simple language and in clearly defined terms.
Applicability	The target population of the guidelines is clearly stated and simple enough to be applied to teenage mothers. The population in this study were teenage mothers. Registered nurses should easily apply the guidelines as end-users. The guidelines were developed to improve health and wellbeing of teenage mothers and to motivate them to return to school after delivery of their babies. The applicability was tested through the Delphi technique in three rounds when experts were involved in the review of the statements used in the guidelines as well as its improvement. However, additional staff and resources may be necessary to achieve the goal (Brouwers, et al 2013:38).
Relevance	The guideline is purposeful and focuses on current society. The findings can be used in similar settings. It will help to improve management effectiveness and enhance maintenance outcome of teenagers in general (Pen Brooke 2015:22). The researcher believes that the improvement of youth-friendly service will benefit teenagers in general. Guidelines will help teenagers in the aspect of social capacity and connectedness through collaboration with other stakeholders by registered nurses in their practise during implementation of guidelines.

2.7.4 Guidelines developers

The researcher used a panel of experts with knowledge and experience due to being involved with teenagers before and during pregnancy and post-delivery. Sampling was done from the population of experts using specific criteria. The population was a combination of individuals with multiple specialities and a heterogeneous group of experts in the medical and nursing field. These experts were working in health sectors or universities and colleges in different disciplines. They also had experience in health promotion among teenage girls

and teenage mothers in collaboration with social workers and other stakeholders who were directly involved with teenagers. The group of experts were geographically dispersed to prevent bias (Du Plessis and Human 2007:15). The researcher invited the experts via text messages to participate in the project, indicating that those who were interested should respond by sending their email addresses to her. After receiving the email addresses of the interested respondents, the researcher sent the questionnaires with preliminary guidelines as well as the information on the overview of the study to the individual experts via emails. A pilot study was conducted prior to data collection with three lecturers at Limpopo College of Nursing (Giyani Campus) to assess the validity and reliability of the instrument and to make changes or add suggestions whichever was applicable. The instrument was critically analysed and then modified.

2.7.5 Validation of guidelines by experts

Validation is a phase in which the research report is critically appraised to determine its scientific soundness (Grove, et al 2013:712). In this study, the trustworthiness of the guidelines was ensured through the use of the Delphi technique and a panel of experts who measured the guidelines until they reached consensus. The Delphi technique is used for obtaining an evaluation and critique from a panel of experts about a possible issue of concern.

Experts were questioned in rounds with a summary of the expert panel's view circulated between rounds to foster consensus without requiring face-to-face discussion. The responses to each round of questionnaires were analysed, summarised and returned to the experts with a new questionnaire. The experts then formulated their opinions while bearing the panel's viewpoint in mind (Polit and Beck 2012:267). Consensus was reached in the third round. The researcher analysed and synthesised the data which led to the development of preliminary guidelines.

The group of experts also contributed their knowledge during the development of guidelines. Guidelines are systematically developed documents in a standardised format that enable individuals with similar backgrounds to come to an agreement about healthcare and devise quality frameworks (Mahtani 2015:2). In this study, the guidelines were critically scrutinised and evaluated by a group of experts. They contributed to the refinement of the guidelines until all were satisfied and agreed on the amended guidelines (Ab Latif et al 2016:93). This process enhanced the validity of the final guidelines. The researcher therefore believes that clients will benefit from the guidelines.

2.7.6 Review of guidelines

WHO (2012:5) indicated that the developed guidelines are guidelines that provide a complete coverage of a health topic and are expected to include recommendations in relation to all aspects of the topic and they have to be reviewed every two to three years (WHO 2012:5). The guidelines will be reviewed after every 3 to 5 years in future. The reviews will be done on a regular basis to ensure that they reflect current decisions that will affect nurses the service in three to five years' time depending on what is required and funded by the government.

2.8 CONCLUSION

In this chapter, the research design and methodology of the empirical study were described in detail focusing on the qualitative, explorative and descriptive design used. The study context for the empirical study was two rural villages in the Greater Giyani Municipality in the Mopani District. Professional nurses were eligible for selection as participants in the study if they met the set inclusion criteria. Teenage mothers younger than 18 years were not included in the interviews. Data was analysed, themes and categories were developed that led to Phase 2, which was the development of guidelines. In this study, the Delphi technique was used to improve understanding of the problem, find solutions and to develop forecasts. By using this technique, the researcher was able to identify and prioritise criteria for the development of guidelines as a framework of reference

Chapter 3 presents an in-depth discussion of the identified themes, sub-themes and categories from the qualitative empirical data obtained from the registered nurse, pregnant teenager and teenage mother participants. Findings were subjected to a literature control and verified by verbatim quotes from the participants.

CHAPTER 3

DATA ANALYSIS, DISCUSSION OF FINDINGS AND LITERATURE CONTROL

3.1 INTRODUCTION

As mentioned, this study was conducted in two phases. This chapter deals with the empirical phase, Phase 1, and describes how the analysed data was interpreted, categorised, tested against literature while verbatim quotes were used to render truthful findings and the interpretation of the findings. The specific objectives of Phase 1 were:

- explore and describe the challenges experienced by registered nurses regarding the promotion of health and wellbeing of teenage mothers
- describe the barriers experienced by teenage mothers to return to school after delivery of their baby.

PHASE 1: EMPIRICAL PHASE

The empirical phase was concerned with the achievement of the objectives for Phase 1. The findings are presented and discussed in this chapter. In Chapter 2 the research design and methodology were thoroughly attended to. For data collection, 15 registered nurses as participants and 15 teenage mothers were purposively selected from two rural villages in the Mopani District in Limpopo. Data was collected in face to face individual interviews with the participants who were divided into two categories, namely, registered nurses and teenage mothers. These categories were recommended by the Ethics Committee of the University of Pretoria. With the permission of all participants, an audio-recorder was used to record the 30 semi-structured individual interviews. The researcher's field notes jotted down during interviews and immediately after each interview assisted with reflection. It was useful non-verbal observations to details like body language, pauses and vocalisation in participants' speech patterns and in general added more meaning to the recorded voices during the data analysis.

The study was conducted in two phases. This chapter deals with the achievement of the objectives for Phase 1. The findings are presented and discussed. Verbatim quotes from the

transcribed interviews strengthened the interpretations and validity of the findings. A literature control was used to evaluate, balance and contextualise the findings in the study field. The themes that emerged from the data of this phase enabled the researcher to develop preliminary guidelines in Phase 2 for the promotion of the health and wellbeing of teenage mothers in Mopani District in Limpopo, one of the nine provinces in South Africa.

3.2 DATA ANALYSIS AND DISCUSSIONS

Themes, sub-themes and categories were identified during the data analysis. The audio-recordings were transcribed verbatim and the field notes used to add richness and a deeper understanding of what exactly transpired during each interview. The transcribed work accurately reflected the challenges experienced by registered nurses regarding health promotion of teenage mothers during provision of health care and the challenges experienced by teenage mothers with regard to barriers to return to school after delivery of their babies. Accuracy was guaranteed in that the researcher checked the transcribed work against the recorded words repeatedly and also made use of the assistance of an experienced research specialist. Descriptive wordings for the topics were checked and turned into related topics which were grouped together to reduce the total list of themes and sub-themes which showed interrelationships. The researcher and research specialist reached consensus on the coding. The coding done led to the development of themes, sub-themes and categories from the data.

Firstly, data was presented, discussed and summarised as themes, sub-themes and categories from interviews with 15 registered nurses as shown in Table 2. This was followed by in-depth discussion of the findings with a literature control. Similarly, the summarised themes, sub-themes and categories from the interviews with 15 teenage mothers are shown in Table 3.3, followed by and in-depth discussion of the findings with a literature control.

3.3 CHALLENGES EXPERIENCED BY REGISTERED NURSES REGARDING PROMOTION OF HEALTH AND WELLBEING OF TEENAGE MOTHERS

In-depth individual interviews were conducted with 15 registered nurses. An interview guide was used containing questions to develop an understanding of the registered nurses' perceptions of the challenges experienced by teenage mothers and their barriers to return to school after delivery. From the analysis of the registered nurses' interviews three main themes emerged: challenges regarding healthcare service provision; challenges of teenage mothers observed by registered nurses, and proposed interventions. From each main theme, sub-themes and categories were identified as set out in Table 3.1 below.

Table 3.1: Themes, sub-themes and categories of challenges identified by professional nurses

REGISTERED NURSES		
THEMES	**SUB-THEMES**	**CATEGORIES**
3.3.1 THEME 1: CHALLENGES REGARDING HEALTHCARE SERVICE PROVISION	3.3.1.1 Sub-theme 1: Before pregnancy (teenage-situated challenges)	• Unpreparedness for pregnancy (physical/psychological)
		• HIV positive
	3.3.1.2 Sub-theme 2: Antenatal care	• Challenges regarding examination of pregnant woman and interventions
		• On-going support and referral
		• Challenges regarding health education and preparation for birth
	3.3.1.3 Sub-theme 3: Post-natal care	• Breastfeeding, care of the baby including bonding
		• Care of mother including referral and family planning
	3.3.1.4 Sub-theme 4: Ensure follow-up	
3.3.2 THEME 2: CHALLENGES OF TEENAGE MOTHERS OBSERVED BY REGISTERED NURSES	3.4.2.1 Sub-theme 1: Community-situated challenges	• Lack of support from family/community
		• Stigmatisation/rejection
		• Partner/peer influence
	3.3.2.2 Sub-theme 2: Unsatisfactory service utilisation	• Late reporting to services/non-compliance during pregnancy
		• Healthcare provider-situated
		• Transport challenges
3.3.3 THEME 3: PROPOSED INTERVENTIONS	3.4.3.1 Sub-theme 1: Teenager-friendly service (accessible)	• Peer group-driven services
		• Mobile clinics
		• Non-judgemental service provision
	3.3.3.2 Sub-theme 2: Information dissemination	• Re-service/reproductive health (campaigns/schools/parents)
	3.4.3.3 Sub-theme 3: Support teenage mothers to return to school	

Table 3.2: Challenges regarding healthcare service provision

THEMES	SUB-THEMES	CATEGORIES
3.3.1 THEME 1: CHALLENGES REGARDING HEALTHCARE SERVICE PROVISION	3.3.1.1 Sub-theme 1: Before pregnancy (teenage-situated challenges)	• Unpreparedness for pregnancy (physical/psychological)
		• HIV positive
	3.3.1.2 Sub-theme 2: Antenatal care	• Challenges regarding examination of pregnant woman and interventions
		• On-going support and referral
		• Challenges regarding health education and preparation for birth
	3.3.1.3 Sub-theme 3: Post-natal care	• Breastfeeding, care of the baby including bonding
		• Care of mother including referral and family planning
	3.3.1.4 Sub-theme 4: Ensure follow-up	

3.3.1.1 Sub-theme 1: Before pregnancy (teenage-situated challenges)

The first sub-theme under Theme 1: Challenges regarding healthcare service provision was before pregnancy (teenage-situated challenges). Two categories were identified, namely unpreparedness for pregnancy (physical/psychological) and HIV positive.

- **Unpreparedness for pregnancy (physical and psychological)**

According to the participants, the teenage girls' total physical and psychological unpreparedness for motherhood was distressing. Their unpreparedness presented challenges because they hid pregnancies and avoided visits to the clinic where they can receive support, information and proper antenatal care.

The following quotes confirm this finding:

> "*Ignorance amongst teenagers results in unwanted pregnancies, in other words, the lack of knowledge about sex is the main cause."* (Participant 5)

> "*The identity crisis as teenager occurs. She does not know whether she is an adult or a child because of being a mother or still a teenager as a result of her age, she still need to play with her peers thus ending up isolating herself.*" (Participant 12)

"*They hide their pregnancy++es and therefore* [do] *not receive health education some do not even know their last menstrual periods and that is the challenge.*" (Participant 7)

"*One notices that children* [girls] *as young as eleven years old are falling pregnant and some do so without having experienced the menstrual cycle.*" (Participant 2)

"*The teenagers are confronted by psychological pressure as the pregnancy is not accepted in the family.*" (Participant 13)

"*Lack of knowledge about family planning also will result in teenagers not going for assistance at the clinic*." (Participant 3)

"*The teenagers are found to be failing to cope well with their pregnancies because this primarily affects their educational prospects and the rejection by the family for the embarrassment caused by the unplanned pregnancy.*" (Participant14)

"*Sometimes teenagers stop taking contraceptives because they want to prove that they can also give birth or to get hold on the boyfriend by falling pregnant. Also, due to the wrong information they have received regarding contraceptives and some end up having unwanted or unplanned pregnancies.*" (Participant 7)

The unpreparedness for pregnancy and motherhood of teenage girls was a major challenge for the registered nurse participants. On the one hand, this unpreparedness implied a critical shortcoming in the girls' understanding and knowledge of their sexuality and what happened to their bodies and emotions as they went through puberty; on the other hand, the shortcoming reflected they received inadequate sexual and reproductive health education, counselling and knowledge sharing as they were reluctant to visit the services.

UNFPA (2013:28) and Suan, Ismail and Ghazali (2015:217) agree in developing countries the majority of girls under 18 years who become pregnant, experience early motherhood and live in rural areas in impoverished households receive little or no sexuality or reproductive education. Growing up in a traditional patriarchal community, where 10-year-old girls are viewed as old enough to be married and to fall pregnant at this tender age when they still want "*to play with their peers*" is particularly stressful and traumatic for young girls (Kathree, Selohilwe, Bhana and Petersen 2014:8). Most of them experience extreme physical and psychological problems before, during and after birth such as severe depression, anxiety and stress-related illnesses. An unwanted or unplanned pregnancy may be a total shock to the young girl leading to psychological problems (specifically in the early postpartum period). She may even withdraw from society; isolating herself because she cannot cope with the

traumatic situation (Anyanwu, Goon and Tugli 2013:923; Kathree, et al 2014:8). Specifically, if it is a first pregnancy, 10- to 11-year-old girls suffer immensely. They do not understand what is expected from them as mothers and are incapable of taking responsibility for a helpless infant – in other words, they are ignorant.

Pender believed that "the goal of nursing was to help people care for themselves" (Sakraida 2010: 434). In the opinion of the researcher, motherhood in a very young teenager is an extremely complicated issue because the girl may have been a victim and not a partner in the sexual encounter which resulted in a pregnancy. A teenager younger than 15 whose body is not fully developed and who do not receive antenatal care from skilled healthcare professionals, may develop nutritional anaemia due to nutritional depletion while also facing immense other physical health risks including "maternal death, illness and disability, including obstetric fistula, complications of unsafe abortion, sexually transmitted infections, including HIV, and health risks to infants" (UNFPA 2013:15). Participant teenage mothers reflected lacked support and guidance from family, peers, and other social clusters during the time of their gravidness and believed that pregnancy would be much better to free their stress (Sanchez, Rowles, and Dube, 2011:5).

In remote areas, registered nurses who work with reproductive health and pregnancy care oftentimes come across situations where girls as young as 10- or 11-years-old are pregnant. UNFPA (2013:24) states millions of girls are forced into child marriages, meaning millions are moved from literally being a mere child one day to being an adult the next with adult and motherhood responsibilities. An unwanted forced pregnancy does not only take away the teenager's right to make her own choices, but also negatively influences her patriarchal family's ideal to preserve her as a virgin thereby having more bargaining power for an arranged marriage. Froschauer (2014:21) explains, patriarchy is a historically developed and a deeply constructed integrated system of male dominance – simply put it is a system where women are considered to be secondary to men.

A current participant's sharing of situations where 11-year-old who have not even "*experienced the menstrual cycle*" have to be dealt with at the clinics, informs *de facto* sexual abusive practices are still performed in the traditional ethnic community where the study was done. A 10- or 11-year-old-girl's horizons are limited if she lives in a society where "a formidable combination of relatives, figures in her community, social and cultural norms, institutions and customary laws, institutions and discriminatory laws block her path forward" (UNFPA 2016:2). According to the Nursing Times (2013:25-6), "nurses need to be vigilant for signs of sexual exploitation and abuse" with all young people (this includes young boys and

fathers) who are particularly exposed to the aforementioned socioeconomic and environmental risk factors.

Family planning is the control of fertility through the use of contraceptive. Thus, having knowledge of contraceptives and contraceptive methods and having access to it but choosing not to make use of it is a senseless and illogical decision if the teenager's reason to become pregnant is to "*hold onto a boyfriend*". This finding strengthens the belief of Young, Furman and Jones (2012:559) that adolescents are not emotionally mature to have sex and are prone to develop psychological disturbances because they are involved in sexual relationships for the wrong reasons. This emotional insecurity is reflected in the words of a participant who agreed that teenagers go through an "*identity crisis".* This identity crisis that girls find themselves in when entering puberty, is described as "a flurry of life-changing events" pulling the girl-child in many directions. "Where she ends up depends on the support she receives and the power she has to shape her own future." (UNFPA 2016:2).

Participants mentioned some teenage mothers were so young they did not possess an identity document (ID) which meant they did not qualify for a child support grant (CSG):

> "*Some were so young that they do not even possess identity documents. These implied that they will not be able to receive child support grants. Due to this problem, some of them register their babies for grants through their parents.*" (Participant 2)

> "*Teenagers who fall pregnant and give birth to babies, get a child support grant, which they utilise for their own needs and not of* [for] *the children."* (Participant 11)

In some cases, the teenage mothers would then use their mothers' ID to register their babies for a Child support Grant (CSG). The Integrated School Health Policy (ISHP) (2012:35) is a key document for alleviating child poverty in South Africa. The policy stipulates that beneficiaries of the CSG are entitled to free healthcare services and education. It confirms that teenage mothers do qualify for a child support grant. However, to qualify for the CSG they need to have an ID and to have an ID document one has to be 16 years old in South Africa. Only a teenage mother 16-years and older can receive this grant. Looking at the verbatim quotes, registered nurses stated the majority of teenage mothers were all younger than 16. By implication, they did not qualify for the grant but their mothers did and they received the monthly CSG as mentioned by a participant. Some controversy was found in literature about whether the CSG encourages teenage pregnancies. Panday, et al (2009:57) found no association between teenage fertility in South Africa and the child support grant apart from a *false perception* [own emphasis] among the general public that teenage fertility *is the result* [own emphasis] of the provision of CSG. Sodi (2009:19) also found that the rise

of teenage fertility predated the introduction of the child support grant. Consequently, it is perceived that the CSG is not a motivation for teenage girls to become pregnant. UNICEF (2010:2) support that Child Support Grant eradicate poverty and allows children of teenage mothers to grow well without impact of malnutrition, therefore the grant should continue.

Early childbearing endangers the mother's education because her dropping out of school limits the potential for future income. Moreover, if she herself is uneducated she may not be able to provide her child or children with a good start in life either. According to UNFPA (2016:6-9), early pregnancy and motherhood brings great risk to the health and welfare of teenage girls and deprives a national economy of the benefits of having better educated young women entering the workforce; instead, they are staying home to rear children which is not necessarily their own choice. Krugu, Mevissen, Münkel and Ruiter (2017:299) confirmed that some of the teenagers expressed fear during sex because of the risk of getting pregnant or because the school had apparently told them that they should not have sex but ended up having sex any way.

- **HIV positive**

All pregnant women are encouraged to book for antenatal care early to confirm pregnancy and to identify those who are HIV positive, including those who seroconvert during pregnancy and breastfeeding. Most teenagers infected with HIV are infected when engaged in unprotected sexual behaviour (often concomitant with substance abuse). The management of an HIV Positive pregnant teenager is a vital step towards the prevention of mother-to-child transmission (PMTCT) of HIV.

On this topic, the participants of this study expressed the following:

> "*We provide HIV testing and counselling and issuing of antiretroviral therapy (ARV) to those HIV positive and referral to social workers where necessary. To continue with ARV to those found to be positive after delivery. Some are found to be HIV-positive at an early stage whereas majority of them are not married but pregnant.*" (Participant 2)

> "*During pregnancy, teenage mothers are not coping if HIV positive. They do not come for ANC or they report once until delivery or not go to hospital if referred to. When they come for antenatal clinic, most of them are found to be human immunodeficiency virus (HIV) positive after conducting a test. It is a big challenge indeed and they will never come to the clinic until delivery or term.*" (Participant 6)

> "*We provide antenatal care where they first book and come for monthly examination. We first counsel them and then test them for HIV. We also collect blood specimen for*

grouping and other tests. Should a patient test positive she is immediately put on ARVS in order to prevent the foetus from contracting the disease. We teach the mother about breastfeeding whether HIV or not it is important." (Participant 7)

"*Most of teenage mothers are found to be HIV positive and some are found to be in a denial state and refuse to go for counselling and testing or to take the treatment as prescribed*." (Participant 3)

"Teenagers do not attend family planning clinics in order to be supplied with contraceptives, free of charge." (Participant 5)

Sexual activity among adolescents remains a major concern for nurses as it negates all the efforts made to prevent the occurrence of unplanned pregnancies, sexual transmitted infections (STIs) including HIV, unsafe abortions and childbirth complications (Fantasia 2011:48). Guidelines for maternity care (2016:109) inform that HIV counselling and testing should be offered to all pregnant and breastfeeding women and pregnant teenagers. Those who were found to be HIV positive were counselled, referred to the social workers for further counselling, and ARVs were prescribed. These mothers had to continue with their ARV treatment regimen after delivery in order to prevent mother-to-child transmission via breastfeeding.

Many pregnant teenage mothers only find out they are HIV positive when visiting the clinics for antenatal care. According to Anyanwu, et al (2013:925), when pregnancy and HIV tests are done, pregnant teenagers become so devastated and shocked when discovering their HIV positive status that they do not adhere to the ARV medication regimen and some never return to the clinic again. Also, girls who report for antenatal care late in their pregnancy caused a lot of concern among the participants. Late reporting means that the pregnant teenagers put the baby at risk of contracting HIV while in utero – but teenagers are unaware of the fact that late bookings could be detrimental to the foetus and could mean giving birth to an HIV positive infant.

Jewkes, Morrell and Christofides (2012:682) argue that although the HIV pandemic greatly contributed towards breaking the silence surrounding the HIV and AIDS issue by opening the door for debates around sexuality, safe sexual practices and sexual health in families, schools and in the media, these discussions have largely focused on HIV prevention, whereas talk about avoiding pregnancy has been more muted. This stance is confirmed by Shefer, et al (2013:8) who assert there still remains an urgent need for teenage learners to be effectively educated about their sexuality as well as promoting safe sexual practices to prevent contracting HIV and/or infecting the foetus in case of a pregnancy.

In the opinion of Beguy, Mumah and Gointtschalk (2014:3), teenagers must be encouraged to test for HIV. The earlier they know their status, the earlier they can be started on ARV treatment and the earlier they can make lifestyle changes to live healthier lives. The attitudes, behaviours and knowledge regarding STIs and HIV and AIDS of 150 learners were tested by Bana, et al (2010:154) in the economically poor Mhlakulo region in the Eastern Cape, South Africa. Of the 86 female Grade 11 and 12 learners, 12.8% fell pregnant of which only one-sixth wanted the pregnancy. All left school and only 30% returned to school after delivery. The researchers concluded that sexual promiscuity and teenage pregnancy were causes for concern among teenagers in poor, remote areas. A current participant's remark that teenagers do not visit health services to collect condoms although it is "free of charge" verifies the finding of the National Adolescent Friendly Clinic Initiative programme (NAFCI) that testing for and collecting condoms to prevent STIs including HIV and AIDS are inconsistent among the youth (NAFCI, 2011:1353). Lince-Deroche, Hargey, Holt and Shochet (2015:73) conducted a mixed-method study on young women's needs and experiences in accessing sexual and reproductive health information in Soweto, South Africa. Their findings reflected that sexually active teenage girls between 15- and 19-years-old are at a high risk of contracting HIV and unwanted pregnancies due to their habit of practising unprotected sex.

The possibility that young teenage girls in rural villages become pregnant without her or the partner knowing their HIV status should be considered ("*When they come for antenatal clinic, most of them are found to be HIV positive after conducting a test"*). This implies that knowledge about contraceptives and safe sexual practices are non-existent among the youth because many of the pregnant girls were not married. Hence, the provision of "age appropriate, culturally sensitive information to young people adopted for their age" (United Nations Mission in South Sudan (UNMISS) 2016:para 9) in rural regions is, in fact, non-negotiable. If girls have information on their reproductive and sexual health which they understand and can grasp, it could result in delayed sexual debut; their focus could be shifted from dreaming of boys, puppy love and sexual matters to completing their education and fulfilling their dreams. Furthermore, young teenage boys should also be engaged – male teenagers need to be provided with age-appropriate information and counselling as well.

Based on the comments of the current participants of this study, it can be deduced that most pregnant teenage girls were unaware of their HIV status – a fact that is reaffirmed by UNFPA's (2013:31) statement that a lack of comprehensive knowledge of HIV and AIDS "is highly correlated with early adolescent childbearing. Girls without this knowledge are more likely to have their first live birth before age 18". Using the teenage girl population in India as an example, UNFPA (2013) declares that 25 per cent of girls in India with "no comprehensive

knowledge have their first live birth before age 18, compared to only 8 per cent of those with the appropriate knowledge".

3.3.1.2 Sub-theme 2: Antenatal care

The second sub-theme under Theme 1: Challenges regarding healthcare service provision was antenatal care. Three categories were identified, namely challenges regarding examination of pregnant woman and interventions; continuous support and referral; and challenges regarding health education and preparation for birth:

- **Challenges regarding examination of pregnant woman and intervention**

The antenatal period was considered by the participants as a crucial part of pregnancy because it was during antenatal visits to the clinics that they assessed whether the foetus and teenage mother's health were normal or whether there were any deficiencies. If a deficiency was found, the registered nurses would immediately initiate interventions or referral to the hospital. The participants confirmed this through the following expressions:

> "*During antenatal clinic (ANC) we teach them different types of family planning such as oral contraceptives, injections and also collect blood for human immunodeficiency virus (HIV)*" (Participant 1)

> "*Pregnant teenagers are provided with antenatal care, where they are screened for sexual transmitted diseases and infections like HIV and AIDS are conducted. We are teaching them about alcohol intake and smoking problems during pregnancies that may affect the baby they are carrying. When the results about the screening are found to be HIV positive, they are counselled and referred to psychologists for further counselling and management. After delivery, they are advised to go to the family planning clinics. They are also referred to the support groups in their areas where such are available*." (Participant 13)

> *"Teenagers do not attend family planning clinics in order to be supplied with contraceptives, free of charge."* (Participant 5)

> "*Most of teenage mothers are found to be HIV positive and some are found to be in a denial state and refuse to go for counselling and testing or to take the treatment as prescribed*." (Participant 3)

Antenatal care is an essential intervention to reduce maternal mortality and morbidity. The antenatal period is critically important in teenage pregnancy because their bodies are not yet

mature enough to carry the burden. Once pregnancy is confirmed in teenage girls, antenatal care is crucial. According to the Guidelines for Maternity Care in South Africa (2016:20), antenatal care is provided to ensure the best possible pregnancy outcome for the mother and her baby. Healthcare during pregnancy focuses on proper screening, assessing risks, treating identified problems, and providing information to the mother-to-be on how best to care for herself and the foetus during her pregnancy. Antenatal care further assists first-time mothers on how to prepare herself physically and emotionally for childbirth and motherhood (for the latter it covers aspects such as breastfeeding, lactation and so forth). But, the current findings substantiate the statement that teenage girls tend to present late (or not at all) for antenatal care (UNFPA 2013:21).

The current participants confirmed pregnant teenagers were educated on "*different types of family planning such as oral contraceptives, injections*" and about "*alcohol intake and smoking problems during pregnancies that may affect the babies they are carrying*" during the antenatal programmes. However, again it was reiterated that pregnant teenage girls in the rural study setting did not favour visiting clinics for antenatal care. In rural and remote areas in developing countries diverse reasons may constitute this problem. For example, there may be no or limited access to clinics; unwed girls who feel guilty and ashamed may not seek or make use of maternity services (Suan, et al 2015:217-8); girls may feel stigmatised and seek an illegal abortion (UNFPA 2013:24); the community expects them to deliver at home; there is no apparent problem during pregnancy and therefore antenatal care is not needed (UNFPA Population Council 2010:46,48). A gender survey done in seven regions of Ethiopia in 2010 showed that in traditional rural communities home births were not unusual, especially among mothers aged 20 years or younger and who had no education (UNFPA Population Council 2010:ii).

Moreover, if it is a first pregnancy, they may not know how important antenatal care is because they do not understand the consequences that not seeking antenatal care early in the pregnancy is "associated with adverse maternal, obstetrical, and neonatal outcomes" (Fleming, et al 2015:743). Millions of young pregnant teenage girls are uninformed about the critical health risks for them and the foetus: poor eating habits leads to higher risk for anaemia and undernourishment of the foetus, dangers associated with the reproductive organs not ready for birth, maternal death due to pre-eclampsia, stillbirth, premature labour, miscarriage, low birth weight or infant death during its first days of life (Aerts, de Lourdes and Giugliani 2004:1364; Mamabolo, Alberts, Steyn, Delemmare-van de Waal and Levitt 2005:505; NDoH 2013:17; Vollan, et al 2014:4; Fleming, et al 2015:740-1; Strukel 2015:6).

In South Africa, the incidence of premature labour, miscarriage and stillbirth are higher among pregnant teenagers when compared to that of older age groups (NDoH 2013:17). Continuing with antenatal care is absolutely critical in teenage pregnancy, but teenage girls tend to present late (or not at all) for antenatal care (UNFPA 2013:21). This is worrying because teenage girls who attend antenatal care programmes are more inspired and motivated to continue attending school during the pregnancy and the post-partum year than peers who do not attend antenatal programmes (Fleming, et al 2015:743-4).

Pregnant teenage girls who tested HIV positive were immediately put on ARV. Participants confirmed most failed to return for follow-up antenatal care or for follow-up ARV treatment; when they "*are found to be HIV positive and some are found to be in a denial state and refuse to go for counselling and testing or to take the treatment as prescribed*". This is a disturbing finding because it meant that when the girl finally returned to give birth, mother-to-child transmission of HIV – which could have been prevented if she had adhered to her ARV regimen – had taken place and the new-born would probably also be HIV positive leaving him or her with a short lifespan. The United Nations Economic Commission for Africa (United Nations ECA 2015:26) asserts of the proven, cost-effective and high-impact interventions to ensure new-born survival include prevention of mother-to-child transmission of HIV and to have skilled attendance at birth. Suan, et al (2015:216) state it seems as if only 56% of births in rural areas are attended by skilled health personnel when compared with the 87% in urban areas while only half of all pregnant women in developing regions receive the recommended minimum of four antenatal care visits. As signified in the findings of Khairani, et al (2010 cited in Suan, et al 2015:216) teenage mothers had less antenatal follow-ups at two major hospitals in Klang Valley, Malaysia. Suleiman, et al (2013:40) confirm nearly a quarter of their pregnant participants also felt they had too few antenatal visits booked at a Malaysian university hospital.

It is therefore important for the registered nurses to understand these girls' lives, their situations, their difficulties and issues in order to render care in a welcoming environment without scolding or judging them (Akella and Jordan 2015:44). In fact, according to WHO (2011:145) reported that, antenatal care is an ideal opportunity for couples' HIV testing and counselling and is a strategy to also reach the male partner for HIV testing and promoting safe sexual practices. Much more attention needs to be paid to developing the parenting skills of male partners during antenatal care. The role of the male in teenage pregnancy is apparently still a grey area. Literature sources admit a scarcity of data exists on the role of the male in teenage pregnancy (UNFPA 2013:15).

Akella and Jordan (2015:44) comment on an important aspect of antenatal healthcare for teenagers – that registered nurses should remain unbiased, not judge the girl neither scold her for not using contraceptives because not all teenage pregnancies are unplanned or unwanted (Fleming, et al 2015:742). It is important to understand the teenagers' experiences, their difficulties and other issues not mentioned in order to render care in a welcoming environment without scolding or judging them.

- **On-going support and referral**

On-going support and referral, which emerged as the second category under the sub-theme, antenatal care, were identified by the participating registered nurses as a major challenge they encountered in teenage mothers who were between 10- and 13-years-old. This finding is verified in the next quotes:

> "*Most children, who fall pregnant at the age between 10 and 13 years, end up in hospital where they give birth through a Caesarean section*." (Participant 5)

> "*Difficult labour is one of the challenges experienced by teenagers because of falling pregnant at the age of maybe 13 to 15 years. Another challenge was lack of transport to the clinic when labour pains commence*." (Participant 2)

> "*Teenagers have a tendency of neglecting their babies because of their tender age and they feel pain when the baby starts sucking and then avoid feeding them. Others end up with swollen breast which end up with boils on the breasts which will need surgery and are referred to the hospital*." (Participant 4)

At these tender ages, girls could not deliver at the clinic due to the likelihood of having severe age-related complications. In the words of a participant, most teenage girls "*between 10 and 13 years end up in hospital*" where a Caesarean birth to save both mother and infant has to be performed and managed by doctors and a multidisciplinary team. The National Association of Community Health Centres (NACHC) (2014:15) reports that in South Africa approximately one in eight teenage deliveries is by Caesarean section. The association confirms the younger the teenage mother, the more inevitable is the risk of having complicated births concomitant with the age group.

But, when a young teenager did not attend antenatal programmes, she is totally unprepared for signs and symptoms of preterm birth and labour because she has not been educated to recognise them. The DoH (2012a:16) indicates that inadequate knowledge may impair healthy development, and in teenage girls with poor nutrition it could delay the onset of puberty and/or lead to the underdevelopment of sexual and reproductive organs that could

result in the birth of low-weight babies and birth complications such as anaemia. Rangiah (2012:15) observes there is an increased risk for young teenage girls to give birth with a Caesarean section because the pelvis may be inadequate leading to obstructed labour, the pelvis is simply not matured enough for normal vaginal delivery in teenagers aged 16 and younger.

What often occurs in rural areas is that teenagers arrive at the clinic when already in labour (Rangiah 2012:15). If the girl is very young and the registered nurses realise that the birth cannot be managed at the clinic, they know they have to transfer the patient to the nearest referral hospital where the birth will be managed in a well-equipped obstetric environment by a knowledgeable and professional multidisciplinary health team including obstetric nurses and doctors (WHO 2007:18). Kathree, et al (2014:9) confirm referrals of complicated and difficult births to designated hospitals ensure better outcomes for teenage mothers and the neonates. In the Guidelines for Maternity Care (2016:18) it is clearly stated some teenagers only visit clinics when they experience complications either during pregnancy or finally when in labour. The NACHC (2014:15) asserts complicated deliveries by Caesarean section resulting from early childbirth are common in South Africa.

The referral system was viewed by the current participants as an essential and crucial element of birth care. They mentioned various situations for which accessible, available and fast transport was essential. Complications occurring during labour in teenagers between 10 and 13 which the participants knew they could not manage at the clinic were referred to the hospital. Anaemia (a common complication in teenagers caused by inadequate nutrition), stillbirth, preterm birth, low birth weight, and asphyxia are high among the new-borns of teenage mothers and increases the risks of death or future health problems for the infant (Cinar and Menekse 2017:20).

For the current participants, when making referrals, the biggest obstacle was to organise transport to the hospital. In emergency cases, the overall unavailability of transport was a huge concern. A participant stated if "*labour pains commences*" at home, getting emergency transport to the clinic was problematic. Although clients organised their own transport for consultation at the hospital, if a young girl was in labour and the clinic nurses knew she needed more specialised help at the hospital, transport to the latter was a dilemma. The quotes proved transport in general was a problematic issue in the two selected villages which often resulted in infant and maternal mortality.

Breastfeeding was another challenge mentioned by a concerned participant. Young teenage mothers are in extreme pain or feel pain when the new-born starts sucking; subsequently,

the mother stops feeding her infant. Developing boils on the breasts require additional surgical removal. Nurses in the clinics must assist and continuously support the teenage mother population to keep on breastfeeding, otherwise they simply discontinue and refuse to feed the new-born (Fleming, et al 2015:741).

In the final analysis, the National Association of Community Health Centres (NACHC) (2014:15) confirms they found that pregnant teenage girls who attended antenatal clinics regularly were more prepared for childbirth than those who did not. The aforementioned strengthens the current participants' resolve that referrals to hospitals for complicated births and on-going support during and post-birth need much more attention than currently receiving. In most developing countries, the majority of young teenage mothers live in remote areas and villages where they receive little health support, guidance or assistance to ensure they as new mothers as well as her newly born babies stay healthy; that the baby is taken care of so that the mother can return to school and continue her education. The United Nations ECA (2015:26) advocate that quality health services rendered at the health facility must be supported by "strong outreach, follow-up and referral services, promoting healthy behaviours at home" in combination with focusing on "social determinants of health (education, income, gender orientation, household food security, water and sanitation etc.)". Strengthening education campaigns for teenage mothers will have the greatest impact on mother and new-born survival as well as for a better future of both the mother and her child.

- **Challenges regarding health education and preparation for birth**

The third category under the second sub-theme, antenatal care, was health education and preparation for birth. The study participants verbalised that antenatal health education programmes were structured to include health education on breastfeeding, antenatal visits, labour and bonding. Family planning was also emphasised as well as the dangers of taking part in unprotected sex. The participants confirmed that:

> "*They* [teenagers visiting clinic] *are taught the importance of breastfeeding and to return for antenatal visit but they do not come. We teach about birth procedures, for example, what will happen in labour and in postnatal ward. We encourage bonding between mother and the baby from birth, hygiene and how to take care of their babies after delivery but only few teenagers report for ANC*." (Participant 1)

> "*Ignorance amongst teenagers results in unwanted pregnancies, in other words, the lack of knowledge about sex is the main cause. Teenagers do not attend family planning clinics in order to be supplied with contraceptives, free of charge. Teenagers hide*." (Participant 5)

> "*They hide their pregnancies and therefore* [do] *not receive health education. Some do not come back on the set date until the time of delivery. As indicated before, some do not even know their last menstrual periods and that is the challenge.*" (Participant 7)

Fasoranti and Adeyeye (2015:225) define health education as "any combination of learning experiences designed to help individuals and communities improve their health by either increasing their knowledge or influencing their attitudes". Riegelman (2010:151) explains that the National Health Education Standards also focus on personal health behaviours while Macdonald, Magill-Cuerden and Warwick (2013:220) confirm that health education is the provision of information tailored to meet the individual needs of the client. Macdonald, et al (2013:218) further assert that decision making and health education are important for health promotion and should be provided throughout antenatal care, labour and in the post-natal period. This information is in line with the findings of this study since registered nurses in the Greater Giyani Municipality, Limpopo provided health promotion through health education.

In this study, giving health education and preparing the new mother for birth came up very strongly during the data analysis. Delivering health education to teenage mothers was experienced by the participants as challenging because "*teenagers hide*". According to the participants, teenagers did not visit the clinics where they could obtain free condoms which would prevent the female from becoming pregnant and protect both males and females against STIs including HIV. Not showing up for antenatal care meant they missed out on reproductive health education programmes and sessions. The registered nurse participants emphasised that proper health education focusing on antenatal care, labour and caring for the infant were provided. Diet and supplements information for the purpose of health promotion were covered by the registered nurses during health education as routine. (Guidelines for Maternity care in South Africa (2016:136).

Oyedele, et al (2013:105) emphasise that registered professional nurses should highlight the importance of quality parent-child relationships. These include informing parents to display warmth and friendliness towards their children. As role models, registered nurses should provide adequate information about sexuality matters to teenagers, be supportive and have the ability to communicate effectively with teenagers visiting the clinic on the latter's level. The parents, a registered nurse, a teacher or a trustworthy adult can fulfil the role of supportive adults who help teenagers to prevent activities that may harm them and make positive transition in the making. Role models and mentors are required at middle and high schools for all teenagers (girls and boys).

According to the ISHP (2012:15), leaners were identified as those requiring health education and other services that cannot be provided at schools. The services which cannot be found in centres such as clinics, should be referred to relevant stakeholders (NGO's, Social workers etc.). In this study, the participants confirmed that registered nurses were functioning according to the policies. They also advised and helped clients who were referred to the hospital in emergency situations to make arrangements for transport. This tie in with the view of Lebese (2009:3) who states poverty and poor health is often related because having no money to pay for transport reduces access to facilities that provide health services. Poverty is therefore an important social issue not only because of its contribution to social exclusion, but also because of its unavailability in times of crisis such as early labour. For example, when transfer is needed as an emergency related to complications with labour, mothers rely on private transport using their own money. This phenomenon is also mentioned by Amnesty International (2014:51) which reveals that women in KwaZulu-Natal, South Africa were encouraged to save money for transport in case there was no transport or 'waiting homes' available. Some facilities in rural areas had beds available for women awaiting labour; hence the waiting homes are places where women who in labour can rest before being transported to the hospital. However, Ware (2013:4) opines that having the actual building in which health services are rendered close by or in the vicinity does not guarantee accessibility to it. The poor and poorest of the poor may not have the finances to make use of the available transport to attend health centres across town.

The findings of the current study further concur with the WHO's (2014:27) recommendation that all women should be given information about the physiological process of recovery after birth. However, this recommendation was not considered by some of the teenage mothers as participating registered nurses confirmed – the former did not comply with the guidelines which resulted in many of them not attending antenatal care activities at the clinics.

3.3.1.3 Sub-theme 3: Post-natal care

Post-natal care was the third sub-theme of challenges in relation to healthcare provision through health promotion. Two categories emerged, namely challenges regarding breastfeeding, care of the baby including bonding, care of mother including referral and family planning.

In this study, the post-natal period was regarded as the period after the end of labour during which the attendance time required of a midwife to a teenage mother and her baby was not less than 10 days. The participants voiced that during this period, bonding between mother and baby was supposed to be enhanced.

- **Breastfeeding and care of the baby including bonding**

The participants agreed that breastfeeding promotes bonding between a mother and her new-born, but they were quite disturbed because they often observed that some young mothers had no idea how to breastfeed nor were they aware of its important linkage to bonding between mother and new-born. The next verbatim quotes verify this finding.

> *"Teenage mothers are encouraged to bond with their babies by placing them on the mother's abdomen, immediately after delivery. They are also encouraged to breastfeed for bonding purposes.*" (Participant 5)

> *"They do not easily bond with their babies and need counselling*." (Participant 12)

> *"Some teenage mothers did not easily bond with their babies and then needed counselling. … They had a tendency of neglecting their babies because of their tender age. They felt pain when the baby starts sucking and then avoided feeding them. Some teenage mothers ended up with swollen breasts, which resulted in the development of boils. They needed surgery."* (Participant 4)

> *"Immediately after birth, the baby is placed on the mother's abdomen for an hour to facilitate bonding and then transferred to post-natal ward where cot bed is no longer encouraged, therefore mothers should sleep with their babies to enable them care for their babies on demand."* (Participant 1)

> "*Teenage mothers between 13 and 15 years are afraid to handle their own babies after delivery, when the baby cries, they also cry. They neglect their babies indicating that they are not theirs because of their tender age and are being disturbed from school*." (Participant 5)

The participants were unanimous in their opinion that the ignorance of young first-time teenage mothers made them scared and nervous to care for their babies, because they were unaware of how to prevent a pregnancy Although sexually active, the delivery of the baby followed by motherhood was traumatic and deeply disturbing for them as the next verbatim quotes verify:

> "*They are sometimes weak due to the pressure of giving birth and they display worry about how to take care of the baby. The non-acceptance of responsibility by the father of the child also causes a psychological trauma to the teenage mother* [who is] *are referred to social workers*." (Participant 13)

> "*The premature birth of the child also causes a stress on the mother with the result that they may even attempt to commit suicide. The dropping out of school as well may result in puerperal psychosis*." (Participant 13)

The same participant emphasised that they, as registered nurses, were acutely aware that they needed to assist and help first-time teenage mothers with breastfeeding so that they could bond with the new-born: "*We* [registered nurses] *teach them to breastfeed their infants to promote bonding.*" (Participant 1)

Nelson (2013:22) reflects on some natural ways of bonding – mother-baby bonding starts during pregnancy and continues after birth. The author explains that while the mother feeds and holds her baby to her breast, a natural bonding occurs. In this study, bonding was also experienced as an enhancing process which began as the newly born baby was placed on the mother's abdomen immediately after birth for an hour. The Guidelines for Maternity Care in South Africa (2016:42) in fact recommends placing the baby on the woman's abdomen immediately after delivery for at least an hour and to also initiate breastfeeding within an hour after birth to increase bonding.

The participants' encouragement for the mother to sleep with her baby on her bed in order to breastfeed the baby on demand strengthens bonding. The stance of the Best Start Resource Centre (2014:5) is that breastfeeding protects infants against a number of illnesses and promotes healthy infant development. Therefore, formal support from health professionals especially in the form of encouragement, information and practical hands-on support may increase teenage mothers' knowledge, skills and confidence in breastfeeding which is a very necessary and natural way to ensure and enhance mother-baby bonding. The participants all shared a great concern about the whole issue of the very young girls' total physical and emotional unpreparedness for this life-changing event called 'motherhood' which, for many, was not of their own choice.

The pain associated with having a normal or difficult birth, breastfeeding, bonding, expressing milk, changing nappies, taking care of the infant – all of this was a new and, in some cases, not a happy experience for the young teenagers. Some verbatim quotes from the participants shed some light on how complex it can be to mould a carefree child into a caring and responsible mother.

> "*They had a tendency of neglecting their babies because of their tender age. They felt pain when the baby starts sucking and then avoided feeding them. Some teenage mothers ended up with swollen breasts, which resulted in the development of boils. They needed surgery*." (Participant 4).

"Some of them rejected their babies indicating that they are not theirs, but for their mothers and some are even afraid to handle their own babies. They did not want to breastfeed their babies." (Participant 1)

"*We continue to teach them about breastfeeding because some of the mothers were mixing herbs with other things. Breast milk should not be mixed with anything unless prescribed by the doctor*." (Participant 7)

"*The psychological problems which she experienced during pregnancy may affect her during delivery. They do not want to breastfeed and end up with breast abscess*." (Participant 14)

Johnson (2014:9) agrees teenage mothers' anxiety about infant feeding decisions and their new role as a mother and parent can play a role in their decision to avoid breastfeeding. The author explains feeding decisions are influenced by the mother's age, maturity level and previous exposure to pregnancy (or then breastfeeding) and therefore teenage mothers are often not comfortable to breastfeed the infant. Tucker, et al (2011:8) agree teenage mothers cannot bond with their babies because they fear breastfeeding (they have sore nipples, pain and breast engorgement) and this results in the development of complications such as boils or then "*breast abscess*" as mentioned by a current participant.

According to Hunter (2014:59), it is understandable that a 10- or 11-year old girl child would shy away from breastfeeding and even more so if she is still traumatised by the birth itself. Being young, inexperienced and fearful herself of the pain she experiences when breastfeeding can drive a 10-year-old to not want the baby to suckle – still a child herself, she also fears the pain. The problem is that boils can develop in the breasts leading to further trauma and complications because they have to be surgically removed (Tucker, et al 2011:8).

The WHO (2013:6-24) recommends for babies aged birth to six months to be fed eight times per 24-hour day. In spite of the fact that the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030:90) strongly recommends exclusive breastfeeding for six months after birth, the participants observed some teenage mothers gave up breastfeeding much earlier. Macdonald, et al (2013:730) found in their study that many teenage mothers gave up breastfeeding before the recommended six-month period because they wanted to return to school. Also, if she is an older mother who wants to return to school, keeping her baby healthy by expressing breast milk takes a lot of time and effort. Although the participants welcomed it when a teenage mother wanted to go back to school, they were concerned about the baby's feeding as evidenced in the next quote:

> "*During school attendance, we encourage them to express milk from breast before going to school, be refrigerated but not to be placed in a freezer, so that the baby can be fed during her absence. The care giver must first warm the milk before feeding the baby as the government encouraged breastfeeding only and nothing else for six months and discourages the use of formula milk as a way of promoting breastfeeding. They are taught about how to exercise. They are also taught about how to breastfeed*." (Participant 1)

The Guidelines for Maternity Care in South Africa (2016:136) does not condone formula feeding, but it does emphasise that mothers who choose not to breastfeed should be counselled and educated on age-specific types of infant formula to purchase, prepare and use safely. The participants in the present study affirmed they explained the process of expressing milk, storing and warming it to the teenage mothers who left their babies with a caretaker at home while they were at school. The participants discouraged feeding the baby formula milk as well as not mixing breast milk *"with anything unless prescribed by the doctor"*.

To further promote breast milk feeding among teenage mothers who choose to exclusively breastfeed for the first six months or express breast milk, Willan (2013:58) proposes for the school to provide a private space for them to do so. Hunter (2014:59) agrees schools should have facilities where mothers can express and safely store milk. Teenage mothers can then attend school while ensuring that their baby still receives breast milk and bonding between mother and baby is possible.

The participants admitted that bonding was not easy for teenage mothers and it was a challenge for the professional nurses to promote bonding, but they were very firm that they did thorough counselling, encouraged and taught the teenage mothers to breastfeed, bond and care for their new-born's. Participants also did counselling to address puerperal psychosis as confirmed by the next two quotes:

> "*Mostly, there is a challenge of puerperal psychosis and failure of the teenage mother to take care of the baby. Sometimes are afraid of changing nappies and breastfeeding.*" (Participant 11)

Especially young mothers fail to care for their new-borns due to this condition. Changing napkins as well as breastfeeding appeared to be a problem for teenage mothers in the current study as a result of puerperal psychosis. Anyanwu, et al (2013:926) add that teenage mothers neglect or abandon their babies post-delivery because of psychosocial pressure and the devastation they experience when having an unwanted pregnancy. In resolving

puerperal psychosis, WHO (2013:4) advises that healthcare professionals should observe any changes in the mood, emotional state and behaviours that are outside of the teenager's normal pattern post-delivery to exclude psychosis. The WHO (2013:4) adds from 10 to 14 days after birth, all mothers should be asked if the occurrence of mild, transitory postpartum depression ("maternal blues") has disappeared or not. If these symptoms persist, the mother's psychological wellbeing should continue to be assessed for postnatal depression or psychosis and, if necessary, she has to be referred to a psychologist or social worker.

According to Kathree, et al (2014:10), the most common symptoms of psychosis include the need to cry, not taking care of one's appearance and feeling the need to be alone. These signs may be caused by rejection or lack of support by a partner, an unwanted pregnancy or premature birth. If not addressed, it may result in attempted suicide. Brits, Adriaanse, Rall, Van Biljon, Van der Walt, Wasserman and Joubert (2015:223) found that smoking and alcohol consumption during pregnancy could not be linked to premature births. However, their findings concur with the current study findings that the characteristics of puerperal psychosis included the inability of teenage mothers to care for their babies due to psychosocial pressures. The health, educational and economic impact that an early pregnancy can have on young teenage girls can leave her feeling rejected, isolated, ashamed, powerless, and hopeless because she may think she has lost the opportunity to reach her full potential (UNFPA 2013:17).

- **Care of mother including referral and family planning**

The care of the mother including referral and family planning was the second category under the sub-theme post-natal care. The participants emphasised that the care of a mother including referral starts immediately after the end of labour and lasts until her reproductive organs have returned to their prim gravid state. The participants confirmed this as follows:

> "*After delivery, we provide monitoring in post-natal care, check the blood pressure, whether the woman is bleeding or not and whether the uterus has contracted or not. The baby is weighed and is also checked whether the cord is clean or not. Episiotomy is checked for healing and if* [whether] *the mother is breastfeeding the baby properly*." (Participant 3)

> "*We also provide workshops where we teach the pregnant teenagers about child birth and baby care. They are also made aware of complications that may occur. We also give post-natal clinic services about how they are to take care of their babies and the wounds they may have received during birth like episiotomy. They are taught about how to exercise. They are taught about how to breastfeed.*" (Participant 15)

The participant confirmed that a post-natal examination was done immediately after the teenage mother has given birth to make sure no abnormalities such as a contracted uterus, bleeding or an episiotomy has occurred during the birth process. Macdonald, et al (2013:727) confirm that the post-natal examination includes monitoring for unnecessary heavy bleeding and the healing of an episiotomy as well as providing advice to the new mother on breastfeeding. It is indeed the duty of the professional nurses to provide care, monitor the progress of mothers in the post-natal period and provide essential advice to the new mothers on infant care. The Guidelines for Maternity Care in South Africa (2016:43) recommends that during the fourth stage of labour, midwives should check whether the uterus **is** well contracted to exclude severe bleeding; they should be alert to note and take immediate action in case of an elevated blood pressure, an abnormal heart rate and respiration to prevent further complications. In this study, the participants appeared to be working according to the guidelines as recommended.

However, the participants did experience challenges post-delivery regarding the care of teenage mothers who needed referrals. The challenges were expressed by participants as follows:

> "*Premature birth of the child causes a stress on the teenage mother with the result that they may even attempt to commit suicide. Threats caused by parents also led* [to] *traumatic stress on the teenage mother, leading to psychosis or depression*." (Participant 13)
>
> *"Except for the routine antenatal care, in case of other problems such as depression she was referred to a social worker or a psychologist for assistance."* (Participant 2)
>
> *"Mostly, it is the puerperal psychosis and the failure of the teenage mother to take care of the baby. They are sometimes afraid of changing nappies and also of breastfeeding their babies.*

Premature births clearly caused immense stress and anxiety for mothers – in some the extent of their stress and worry resulted in suicidal tendencies. Hunter (2014:29) asserts that teenage mothers are most at risk of pre-term births because of their young age and the immaturity of their reproductive organs. Beguy, et al (2014:8) report that teenage mothers usually deliver premature babies and are more likely to die during pregnancy and delivery because of the unusually high level of stress they endure. The authors further assert that, as a result of the teenage mothers' physical immaturity, their babies tend to die before the age of five. This statement is confirmed by the National Association of Community Health Centres (2014:15) in which it is reported that teenage mothers have a high incidence of

premature labour, miscarriage and stillbirths while their living infants generally have a very low birth weight. Higher rates of infant mortality and morbidity are experienced among teenage mothers than among older adult mothers.

The strain associated with giving birth weakened teenage mothers physically and emotionally and this was aggravated by worries about how to take care of their babies. The participants also noted that failure of the father to take responsibility for the child and "*threats caused by parents"* caused further psychological trauma to the teenage mothers who eventually then ended up depressed or with puerperal psychosis and they were referred to the social worker or psychologist as confirmed by the verbatim quotes. These findings concur with the ISHP (2012:25) and the WHO (2013:25) in which it is documented that teenage mothers who develop postpartum depression ("maternal blues") show high rates of anxiety disorder, post-traumatic stress and depression among female teenagers are related to pregnancy and other factors incidental to pregnancy and birth. According to Kathree, et al (2014:10) and Johnson (2014:9), psychosocial stressors trigger depression. In the view of these authors, depression (especially severe post-natal depression) among young teenage mothers is most of the time indicative of a much bigger problem in the sociocultural context of the young mother. It may be an unwanted pregnancy; the parents may reject the pregnancy and withdraw emotional and/or financial support or the boyfriend (father of the baby) may reject the mother as well as the baby/child.

In the current study participants perceived that the teenage mothers in the study setting chose to become pregnant willingly to save their relationships or became pregnant not of their own choice, but because they failed to make the decision to use contraceptives even if they were knowledgeable about it. The participants mentioned that:

> "*Sometimes teenagers stop taking contraceptives because they want to prove that they can also give birth or to get hold on the boyfriend by falling pregnant. Also, due to the wrong information they have received regarding contraceptives and some end up having unwanted or unplanned pregnancies*." (Participant 7)

> "*Presently we have a contraceptive called an implant and when these teenagers come for it, some nurses will ask them if they no longer want to bear children, which will cause the girl to think that if she goes ahead with this thing, she will never bear children again, which is incorrect information. So, the negative attitude of some of us as nurses resulted in teenagers not attending family planning services and end up with unwanted pregnancies. Lack of knowledge about family planning also will result in teenagers not going for assistance at the clini*c." (Participants 3)

> "*The contributing factor is about the wrong information they receive from other teenagers about the side effects of contraceptives, like becoming obese or looking elderly due to their use.*" (Participant 12)

To the participants it seemed as if teenage girls wanted to prove their fertility to win over or remain with a boyfriend. The participants attested that a lack of knowledge and receiving wrong information from the professional nurses themselves caused unwanted pregnancies among the female teenagers. Mnyanda (2013:17) agree with what the participants expressed by stating that most female teenagers who knew about contraceptives did not use it for fear of losing their boyfriends; they thus perceived the use of contraceptives as 'bad' for their relationship. This author also mentions that females complained contraceptives make a girl wet or contribute to weight gain and therefore they become reluctant to use it and, consequently, their decision to not use contraceptives result in an unwanted pregnancy. Nelson (2013:19) agrees with Mnyanda (2013) that in some cultures female teenagers want to prove they are fertile; they thus choose pregnancy above having safe sex. The aforementioned authors' findings as well of that of the current study reaffirm the assertion made by Charco, Kipp, Laing and Lake (2007:323) exactly 10 years earlier that teenage girls have sexual relationships with boys and become pregnant in order to please them. Nelson (2013:19) further posits that in some cases teenage girls may choose to become pregnant and have a baby to counteract loneliness.

In the South African context, unequal decision making about sex among partners is the norm. Girls lack autonomy and obediently comply with the likes and dislikes of boys they want to please and whose attention they want to keep. Girls do not make the decision about safe sexual practices. If the boy prefers sexual intercourse without a condom, a girl will seldom (if at all) negotiate for safe sex but will comply with the boy's wish (IBIS Reproductive Health 2013:15).

Mothiba and Maputle (2012:2) found in the Capricorn district in Limpopo that the staff's attitude and their lack of knowledge about contraceptive use served as a barrier for teenagers to access family planning. Beguy, et al (2014:8) also report that the nature of service provided and attitude of the provider influence teenagers' attitudes towards contraceptive use. According to the IBIS Reproductive Health (2013:20) report, various barriers deter contraceptive use by teenagers in South Africa. These barriers include the lack of access to services, fearing the professional nurses' disrespectful and/or judgemental attitude and the teenagers' concern about confidentiality. Mothiba and Maputle (2012:4) add further barriers such as peer pressure, sexual coercion and poverty. The participants in this study did emphasise the attitude of the clinic staff as contributory factors to the failure of

teenagers to make use of the available contraceptive methods at clinics. Hence, as far as visiting clinics to ask for advice on contraceptive use or to obtain free condoms, the negative attitude of some of the clinic nurses hindered teenagers to access these health services and acquire knowledge on safe sex practices as well obtaining contraceptives. Consequently, this resulted in unplanned or unwanted teenage pregnancies. In the current study, some participants voiced that teenage girls received false information from some professional nurses on the consequences of an implant which made the former decide not to make use of this contraception method.

A further concern mentioned by Holt, Lince, Hargey, Struthe, Nkala, McIntyre et al (2012:288) is that in many traditional households, parents do not talk to their children about sex at an early age. The children therefore end up getting incorrect information from other sources such as peers who themselves lack correct knowledge of sexuality and contraceptives. In addition, Thobejane (2015:274) found the lack of knowledge sharing and parental guidance on issues of sexuality have a major impact on teenage pregnancy because most parents do not have – or do not make – time to discuss sexual matters with their children.

3.3.1.4 Sub-theme 4: Ensure follow-up

Ensuring follow-up was the last sub-theme under the first theme, healthcare service provision. The participants reported that health professionals working in reproductive health and pregnancy-related services always tell their clients to come back for follow-up after rendering certain services. All the participating registered nurses affirmed they requested the teenage mothers to re-visit the clinics for follow-up as indicated by the next two verbatim quotes:

> "*We encourage them to come back for post-natal checking after five days both the mother and the baby in order to assess their health. The mother is also checked if breastfeeding the baby properly. After six weeks, we start with under-five clinic and family planning*." (Participant 1)

> "*Post-checking after birth is done to assess the healing of episiotomy if any. The mother is checked if breastfeeding the baby properly. The child is checked if vaccinated. They are encouraged to go for family planning and test for HIV*." (Participant 4)

The participants verbalised that they advised teenage mothers on discharge to come back for post-natal checking after five days to assess both the mother and the baby. During this

first follow-up, the registered nurse checked whether the mother was breastfeeding the baby properly and then started advising her about under-five clinic visits and family planning and the significant of bonding. The consultations participants did are confirmed in the Guidelines for Maternity Care (2016:136) where it is indicated that mothers are encouraged to attend the local clinic for check-ups to monitor and ensure the wellbeing of both the mother and baby. The registered nurses documented that teenage mothers were encouraged to engage with check-up activities. The findings were in line with the Guidelines for Maternity Care (2016) as well as with the recommendation of the WHO (2013:25) that follow-up care should be done between 10 and 14 days after birth to monitor the mother and baby for symptoms related to any post-birth complications that could occur. In fact, the current participants recommended that all mothers should be questioned about the resolution of mild, transitory postpartum depression ("maternal blues"). In this regard, the WHO (2013:25) states if suspicious signs are observed, subsequent follow-ups need to be done to specifically address depression.

However, the study participants admitted they encountered certain challenges with regard to postnatal follow-up care. From their verbatim quotes, the following challenges emerged:

> "*Some teenage mothers do not come back for follow-up care they may need. They will only come to the clinic when either the mother or the baby is not feeling well*." (Participant 2)

> "*They* [young teenage mothers] *are sometimes weak due to the pressure of giving birth and they display worry about how to take care of the baby. The non-acceptance of responsibility by the father of the child also causes a psychological trauma to the teenage mother are* [who is then] *referred to social workers*." (Participant 13)

> "*Late bookings are the main problem as they do not know about when they fell pregnant. They default attendances at the ANC* [antenatal care]. *After testing positive for HIV, they will never return to the ANC until a follow-up was done*." (Participant 15)

Follow-up was emphasised as the method of ensuring quality in service provision. In this study, follow-up was done to assess the healing process post-delivery for both the mother and baby. However, according to the registered nurse participants this posed an immense problem for teenage mothers who tested HIV positive – they hardly ever returned for follow-up visits which put the babies at a high risk for being in contact with HIV. Medmorth, Batterspy, Evans, Marsh and Walker (2011:542) confirm that women seem to avoid or are not concerned about follow-up clinic visits despite being instructed to do so. These authors explain that after an implant or intrauterine device insertion has been done as a contraceptive method, a follow-up visit is usually prescribed for the woman to exclude the

possibility of infections. Alternatively, she is advised to immediately report any signs of infection. According to Medmorth, et al (2011:542), in their experience women just do not keep follow-up visits and neither do they provide feedback to the registered nurses on the success or failure of the implant, for example. The participants said teenage mothers only came to the clinic "*when either the mother or the baby is not feeling well.*"

The DoH (2007:16) affirms the current findings and states some teenage mothers who were consulted felt that maternity services were biased and did not consider the unique needs of teenage mothers. Examples given included midwives and other maternity staff demonstrating a judgemental attitude towards teenage mothers and this discouraged the latter from attending antenatal classes. Willan (2013:7) confirms teenage mothers are unwilling to attend health services due to feeling ashamed and guilty – feelings fuelled by previous experiences of PHC staff's prejudiced and unkind treatment of pregnant teenagers, hew mothers (e.g. infections) or teenagers with problems related to sexual health such as STIs. According to Ediau, Rhoda, Wanyenze, Machingaidze, Otim, Olwedo et al (2013:8), everybody in a community (thus including healthcare workers and parents) should make an effort to encourage all pregnant women and girls to visit health facilities (clinics) for ANC to improve their health.

3.3.2 THEME 2: CHALLENGES OF TEENAGE MOTHERS OBSERVED BY REGISTERED NURSES

Challenges of teenage mothers observed by registered nurses during provision of health and wellbeing was identified as the second theme. From this theme, two sub-themes, namely community-situated challenges and unsatisfactory service utilisation emerged. The themes, sub-themes and categories are summarised below in Table 3.3.

Table 3.32: Challenges of teenage mothers as observed by registered nurses

THEMES	SUB-THEMES	CATEGORIES
3.3.2 THEME 2: CHALLENGES OF TEENAGE MOTHERS OBSERVED BY REGISTERED NURSES	3.3.2.1 Sub-theme 1: Community-situated challenges	• Lack of support from family/community
		• Stigmatisation/rejection
		• Partner/peer influence
	3.3.2.2 Sub-theme 2: Unsatisfactory service	• Late reporting to services/non-compliance during pregnancy

	utilisation	• Healthcare provider-situated • Transport challenges

3.3.2.1 Sub-theme 1: Community-situated challenges

Community-situated challenges observed by registered nurses was the first sub-theme from which three categories emerged, namely, lack of support from family/community, stigmatisation/rejection, and peer/partner related challenges. It must be noted that 'family' in almost all instances refer primarily to mothers who are by nature and being of the same gender the ones mostly involved in their daughters' pregnancy.

- ***Lack of support from family/community***

The nature and quality of the relationships between teenagers, parents and community members seem to have a major influence on teenagers' sexual behaviours and attitudes. Poor relationships in the household with little or no communication about boy/girl relationships and an unsupportive, poor community who was not knowledgeable about how to guide teenagers to become responsible adults influenced the teenagers' social attitudes which included risky sexual behaviours. This is evidenced by the following three verbatim quotes:

> "*Pregnant teenagers and teenage mothers lacked guidance from parents* [mothers] *that led to lack of knowledge because talking about sex to their children was regarded as taboo which led them to have sex early. Teenagers lacked information concerning safe sex and family planning.*" (Participant 12)

> "*Attitude of the community, parents and teachers and regarding use of contraceptives also contributed to not using contraceptives. Parents must be taught to support their children and to encourage them to return to school after delivery. Lack of income may lead teenagers to engage in unsafe sex with men who will give them money. Exploitation may be done by elderly men, taking advantage of young girls by enticing them with money and expensive gifts.*" (Participant 4)

> "*Teenagers do not attend family planning clinics in order to be supplied with contraceptives free of charge. Some have pregnancy intentionally in order to have financial support of government grant or being sexually abused by elderly people*." (Participants 5)

The participants noted especially teenage girls lacked guidance and knowledge about "*safe sex"* and the use, availability and accessibility to SRH services. Mothiba and Maputle

(2012:2) state teenage mothers lack knowledge specifically about contraceptives and ANC due to the absence of knowledgeable and supportive female role models. The teenagers were unaware about issues like family planning, using contraceptives to prevent unwanted pregnancies and STIs including HIV. Money and the absolute lack thereof was a major factor that drove teenage girls to engage in unsafe sexual practices with rich, older men. In their families and at school there were apparently no adults ("*the community, parents and teachers*") who guided the teenagers or to whom they could turn for advice on sexuality and pregnancy prevention.

A few ubiquitous factors are mentioned in the literature with regard to how the attitudes of communities, parents and teachers contribute specifically to teenage girls' lack of knowledge on sexual and reproductive health-related matters. Ramkissoon, Searle, Burns and Beksinska (2010:34) hold that gender inequality and gender division "are nowhere more apparent than in relation to sexual freedom and reproductive expectations, as in responsibilities and experiences of men and women". The stance of Ware (2013:24) is that teenage pregnancy is driven by gendered expectations of how boys and girls should behave – sexual taboos for girls as opposed to sexual permissiveness for boys which is aggravated by poverty, poor access to contraceptives, legalised abortion and the apparent judgemental attitudes of the health providers contribute towards the position on gender discrimination taken by (Ramkissoon, et al 2010:34).

The lack of social support contributes to the difficulties that teenage girls experience when they become pregnant (Yate 2011:89). The author encourages nurses to involve parents on how to teach their children about family planning and also makes the point that many families demonstrate a similar reaction to a teenage daughter's unexpected pregnancy. At first, the family tends to be negative, judgemental and disappointed but they eventually support her emotionally and, where possible, financially.

According to the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030 (2016:91), the community should become engaged in learning programmes to increase their understanding of the health behaviours of teenagers and to learn how to support the latter. These assertions from literature concur with the participants' reflections that teenagers lack information concerning safe sex and family planning and with the view of Mchunu, Peltzer and Seutlwadi (2012:432) that the South African youth still engage in dangerous sexual behaviours due to a lack of knowledge and they therefore make risky sexual decisions. The community, parents and teachers need to be informed and knowledgeable to support teenagers. Bana, et al (2010:154) explain in traditional African regions where

everyday life in communities is lived according to prescribed and inherited age-old norms and values, an unwed teenage mother is prone to be ostracised.

Panday, et al (2009a:56) and Mchunu, et al (2012:432-433) found towards the end of the previous decade and the beginning of the current one, many teenagers did not have adequate knowledge on contraceptives. The situation seemed to improve when Willan (2013:28) commented in 2013 that teenagers in South Africa apparently have a good basic knowledge about contraceptives, but significant gaps and inaccuracies were still present in their awareness. Injections birth control pills and condoms were known, but very few recognised the importance of dual protection (using male and female contraceptives together) and that correct, persistent condom use is essential to protect against HIV and other sexually transmitted infections (STIs). The National Youth Risk Behaviour Survey reported among secondary school learners correct and constant condom use was only 31% (Reddy, James, Sewpaul, Koopman, Funani, Sifunda, et al 2010:11).

Mthobeni and Peu (2013:6) found young people often experience resistance from parents who consider it religiously or culturally taboo for older people to talk about safe sex, condom use and the transmission of HIV to younger people. Without support, young people may have unnecessary, ungrounded fears about contraception and may not know how to prevent HIV/AIDS and STIs (DoH 2013:17). Adolescent- and youth-friendly healthcare services that are acceptable, accessible, appropriate and effective are therefore essential.

Tighe (2010:295) on the other hand argues teenage mothers' attitudes towards health service ranges from boredom, showing disinterest and lacking enthusiastic cooperation when attending ANC to simply not attending ANC because they feel they already know enough about it. Despite the fact that Contraception Policy and the HRSA Guidelines (2015) emphasise education and counselling regarding various contraceptives, teenage mothers are still judged and fail to obtain them from the services.

The participants of this study reflected that parents must be taught to support their children and to encourage them to return to school after delivery. Malahlela and Chireshe (2013:140) argue that teenage mothers are not well supported by their families to enable them to return to school and therefore dropout. There would be no one to look after the new-born babies as they may not have anyone to assist them at home. The participants of this study concurred with these authors as they also reflected that the attitudes of the community, parents and teachers regarding the use of contraceptives contribute to teenagers not using contraceptives. Willan (2013:28) argues that poor knowledge is often the reason for ineffective or non-use of contraceptives.

- **Stigmatisation/rejection challenge**

The participant in this study revealed that teenagers had stigma towards being examined by a man even if they see the status of a nurse and in some cultures the community do not believe in using contraceptives. The participants in this study stated:

> "*Teenage mothers have stigma as they are shy and refused to be examined by me as a male nurse even though they realised that I am a nurse and that it is part of my work. Adult clients do not have such a problem*." (Participant 3)

> "*The teenager is found to be failing to cope well with the pregnancy, because it primarily affects her educational prospects, the rejection by the family for the embarrassment caused by the unplanned pregnancy. The teenage girls further experience rejection within the community or the church because of the embarrassment caused by the pregnancy outside the wedlock. The rejection is also experienced at school*." (Participant 14)

> "*Some parents chase teenagers away from home if pregnant and these caused them to go and stay with their boyfriends at their families. They are also rejected by the parents, teachers and the community at large regarding pregnancy out of wedlock, which contributed teenagers failing to return to school*." (Participant 10).

The participants in this study reflected how religion and culture could influence the use of contraceptives by teenage mothers. The participants revealed that a male nurse was "*stigmatised*" by teenagers while rendering the services. They also reflected that parents and the community rejected pregnant teenagers because they expect them not to become pregnant before marriage. The participants indicated that pregnancies led them to be chased from home and ended up staying with boyfriends. They were further afraid to be seen when obtaining contraceptives in the health services as they feared stigmatisation.

In confirmation of these discussions, Davids and Waghid (2013:141) found that culture and religion did not encourage teenagers to use contraceptives nor to return to school. It was found that discrimination was done on return to school of teenage mothers a year after expulsion. Da also indicate that the principal in this instance rejected the readmission of a teenage mother because she was married by religious rites. Mchunu, et al (2012:427) also state that the South African youth are still engaged in risky sexual behaviours and they are very much affected by the stigma attached to being pregnant; therefore, they cannot access public health services.

Shefer, et al (2013:5) assert that teenage mothers who return to school are sometimes rejected by the teachers and learners because of their motherhood. The authors also indicate that teenagers, who return to school without going through any counselling preparing them to deal with schooling and parenthood simultaneously, mostly get overwhelmed by their situation in school and some fail to cope resulting in dropping out of school. Neu (2008:36) also indicate that when estrangement from friends and family occur, it is painful for the young mothers as they are sometimes "disowned" by their families instead of being supported. The participants (registered nurses) agreed with Neu and Robinson (2008) by stating teenagers fail to cope well with a pregnancy because it primarily affects their educational prospects as well as rejection from by the family members because of the embarrassment caused by unplanned pregnancy.

The National Department of Health (2010:25) reports that the majority of teenagers use contraception but fear to go to the clinic to access advice and support before they have their first sexual experience. Teenagers do not use contraception consistently and end up conceiving. Macdonald, et al (2012:336) add many teenagers have unprotected sexual intercourse partly due to their attitudes towards risk taking and partly due to ignorance about contraception or fear of seeking advice. While at school, pregnant teenagers react negatively to stigmatisation of being pregnant displaying behaviours observed by educators as aggressiveness, shyness and isolation (Malahlela and Chireshe 2013:142).

The participants revealed that the communities and church leaders and peers had negative attitudes towards pregnant teenagers or teenage mothers who became pregnant out of wedlock. It was stated that teenagers also feel embarrassed to visit the clinics for contraceptives because they are rejected in the community by their peers at schools. The community also perceived pregnant teenagers as prostitutes which contributed to rejection. Davids and Waghid (2013:148) found that the exclusion of the pregnant teenagers was inconsistent with the provisions of the SA Schools Act and the Constitution regarding pregnant and teenage mothers. The authors additionally mention that in some schools, pregnant teenagers and mothers were accepted while in others they were rejected. On the other hand, these schools exist because of a diverse understanding of citizenship that individuals have the right and protection of the state to exercise their beliefs. In addressing the unacceptably high rate of teenage pregnancy, and sensitive to the impending banishment of the pregnant mother-to-be, Davids and Waghid (2013:139) argue that the SA Schools Act makes provision for compulsory attendance of all children "until the last school day of the year in which such a learner reaches the age of fifteen years (84 of 1996, Chapter 2, 3(1)). These aspects inhibit the school the rights to expel learners. In this study, teenagers and teenage mothers were accepted in schools, but still experienced the challenge of

rejection by some of their peers and the teachers. Thobejane (2015:274) concurs with the study participants on the rejection issue. Teenagers who were born and grew up in poverty, may end up doing prostitution as a way of compensating for the salaries of their parents leading to further rejection by the community. Anyanwu, et al (2013:297) agree that stigmatisation associated with pregnancy at an early age is high and teenage mothers face fear, shame and embarrassment when their pregnancy is eventually revealed to their families, partners and the community and they are rejected because of their pregnancy status.

- **Partner/peer related challenge**

A peer group can easily influence one another in order to qualify for that particular group. The participants reflected that peer group influences do occur in their environment. One participant once witnessed a teenager who was laughed at by her peers for using contraceptives and not receiving a child social grant. The participants mentioned that:

> "*Sometimes peer group pressure may result in a teenager abandoning the use of contraceptives, like what happened and I witnessed at this clinic one day. One girl, who had come for an injection, met others who had brought their babies for immunisation and check-up. They literally laughed at her for using contraceptives. They mocked her by saying that, you are still proud of getting injections whilst we feel proud of the R300 grants we receive monthly?*" (Participant 2)

> "*Peer pressure is a real threat as they are ridiculed if they do not have a baby and not getting a grant. They are ridiculed when they go for family planning. They usually commit abortion. They are told that condoms are containing worms. They also watch sex films so they would like to experiment on what they have observed. They use drugs and substance abuse.*" (Participant 9)

> "*Teenagers do not care because they are given information anywhere, at schools, clinics, even in media but they don't care. Some see friends with boyfriends so they feel pressured to have one but do not go for family planning*." (Participant 7)

> "*I also wanted to change school because I was afraid to face teachers and students. I thought teachers and other students will continue torturing me. Unfortunately, I dropped out from school*." (Participant 14)

Peer pressure is probably one of the biggest challenges for a teenager to withstand. Deciding not to use contraceptives, being ridiculed by peers when going for family planning,

experimenting with drugs, alcohol and sexually and wanting a baby to please a boyfriend – this is the way teenagers influence each other. Teenagers do not think about their future, they think only about what is happening in the now and here. In South Africa, “teenage pregnancy is an emotive subject” (Padarath and Barron 2017:258). Much research done by researchers, organisations and NGOs on teenage pregnancy, contraceptives and SRH encounter the same barriers teenagers have towards practising safe sex.

According to Flanagan, et al (2013:13), barriers include the girls’ desire to prove fertility and womanhood, a lack of access to SRH services, fear of adult (nurses and educators specifically) biases, adherence to peer norms to be included in the group, and concern about confidentiality. Winters and Winters (2012:4) agree that peer groups play an important role in contributing to teenage pregnancy, non-use of contraceptives and sharing wrong information with each other. Holt, et al (2013:74) also agree that peer norms play a role because information (usually wrong or misinterpreted) regarding the use of contraceptives is acquired from peers. Nelson (2013:28) confirms that some teenagers in South Africa have basic knowledge of contraceptives and some do use them; however, many only know about the injection, pill and condoms but they have negative attitudes towards using it. Conversely, IBIS Reproductive Health (2012:43) reported that teenagers are influenced by their peers in order to be acceptable to the group as they fear rejection. They also influenced each other to be pregnant in order to receive child support grant, to prioritise child care and motherhood potentially at the expense of their academic progress or to continue with schooling.

Adolescents engage in sex. A survey conducted in the USA in 2008 revealed that seven per cent of high school children had sex before the age of 13 and two-thirds of the children in Grade 12 were sexually active (Kim 2008:1). Data from a 2016 Southern Africa Labour and Development Research Unit report for the SAHR done by Branson and Byker (2016 cited in Padarath and Barron 2017:258) evidence “teenage mothers only start to use contraception after a first birth. By geo-linking several sets of data (the love-life Project Monitoring Database, District Health Information System facility data, National Income Dynamics Study (NiDS) data and Census 2001 data), the study showed that, among women who gave birth by 2012, access to a National Adolescent Friendly Clinic Initiative (NAFCI) clinic delayed childbearing by approximately 1.2 years on average.”

Conversely, Ibis Reproductive Health (2012:43) indicates that many pregnant teenagers are encouraged by peers to be involved mothers and also continue with schooling. Peers can also add to the pressure experienced by teenage mothers who are being encouraged into two contradictory roles, to prioritise child care and motherhood potentially at the expense of their academic progress or to continue with schooling.

3.3.2.2 Sub-theme 2: Unsatisfactory service utilisations

Several factors affect teenagers to access health services especially family planning to obtain contraceptives. Stigmatisation, peer pressure and community culture or health service staff contributes to unsatisfactory use of health service. Community situated challenge is the first category discussed.

Unsatisfactory service utilisation as challenges observed by registered nurses was the second category under the theme challenges of teenagers regarding the service. Four subcategories arose, namely late reporting for service, healthcare provider situated, community related stigma, and transport.

- **Late reporting to service/non-compliance during pregnancy**

Late reporting to service/non-compliance was seen as a problem among pregnant teenagers. It was found that some of the teenage mothers did not know the actual date of conception. These teenage mothers reported late to the service when they discovered that they were pregnant and did not follow the instructions from the registered nurses. The expressions of the participants (registered nurses) were:

> "*Late bookings are the main problem as teenagers do not know about the time they fell pregnant. They default attendances at the ANC. Some do not come on the return date because they attend school. After testing positive for HIV, she will never return to the ANC until a follow-up is done*." (Participant 15)

> "*Teenage mothers do not comply with the instructions given upon on discharge from the hospital regarding follow-ups, they do not come to the clinic for any follow-up care they may need. They will only come to the clinic when either the mother or the baby is not well*." (Participant 1)

> "*They do not come to the clinic for immunisation or for any follow-up care they may need. They do not come at all, they rather stay at home. They will only come to the clinic when either the mother or the baby is not well, pregnant or about to give birth. The child must therefore be given catch-up vaccines because all the other vaccines were not given because the mother did not comply with the instructions given and reported only when crisis arise regarding babies or themselves*." (Participant 2)

In this study, the participants (registered nurses) indicated that teenage mothers made late bookings they did not know the time of conception. After bookings, they defaulted on attendance of ANC and immunisation of their children. They also did not take instructions

from registered nurses and reported to the clinic only when either the mother or the baby became ill, had pregnant complications or when about to give birth. Nelson (2013:30) argues that registered nurses are supposed to provide information to teenagers regarding contraception in order to prevent teenage pregnancy and in the case of a pregnancy, to ensure reporting to the clinic on time. The same author emphasises that teenagers should be discouraged to have sex when they are still young; however, the author also argues that registered nurses are not comfortable to provide information as their expectation is for teenagers to abstain from early sex. Ware (2013:4) states the physical availability of health services begins with the existence of those services – but this does not guarantee they are able to access it. For example, in villages transport to attend centres across town is not available. In support of the expression of the participants and Nelson (20113:30), Willan (2013:11) indicates that the South African Children's Act (No.41 of 2007 as amended) provides teenagers with the opportunity to access sexuality information at healthcare services. The ISHP (2012:10) also supports the improvement of the general health of school-going children as well as addressing health barriers to learning in order to improve education outcomes and access to school.

Department of Health 2012:14) states there is a national commitment for the maintenance of sexual and reproductive rights as well as access to reproductive healthcare. In the Constitution of the Republic of South Africa (Act No. 108 of 1996) enshrines reproductive rights and the right of access to reproductive healthcare are enshrined. Accordingly, everyone has the right to bodily and psychological integrity, thus including the right to make decisions concerning reproduction. The goal of the ISHP (2012:10) is to contribute to the improvement of the general health of school-going children as well as the environmental conditions in schools and address school barriers to learning in order to improve education outcomes. The author reaffirms that the Act allows for children over 12 years to access health service without parental consent. Karra and Lee (2012:7) and Willan (2013:11) agree that teenagers are allowed to access clinics for check-ups regarding reproductive health advice and free contraception without parental permission.

Panday, et al. (2009a:40) note that despite progressive polices, programmes and strategies, many teenagers avoid accessing family planning and antenatal services until very late in pregnancy. According to Mothiba and Maputle (2012:1), some parents are reluctant to communicate about sexual and contraceptive matters with their teenage children because the parents are afraid that the teenagers may interpret this as permission to engage in sexual activities. It seems as if that teenagers are reluctant to visit clinics to obtain contraceptives and thus do not make use of available health services. This study findings confirm that teenagers are reluctant to visit clinics to obtain contraceptives and thus do not

make use of the available health services. The study findings of both Panday, et al (2009a:40) and Mothiba and Maputle (2012:1) are similar to that of the current study in that teenage mothers do not comply with instructions given by nurses regarding ANC as well as obtaining family planning:

- **Healthcare provider-situated**

Healthcare provider-situated was the first subcategory emerging from the second category, unsatisfactory service utilisation. The participants voiced that teenagers were afraid to visit healthcare service providers as they perceived nurses scolded them because they were young, sexually active and pregnant. Apparently, the attitudes of nurses in the health services did contribute to teenage pregnancies as signified in the following quotes:

> "*Teenagers are afraid of facing the healthcare providers, who will sometimes scold them and say they are so young and yet they sleep with boys and that they cannot be provided with anything for family planning because they do not have families. Then they go home without receiving any contraceptives and they fall pregnant as a result of attitude of some healthcare providers*." (Participant 1)

> "*We as nurses will start accusing them of having started to engage in sexual activities, instead of assisting them. The staff members must also be taught to be of assistance to the teenagers who come for family planning instead of discouraging them. The staff's attitude may scare teenage mothers to come to the clinic for family planning. Attending schools also prevent them to manage to arrive to the clinic on time and the nurses return them without helps*." (Participant 3)

> "*Teenage mothers are sometimes discouraged by the attitude of the staff towards them when they come for family planning. If they take oral contraceptives, they sometimes forget to take them and end up falling pregnant. They sometimes stop taking the contraceptives in order to please their boyfriends who demand having babies as proof of their love*." (Participant 11)

The participants indicated that nurses deny learners contraceptive services in spite of the fact that it was important for them to receive it because they started to be sexually active at an early age. The participant attested that teenagers sometimes stop taking some contraceptives to please their boyfriend and prove their love him. Also, attending school also prevented them from arriving at the clinic on time and they returned home without having received assistance or attention from the nurses. They then had unprotected sex and became pregnant.

Beguy, Mumah and Gointtschalk (2014:8) confirm the findings and report that barriers to access healthcare services such as the lack of having decision making power, access to and control over resources, socio-cultural norms regarding sexual behaviour, and childbearing contributed to the low use of contraceptives by teenagers. Moreover, the nature of service

offered and the attitudes of who is offering the service influence teenagers' attitudes towards contraceptive use and expressing their specific needs. Willan (2013:29) argues that despite the fact that the Contraception Policy Guidelines (2012) emphasise the availability of contraceptives including emergency contraceptives and that male condoms should always be in stock at health facilities, the lack of condom at these sites is a major problem. The author further mentions that teenagers still face the judgemental attitudes of certain staff members and therefore fail to obtain contraceptives. This is in line with this study's findings that the negative attitudes of the staff scared teenage mothers to visit the clinic for family planning. Mchunu, Peltzer, Tutshana and Seutlwadi (2012:432) also report that young South Africans still engage in risky sexual behaviours, not only due to a lack of knowledge but also because of the unfavourable decisions that they make if they do not seek information they need regarding contraception from healthcare providers.

Department of Health (2012:16) report that only about one-third of clinics providing contraceptive give options to people seeking contraceptives and that clinic opening hours, waiting times at clinics and concerns around confidentiality make the environment unfavourable for teenagers resulting in failure to use the services. The WHO (2011:163) indicates that an attempt should be made to intervene and make some changes about attitudes concerning pregnancy and early marriage-related behaviour among relevant stakeholders such *as* parents, community leaders, religious leaders, and policymakers regarding girls at risk of pregnancies and child marriages. There is similar information between this current study and the Department of Health (2012:16) regarding clinic staff being biased and judgemental towards teenagers when they visit the clinics for contraceptives. Therefore, to assist the situation, all staff needs to be educated on rendering youth-friendly services to assist teenagers on their level.

- **Transport challenge**

Transport was the last subcategory under the category unsatisfactory service utilisation. Transport remains a very serious problem in the rural areas around Muyexe village. The participants said transport was a major problem when pregnant teenagers needed to be transferred to the hospital urgently. Difficult labour was mostly the consequence because of their age. During the first pregnancy, all teenagers are transferred to the hospital for delivery to prevent complications. The participants (registered nurses) in this study expressed their concerns about transport as follows:

"*The challenge is lack of transport to the clinic, when labour pains commence. In case of orphans who are transferred to the hospital for delivery they will not have somebody to visit them there*." (Participant 2)

"*We tell them when to come for regular check-up until they give birth. We tell them about lack of transport in case transfer is needed.*" (Participant 12)

"Tracing them (teenage mothers) is difficult and there is a problem of transport in case transfer is needed especially during the night to the hospital. Ambulances are scarce and unlikely to arrive on time in case of emergency." (Participant 8)

In this study, the challenges experienced by the participants were difficult labour for pregnant teenagers who had to be transferred to the hospital. Transport was the greatest challenge when transferring them to the hospital because they did not have money to pay for the transfer. Nurses also further failed to reach nearby villages as a result of the scarcity of transport. The Guidelines for Maternity Care in South Africa (2016:47) states all complicated/difficult labour such as Caesarean sections must be transferred from the clinic to the district hospital as an emergency; transport must be available on a 24-hours-a-day basis. The study participants indicated that an episiotomy is done at the clinic and if the woman is at risk she is referred to the district hospital. This means the registered nurse participants complied with the guidelines. An episiotomy is done in normal delivery and a Caesarean section delivery is greatly associated with risk of maternal infection, haemorrhage, thromboembolism, post-partum death and obstetric complications (Guidelines for Maternity Care in South Africa 2016:47).

The National Association of Community Health Centres (2014:15) confirms that in South Africa approximately one in eight teenage deliveries is done through a Caesarean section – this implies the pregnant teenager cannot deliver at a clinic and has to be transferred to the hospital. Shefer, et al (2012:78) highlight that transport costs in particular create a barrier to access services when public transport is not accessible (e.g. at night) and there are difficulties in getting an ambulance. The costs of private transport can be beyond the reach of many households. According to Ware (2013:4), the physical availability of health services such as transport begins with having these services available and ready. However, the physical presence of a health service also does not guarantee the ability to access it, according to Ware (2013:4). For example, rural people may not have transport to attend centres across town. Efforts should be made to reduce the time and effort learners spend to get to school. "When schools are built closer to the communities they serve, it becomes easy

for girls to attend class. Also, offering flexible school schedules can make attendance easier for girls who have work responsibilities at home (UNFPA 2016:66).

In addressing the transport issues, the participants indicated lack of transport as a challenge; this was especially frustrating when complications occurred. A lack of transport creates a barrier to access health services in rural areas. The scarcity of ambulances (in working condition) and safe public transport are big issues if girl-teenagers are in labour distress and both her life and the baby's life are at stake.

3.3.3 THEME 3: PROPOSED INTERVENTION

Proposed intervention is the last theme identified as a challenge experienced by registered nurses regarding the promotion of health and wellbeing of teenage mothers. Three sub-themes emerged, namely teenage friendly service, information dissemination, address causes of pregnancy, and encourage back to school by family as shown in Table 3.4.

In this study, proposed intervention related to the action taken to make the client realise the health outcome in order to improve functional ability or quality of life by carrying out the plan of action (Healthy Ireland 2013- 2025).

Table 3.43: Theme 3 Registered nurses' suggestions to promote the health and wellbeing of teenage mothers

THEME	SUB-THEME	CATEGORIES
3.3.3 THEME 3: PROPOSED INTERVENTION	3.3.3.1 Sub-theme 1: Teenage friendly service (accessible)	• Peer group-driven services
		• Mobile clinics
		• Non-judgemental service provision
	3.3.3.2 Sub-theme 2: Information dissemination	• Re-service reproductive health/ campaign/ schools/parent
		• Encourage back to school (family support)
	3.3.3.3 Sub-theme 3: Support teenage mothers to return to school	

3.3.3.1 Sub-theme 1: Teenage friendly service (accessible)

Teenage friendly service that was accessible was the first category emerging from Theme 3. Three subcategories were identified, namely peer group-driven service, mobile clinics and non-judgemental service provision:

- **Peer group-driven service**

When teenager girls become pregnant, they find it difficult to face other learners and even friends. They need teenage-friendly services involving peer groups to render service and provide assistance to them in a uniquely caring and supporting way. The participants reflected on this idea as follows:

> "*The Healthcare Providers should encourage these teenage mothers to form their support group where they will be in a position to discuss freely and to take contraceptives. The community must encourage nurses to conduct health talks or health campaigns in order to teach teenagers about the importance of education*." (Participant 5)

> "*The teenagers should engage themselves in various sports activities after school which will leave them tired and then they will go home and sleep instead of roaming around and to continue with the youth-friendly service*." (Participant 4)

> "*Community awareness campaigns should be conducted by the healthcare providers involving teenagers to empower other teenagers about contraceptives and teaching them about reproductive health.*" (Participant 2)

> "*Services that cater for teenagers are not adequate and not available in all villages. We must give lectures to them and encourage them to meet in groups where they will discuss about how to take care of their pregnancies and their children. There should be follow-up sessions where it will be verified whether they stick to the education or lectures given.*" (Participant 10)

It was clear the participants felt that healthcare providers should encourage teenage mothers to form their own support groups as part of peer group-driven services. In a group with other girls in similar situations they will understand what their friends are going through physically and emotionally; they will be in a position to discuss their feelings and fears freely and also encourage contraceptive use among each other. This support group can be perceived as a peer youth support group. In a study done in the Mhlakulo region, Eastern Cape, on sexual activity, pregnancy, contraception and substance abuse among 360 learners aged 15- to 24-

years-old, the majority preferred “to communicate with friends (38.67%) and siblings (28%) about sex. Only 15% talked to either parent (Bana, 2010:155). Most of these learners came from homes with a low socioeconomic status in a small rural community similar to that of the current setting.

The Adolescent and Youth Health Policy (2012:21) suggests that all policies and programmes developed and implemented by the NDoH must specifically identify and address the health needs of teenagers relating to peer group-driven services. All efforts should be focused to make health services more youth-friendly. In this regard, UNFPA (2013:14-5) calls for an “unprejudiced and deeper understanding of the determinants of pregnancies among teenage girls and their challenges, their vulnerabilities and the overall impact that pregnancy and young motherhood can have on their future lives”.

In the Adolescent and Youth Health Policy (2012:21), the promotion of peer counsellor/training programmes needs to be facilitated and developed in combination with youth action groups. These groups need to take responsibility for their involvement in all stages – from planning and implementing to facilitation and monitoring. Chauke (2013:70) notes educators should be flexible and willing to attend in-service training on how best to support teenage mothers in schools and also how to refer them to other facilities such as clinics and social services. Beguy, et al (2014:9) sides with Chauke (2013:70) and opines that innovative ways to clarify comprehensive sexuality education and using innovative ways to teach or deliver sexual health should be brought to all schools.

It is a critical aspect of youth-friendly services that nurses who work with teenage clients in health facilities such as public clinics on a daily basis, should understand that teenagers have unique health needs and they must be treated ‘differently’. For example, Berg, Idvall, Katajisto and Suhonen (2012:144) maintain “nurses should assess the characteristics and needs of their patients, coming to know the individuals before being able to care for them … a ‘one-size-fits-all’” does not meet the unique needs of vulnerable, insecure teenage youths. For this to happen, the participants suggested for nurses to engage more with the community to get them interested in the youths’ lives by conducting health talks or organising health campaigns and involve parents, families, and businesses to become engaged in educating teenagers about the importance of education as opposed to living a life of unsafe sexual freedom.

Ibis Reproductive Health (2013:27) reveals that providing access to universal education will equip teenagers with more resources and empowerment to make informed choices regarding their sexual health. These could help them to negotiate safer sex on their own.

According to Malahlela and Chireshe (2015:146), sex education programmes for teenagers can be successful in case where the registered nurses have confidence of choosing with whom to cooperate to in informing teenagers about sexual behaviour involve also other stakeholders (parents, religious leaders, educators and so forth) in the implementation phase. According to Oyedele, Wright and Maja (2013:107), knowledge and understanding of teenagers about their sexuality can be increased though peer group involvement, which can lead to the reduction the rate of pregnancies. These authors also indicated that services catering for teenagers are neither adequate nor available in some villages in the Mopani District.

- **Mobile clinics**

Mobile clinics are customised vehicle that travels to the heart of the communities, both rural and urban, to provide prevention and healthcare services where people work, live and play. They overcome barriers of time and money and must be trusted to provide community-tailored care to vulnerable populations (Srinivasan 2015:n.p)**.** Mobile clinics in this study were found to be available in areas where there was lack of clinic structures. The participants suggested that mobile clinics should be available even after hours in case of emergency. These feelings were expressed as follows:

> "*Mobile clinics should be available after school so that teenagers can have access to the service. Services that cater for teenagers are not adequate and not available in all villages. Sex education should not be a taboo at home and at school, even in primary schools.*" (Participant 10)

> "*Workshops on family planning are not conducted at schools and mobile clinics are found in visiting points and villages without clinics but should be introduced in all villages without clinics. The boyfriends will sometimes pass funny remarks about the contraceptives taken thus causing the girl to avoid using them.*" *(Participant 9)*

> "*Yes, I can add that teachers should be equipped to teach about family planning, pregnancies and HIV at school. Mobile clinic should remain in the visiting point until teenagers are out from school in order to access services*." (Participant 15)

The participants cited the need for mobile clinics in some villages where clinics are not available. They also indicated that the mobile clinics should be available after school so that teenagers can have access to the services for contraceptives. The ISHP (2012:15) identified service provision by specialised school health mobiles as the mechanism of choice to provide healthcare services to leaners in schools. These services may also be provided

using existing mobile services such as PHC, dental or optometric mobile. Jamir, Nongkynrih and Gupta (2013:19) also cite that mobile health clinics are used to achieve the heath care offered in urban areas with insufficient resources where each cluster was visited twice a week. The team comprised of a medical officer, auxiliary nurse and midwife to provide health education and HIV and AIDS counselling. This differs with the study participants' wish that services rendered in the mobile clinics, namely family planning, would wait for the learners after school to enable them to obtain the services after school. This causes a barrier for teenagers who attend schools.

Mopani District Integrated Development Plan (2014/2015:123) in Limpopo has mobile clinics based at various sub-districts and has visiting points where all health services to rural areas are provided – there are no clinics to cater for services such as mother and child health, reproductive health, youth services, family planning, etc. According to Clarke (2014:33), mobile health services are used in provincial or local authorities. In these clinics, the role of a nurse ranges from promoting the health of individuals, families and communities to prevent and minimise the progression or spread of diseases, and to improve wellness and quality of life and habitation in order to change behaviour life styles to aid in the development and improvement of communities. The nurses, in other words, mobilise people in the community to take action for their own health and social issues:

- **Non-judgmental service provision**

The participant wished for the healthcare providers who provided SRH services to teenagers or teenage mothers to have a non-judgemental attitude towards these young people when they visited the clinic to obtain contraceptives. The participants made the following comments:

> *"They* [girl teenagers] *are afraid of facing the healthcare providers, who will sometimes scold them and say they are so young and yet they sleep with boys and that they cannot be provided with anything for family planning because they do not have families. Then they go home without receiving any contraceptives and they fall pregnant as a result of attitude of some healthcare providers judging them*." (Participant 1)

> "*Attitude of nurses, parents, teachers and community regarding use of contraceptives also contributed not to use the service. The staff's attitude may scare pregnant teenagers to come to the clinic for family planning. The staff can also change their attitudes, go out and teach them about family planning. This will help them to come to*

the clinic and enquire more information from us thus reducing pregnancies." (Participant 6)

"*Some feel embarrassed to go to the clinic for family planning as according to some community adults, they are telling them that they have now started to engage in sexual intercourse and or that they have become prostitutes. Some are afraid of an injection as a contraceptive.*" (Participants 4)

Teenage girls were obviously hesitant and scared to visit the clinic for contraceptives. Young mothers were similarly hesitant and afraid to go to the healthcare providers because the latter seemed to scold and judge them instead of giving advice and support. Attending school was also a barrier which prevented them to visit the clinics for contraceptives.

Ware (2013:7) states poor access to health services for advice and support by teenagers occur because they fear the harsh remarks and scolding from some nurses. So, they do not visit clinics, but do not make use of contraceptives if sexually active which can result in an unwanted and unplanned pregnancy. The NDoH confirms teenagers need to access and know how to use contraceptives effectively when they do reach the stage where they become sexually active so they can avoid unplanned pregnancies and sexually transmitted infections (STIs). But, as the study findings verify, teenage girls are afraid of healthcare providers' (nurses') victimisation, name-calling and scolding or criticising their lifestyle.

Macdonald, Magill-Cuerden and Warwick (2012:336) reflect that teenagers remained one of the biggest challenges for the family planning service. These authors assert that sexual activity can start early – sometimes young boys and girls start practising unsafe sex as young as 10 – 12 years. They keep it secret from their parents and, according to the authors, this is all the more reason why reproductive health services for teenagers should be freely accessible, non-judgmental but should provide privacy and support in terms of safe sex education and encouraging the use of contraceptives.

To positively improve the attitude of nurses to understand teenage sexuality and teenagers as human beings better, Ibis Reproductive Health (2013:20) states love-life as an independent NGO was influential in the development, implementation, and evaluation of the National Adolescent-Friendly Clinic Initiative (NAFCI) in South Africa that increased healthcare provider competencies and encouraged accepting, non-judgmental approaches to healthcare provision. It made healthcare environments more inviting for teenagers, increasing accessibility to healthcare services in support of teenage health needs which reduced the negative and stigmatising attitudes of health staff.

The WHO (2015:31) asserts that parents, caregivers, religious and traditional leaders, municipal councillors, school governing bodies and youth forums should increase access to health services and information in an effort to reduce the incidence of unplanned pregnancies among teenage girls. James, Rall and Strümpher's (2012:7) opinion is that in a clinic environment that is non-judgmental and stress-free to pregnant teenagers, it is possible to have many more teenagers coming for HIV and AIDS testing, pregnancy testing and then commencing with the necessary treatment and supervision as early as possible. Health education and advice related to family planning and sexuality could be conducted as a means of empowering the teenager to plan for future pregnancies.

3.3.3.2 Sub-theme 2: Information dissemination

- **Re-service/reproductive health (campaigns/school/parents)**

Information should be disseminated through health education. All stakeholders should be involved in teaching teenagers about contraceptives at an early stage and this definitely includes parents and the church. Information dissemination in this study refers to the ability to take action which can be achieved by the provision of training and guidance in action performing. The participants (registered nurses) in this study made the following statements in this regard:

> *"Nurses give talks to those who come to the clinic for contraceptives and request them to impart the information to their friends and family members. If there are pamphlets available about health, we distribute to them and ask them to take some for their friends as well. That is how we try to reach as many people as possible. Community awareness campaigns should be conducted by the healthcare providers involving teenagers to empower other teenagers about contraceptives and teaching them about reproductive health."* (Participant 2)

> "*I think we did not touch the issue of the parents teaching the teenagers about reproductive system and reproductive health and sexuality. Churches should also be prepared to teach the teenagers, both boys and girls, about the importance of retaining their virginity, and where they deem it impossible to go to the health services for family planning*." (Participant 11)

> "*Communities should be involved in the wellbeing of their growing children within the community. Pastors should also have programmes in church to teach teenagers about the importance of keeping one's virginity and to teach about abstaining and*

safe sex. Educators should be empowered about reproductive health in order to disseminate information to the school children." (Participant 12)

The participants stated that they provide information to all teenagers who report to the clinic on contraceptives and disseminate information by issuing pamphlets to impart information to their friends. They also proposed that communities and pastors be involved in promoting abstinence and condom use.

Beguy, et al (2014:8) assert reaching teenagers at an early stage of development (while still at school) has the potential of reducing unwanted pregnancies; thus, concurring with the current study that teenagers should be taught about contraceptives at a younger age. Mahlalela and Chireshe (2013:147) state through sex education learners should be to abstain from having sex until completion of their studies. Those who fail to abstain could be encouraged to use condoms. Hamilton, Martin and Ventura (2012:n.p.) indicates that knowledge of sexual reproductive health and pregnancy is essential to reduce teenage pregnancies. These authors reflect that parents and other trusted adults may also play an important role in helping teenagers to make healthy choices about relationships, sex, abstinence and other methods of contraceptives. They further point out that teenagers need to access youth-friendly services. The participants in this study concurred with youth-friendly services, abstinence and that use of condoms should be reinforced.

Nkani and Bhana (2016:8) state programmes based on preventing and reducing teenage pregnancies need to engage male teenagers more to make the right choices and to help them to understand girls and women do have the legal right to make choices about their own reproductive health. The possibility that young teenage girls in remote villages become pregnant without her or the partner knowing their HIV status should be considered.

Reaching out to young men is important. UNFPA (2013:77) states research has shown that "unhealthy perceptions of sex, including seeing women as sexual objects, viewing sex as performance-oriented and using pressure or force to obtain sex, begin in adolescence". Addressing the other person involved in a pregnancy, the male, should include making him aware that fathering a child does not express his manhood. It seems as if combatting HIV transmission during intercourse has reached the stage where the male's role is finally addressed. Voluntary medical male circumcision (VMMC) is getting more attention not only to prevent transmitting HIV to the female, but also as a form of protection against being infected with HIV himself. Observational data and ecological studies have evidenced that VMMC "can reduce the risk of HIV transmission in heterosexual men by approximately 60%" (Bertrand, Rech, Dickens, Frade, Loolpapit, Machaku, et al 2012:9).

Hence, the provision of "age appropriate, culturally sensitive information to young people adopted for their age" (UNMISS 2016:para 9) in remote areas is, in fact, non-negotiable. Young teenage boys should also be engaged – male teenagers need to be provided with age-appropriate information and counselling as well. If girls have information on their reproductive and sexual health which they understand and can grasp, it could result in delayed sexual debut; their focus could be shifted from dreaming of boys, puppy love and sexual matters to completing their education and fulfilling their dreams. The use of implants and other longer-term family planning methods was suggested during the Ibis Reproductive Health (2013:28) meeting held on behalf of the Ford Foundation, where the issue of South African unintended pregnancy was discussed in order to find a solution of preventing the on-going confinements.

3.3.3.3 Sub-theme 3: Support teenage mothers to return to school

Pregnancy and motherhood does not necessarily end a girl's schooling. Many teenage mothers, who remain in school or return following childbirth, are affected in their grades and sometimes in academic progression. However, these teenage mothers need to be encouraged to go back and complete their schooling as the next verbatim quotes affirm:

> "*As a family member, one should sit down with teenage mothers and discuss about advantages of going back to school and what they are going to benefit by doing so. Also, that having a baby is not the end of the road for them, but they must just be courageous and go back to school. Warn them about the disadvantages of not going back to school because education is a key to life.*" (Participant 1)

> "*As a parent, it is a need to be supportive towards the teenage mothers and encourage them to return to school in order to prepare for their future. They should be supported and the baby be look after by the family members so that they can be in a position to go back to school. If they engage in sex, they should be encouraged to use condoms.*" (Participant 12)

> "*Families should take care of babies while teenagers are attending school. As registered nurses, we must be teaching them about the dangers of HIV and AIDS. Schools should have lessons on teenage pregnancy and prevention and teachers should be trained to be competent in teaching reproductive health*." (Participant 9)

The participants in this study indicated that family members should encourage teenage mothers to return to school; the families must clarify the benefits and disadvantages of not going to school and make the young mother understand that education is the key to life.

Shefer, et al (2012:39) explain often when teenage mothers return to school, their performance is affected – whereas they did well academically they become average because of the time and stress they use to balance motherhood and schooling. However, some teenage mothers had reported different experiences – they did well academically because they had childcare support at home. This is a supportive home strategy also mentioned by the current participants. Willan (2013:39) found that families can and do assist teenage mothers with childcare; especially the girl's mother is normally the supportive grandmother. This author found that teenage mothers who had support from their mothers were the most likely to return to and remain at school. Chigona and Chetty (2008:277) agree the best solution for the teenage mother to complete their schooling successfully is to have family support and to find preventative measures to prevent another pregnancy. They therefore suggest for educators to address leaners in school and highlight the challenges teenage mothers have to overcome to continue with their education. Hopefully, according to Chigona and Chetty (2008:278), this would discourage other learners' risky of unprotected sex that may expose them to HIV/AIDS.

Mahlalela and Chireshe (2013:140) point out that pregnancy and motherhood made some girls realise that their future is important and that they should work towards a better life for her and her child, the first step being to return to school. Similar to the current study finding, Willan (2013:39) also found that family support assisted in enabling teenage mothers to return to school. However, Shefer, et al (2013:139) posit that even if these mothers return to school, their performance is not good except if they have parental support. Panday, et al (2009:109) believe that for teenage mothers to be successful in life, they must be encouraged to focus on the responsibilities of motherhood and to acquire knowledge and skills that will empower them to leave their impoverished past behind as they become responsible adults. For this, they need to build a supportive network of understanding, supportive family, community members and a society and policymakers who are actively involved in uplifting the health and wellbeing of teenage mothers.

Department of Health (2015:33) envisions achieving the protection of teenagers from STIs including HIV by getting them to freely and openly access healthcare services where they receive youth-friendly care, support and education on SRH from unbiased professionals. It is a critical aspect of youth-friendly services that nurses who work with teenage clients in health facilities such as public clinics on a daily basis, should understand that teenagers have unique health needs and they must be treated 'differently'. For example, Berg, Idvall, Katajisto and Suhonen (2012:144) maintain "nurses should assess the characteristics and needs of their patients, coming to know the individuals before being able to care for them." A 'one-size-fits-all' kind of service does not meet the unique needs of teenage youths.

3.4 DISCUSSION OF DATA OBTAINED FROM TEENAGE MOTHERS

The objective of this part was to explore and describe the challenges experienced by teenage mothers to return to school after delivery of the baby. In-depth individual interviews were conducted with 15 teenagers (a combination of pregnant teenagers and teenage mothers). An interview guide was used containing questions to develop an understanding of the challenges experienced by teenage mothers and their challenges to return to school after delivery. From the analysis of the interviews four main themes emerged: challenges experienced before pregnancy, during pregnancy and during labour; challenges to return to school; challenges experienced to access service delivery; and suggestion to overcome challenges. From each main theme, sub-themes and categories were identified as set out in Table 3.5 below.

Table 3.5: Challenges reported by teenage mothers

(b) TEENAGERS		
THEMES	**SUB-THEMES**	**CATEGORIES**
3.4.1 THEME 1: CHALLENGES EXPERIENCED BEFORE, DURING PREGNANCY AND LABOUR	3.4.1.1 Sub-theme 1: Before pregnancy	• Unintentional pregnancy
	3.4.1.2 Sub-theme 2: During pregnancy	• Physical symptoms
		• Response of learners (support vs stigma)
		• Response of teachers (support vs rejection)
		• Response of family (parents)
	3.4.1.3: Sub-theme 3: During labour	• Birth
		• The baby
		• Experience (pain/kindness)
	3.4.2.1 Sub-theme 1: Post-natal barriers to return to school	• Will to return to school
		• Reaction from learners (stigma vs) support
		• Lack of support from parents (caregiver)
		• Role demands
	3.4.2.2 Sub-theme 2:	• Community/ parental/ personal

3.4.2 THEME 2: CHALLENGES TO RETURN TO SCHOOL	Factors to enhance return to school	encouragement
		• Family/partner support
		• Day care for baby near school
	3.4.2.3 Sub-theme 3: Financial challenge	• Financial limitation
		• Need for child grant
3.4.3 THEME 3: CHALLENGES EXPERIENCED TO ACCESS SERVICE DELIVERY	3.4.3.1 Sub-theme 1: Access to contraception before pregnancy	• Fear of parents
		• Fear of nurses' response
		• Teenage ignorance (insufficient information)
		• Wanted to keep boyfriend/relationship challenge
		• Sexual abuse
	3.4.3.2 Sub-theme 3: Contraception after pregnancy	
3.4.4: THEME 4: SUGGESTION TO OVERCOME CHALLENGES	3.4.4.1 Sub-theme 1: Teenage friendly services to be accessible	• Contraception after pregnancy
	3.4.4.2 Sub-theme 2: Information dissemination including males	• Nurses to promote teenage family planning
		• Non-judgmental/accessible service provision
		• Peer group driven information/campaigns
		• Community-driven information
		• Parent driven
		• Nurses driven

3.4.1 THEME 1: CHALLENGES EXPERIENCED BEFORE, DURING PREGNANCY AND LABOUR

Pregnancy and childbirth are particularly vulnerable periods for a teenage girl; especially the first pregnancy for a young girl can be a physically and emotionally devastating and traumatic experience. Teenage mothers experience challenges before pregnancy, during pregnancy and labour as well as problems regarding going back to school after giving birth.

Table3.6: Challenges experienced by teenage mothers before pregnancy, during pregnancy and labour

THEMES	SUB-THEMES	CATEGORIES
3.4.1 THEME 1: CHALLENGES EXPERIENCED BEFORE, DURING PREGNANCY AND LABOUR	3.4.1.1 Sub-theme 1: Before pregnancy	• Unintentional pregnancy
	3.4.1.2 Sub-theme 2: During pregnancy	• Physical symptoms
		• Response of learners (support v/s stigma)
		• Response of teachers (support v/s rejection)
		• Response of family (parents)
	3.4.1.3: Sub-theme 3: During labour	• Birth
		• The baby
		• Experience (pain/kindness)

3.4.1.1 Sub-theme 1: Before pregnancy

Before pregnancy, was the first sub-theme identified under Theme 1: Challenges experienced before, during pregnancy and labour. Unintentional pregnancy was the only sub-theme identified from the collected data:

- ***Unintentional pregnancy***

In this study, unintentional pregnancy referred to becoming pregnant against the teenage girl's will or when she was not prepared to be pregnant which resulted in an unwanted pregnancy Some participants (teenage mothers) indicated that they were forced to have sex while others stated that they were not forced but had intercourse not knowing that they could become pregnant. They expressed their different experiences as follows:

> "*I was not forced to consent to sexual intercourse, but I had sex and I did not expect to fall pregnant. I did not know what I was doing. I was discovered early that I am pregnant because of my illness*." (Participant 2)

> "*I was only fifteen years old when I became pregnant. I was inspired by what I saw in a media. I thought making love is an easy thing. I realised late that it was a bad experience. I was not forced to consent to sex, but I had sex.*" (Participant 7)

> "*I was only thirteen when I become pregnant. I did not know what I was doing. A man just robbed and forced me to have sex. I never had periods as my friends were telling me that I will be menstruating not long. I did not know that I am pregnant but nurses said that the baby is light for date*." (Participant 11)

> "*I was in grade nine when I fell pregnant and it was not a planned pregnancy. I was not happy at all when I discover that I am pregnant. I was too young and I did not use contraceptives. I did not decide to be pregnant, it just happened. I did not know what I was doing. I think it is due to the adolescent stage and peer group pressure. When I find out that I missed my periods, I went to the clinic on my own and was told that I am pregnant.*" (Participant 5).

It emerged from this study that most participants were too young to make a decision regarding sexual relationships which resulted in unwanted pregnancies. Forced sex and very young girls who were not in menarche became victims of an unwanted pregnancy. This confirms that the participants lacked knowledge of the consequences of unprotected sex. One said she was "*inspired by what I saw in a media"* and engaged in consensual sex.

According to the Directorate of Population and Development report teenagers in Limpopo are exposed to sex at an early age and the norm for progressing from sexual debut and first pregnancy is one-year. Limpopo Provincial Government 2012:42) The Directorate report confirmed the finding that the popularity of radio and television was a contributory factor for teenage pregnancy as was the problem that teenagers were vulnerable to forced sex and sexual abuse or rape. The Province of the Easter Cape Social Development of Special Programmes (2012:27) and (Department of Health 2012:18) concurs and observes that some of the challenges facing teenagers are unanticipated sex, sexual coercion or misinformed ideas about conception, reproduction and contraceptives. Hamdela, Mariam and Tilahum (2012:1) and Willan (2013:26) are in agreement that poor knowledge of contraceptive use is one of the reasons why unwanted pregnancies occur. This strengthens the finding of Mthobeni and Peu (2013:6) that young people often experience resistance from parents who consider it religiously or culturally taboo for older people to talk about safe sex, condom use and the transmission of HIV to younger people. Without support, young people may have unnecessary, ungrounded fears about contraception and may not know how to prevent HIV/AIDS and STIs (NDoH 2013:17).

Conversely, Ibis Reproductive Health (IRH) (2013:19) states some researchers consider pregnancy as positive because early childbearing provides a way for teenagers to show that they are able to go through a successful transition to womanhood if they are fertile and can conceive. Some researchers argue that becoming pregnant was a rational and conscious decision that a teenage girl makes and it cannot be blamed on a lack of knowledge about contraceptives or because of situation or circumstances like "*it just happened. I did not know what I was doing".* Panday and Mabunda (2009a:56), for example, argue that teenagers are well informed about modern methods of contraceptives but they simply choose to ignore it. The conclusions of a study by Bhandari in Nepal reflect that more than half of the 100 respondents (all 15- to 19-year-old females) "had adequate knowledge about consequences of teenage pregnancy to mother and baby and that there is a relation between knowledge regarding the consequences of teenage pregnancy and educational level. Education, advocacy and proper counselling can help reduce teenage pregnancy." (Bhandari 2014:16). Sexual attitudes and behaviours of young girls are oftentimes influenced by the society, community or households they grow up in. In some traditional societies, for example, teenage motherhood may not be condemned.

Serious challenges disregarding the ethical and human rights of teenage girls were mentioned by the participants as leading to unintended pregnancies. Sexual abuse, forced marriage resulting in forced sex and financial problems were major challenges as the verbatim quotes signify:

> "*Some of us are orphans and are sexually abused in exchange of money, therefore have unplanned pregnancies and also receive child grant*." (Participant 2)
>
> "*Some of us as teenagers are sexually abused and have unplanned pregnancies as a result of poverty and financial problems while others are child-headed due to the death of the parents."* (Participant 7)
>
> "*I was not aware of the fact that one may fall pregnant on the first day of enjoying sexual intercourse, though I was forced to do so by a family member. That was the first and the last to have sex until I was told I am pregnant. Family sexual abuse should be dealt with.*" (Participant 12)

Participants shared they were sexually abused. One said she was *"forced to do so by a family member*" while financial constraints forced many to unwillingly engage in unsafe sexual practices. Unfortunately, sexual abuse continues to exist in South Africa. Teenagers are afraid to report the culprits as confirmed in the 2005 National Youth Victimisation Survey conducted by the South African Centre for Justice and Crime Prevention (CJCP).

Victimisation such as rape, assault and abuse “clearly impact on the overall quality of life of South African youth and children” but very few cases are reported. Of the 4.3 million children surveyed, 21.2% cited rape or sexual assault as “the thing they are most scared of” (Burton, 2006:13).

According to the Jamieson, Mathews and Berry (2017:2), teenage girls are vulnerable to sexual violence and abuse therefore there is a need for health workers to identify and counsel them. The issue of abuse in this study concurs with that of the Provincial Health Research Day (2012:44) which indicates poverty and the abuse by relatives (usually the father) go hand in hand. Thobejane (2015:273) also emphasises that poverty may increase the chances for teenagers and children to suffer sexual abuse due to unequal power relations – especially if the male is the breadwinner. The fact that a male family member forced himself on a teenage girl sexually while knowing that she was too young to make a decision, defies the aforementioned perception of researchers like Panday and Mabunda (2009:56) that young teenagers have the knowledge and power to make decisions when in a compromised sexual situation. Teenagers are at risk of being victims of sexual abuse as men use physical power to threaten and the victim stay silent to avoid social stigma (Thobejane 2015:27). Willan (2013: 36) argues that the primary reason for teenage mothers leaving school was usually economic and not the birth of the baby. Yet, the author acknowledges that the birth of the baby may contribute to a teenage mother’s decision to leave school.

3.4.1 2 Sub-theme 2: During pregnancy

The second sub-theme derived from Theme 1: Challenges experienced before pregnancy, was during pregnancy. Four categories emerged, namely physical symptoms; response of learners (support v/s stigma); response of teachers (support v/s rejection), and response of family (parents).

- **Physical symptoms**

The participants experienced physical changes after conception. Still attending school, pregnant girls started experiencing the physical symptoms accompanying pregnancy such as feeling nauseous, vomiting and having swollen feet. It made attending school and studying difficult and many chose to terminate their schooling because of pregnancy-related challenges:

> “*I stopped going to school because every time I went to school, I got sick. I was vomiting, feeling nausea, headache or fainting. My legs were swollen.*” (Participant 4)

> "*During pregnancy, I used to feel nauseous and vomited a lot when entering a classroom full of people. I was discovered early that I am pregnant because of my illness*." (Participant 2)

> "*I was fourteen years old when I fell pregnant and I was not even aware of what was happening to me. I felt nausea, had a headache and my feet were swollen. When I was taken to the doctor, it was then discovered that I was pregnant.*" (Participant 14)

While the teenage participants in this study were pregnant and attending school, they were challenged by pregnancy-related conditions such as nausea, vomiting, headaches, swollen feet and fainting. The above quotes from the teenage participants on their unexpected pregnancies (one said it was "*discovered early that I am pregnant because of my illness*" and another only heard about her pregnancy when the doctor was consulted for her headaches, nausea and swollen feet) convey two troubling facts. The first being the girls' naivety about how one becomes pregnant, and the second that pregnancy made them leave school.

According to Young, et al (2012:559), adolescents are not yet emotionally mature enough to have sex and are prone to develop psychological disturbances while Anyanwu, et al (2013:927) state when very young, teenage girls are prone to physical health problems that could lead to impaired mental health. This is why Fleming, et al (2015:741-2) advocate for "routine and repeated screening for and treatment of mood disorders" in the 14- to 19-year-old pregnant teenage populations.

The current study findings reaffirm Anyanwu, et al's (2013:927) findings as well as those of Malahlela and Chireshe (2013:141) that pregnancy-related physical illnesses cause young teenage girls to drop out of school. In the case of teenage pregnancy, the younger the girl, the less resistance and immunity she has to sexually acquired infections. Because of the physiologic immaturity of her cervix, sufficient and normal protection of the tissues against infections (for example, vertical transmission of chlamydia during vaginal delivery, HIV transmission, and postpartum infections) is lacking (Berman and Hein 1999 cited in Fleming, et al 2015:744). Karra and Lee (2012:3) observed younger mothers were less likely to return to school after delivery as a result of physical diseases experienced during pregnancy. These authors found in their study young mothers who had their first child at 17 or younger were more likely to drop out of school than non-teenage mothers.

According to Rangiah (2012:17), in a society like South Africa in which one's human rights are upheld, young girls who fall pregnant should not be denied access to education as it is entrenched in South African law through section 27(1) of the Constitution (1996:14) and the School Act (84 of 1996 as amended by Act No. 100 of 1997:6). Drugamut, Stuurman,

Petherbriedge (2013: 164) indicated that, in Article 28(1) (e) of United Convention on the right of the child (UNCRC), South Africa must: “take measures to encourage regular attendance of schools and the reduction of dropout rates” Moreover, pregnant teenage girls may not be refused to attend school (except in case of ill-health) and they have to be re-admitted if they apply after giving birth (Rangiah 2012:15).

- **Response of leaners (support vs stigma)**

The participants responded very strongly and indicated as learners in school and being pregnant, they were rejected by other learners at school who mocked them about sleeping in class, whether pregnant or already mothers. According to the participants, they received no support from fellow classmates as the following quotes signify:

> "*The students* [learners] *used to talk bad things about me saying that they were now attending school with mothers. Some of my friends rejected me*." (Participant 29)

> "*Other children will sometimes say, 'Is there any one pregnant here? Why are we sleeping like this?' I felt as if they are aware that I am pregnant. From there, I never returned to school with the fear that students* [learners] *will make fun of me, stigma attached.*" (Participant 1)

> "*My peers were gossiping about me. They always laughed at me as I pass next to them. When people look at me, I felt as if they see my pregnancy. I was not comfortable at all. I decided to walk alone during breaks.*" (Participant 8)

In this study, participants expressed the way other learners treated them while they remained at school during pregnancy. They were mocked, gossiped about and rejected by some friends. One said she eventually left school and another isolated herself from the other learners during breaks.

Molapo, Molapo and Zulu (2014:28) mention in their study in the Leribe District in Lesotho some of the pregnant teenage girls were ridiculed, labelled and laughed at by other leaners. The victims felt lonely in the school environment and therefore terminated school. It emerged from the current study that pregnant teenage leaners were treated in a similar abusive manner while attending school which resulted in school drop-out. Malahlela and Chireshe (2013:142) concur with these findings as they reflect they also found pregnant teenagers in South African secondary schools experienced the same stigmatisation as the current teenager participants. Thobejane (2015:277) further reveal most teenage girls who become pregnant and even those who decide to return to school after delivery end up friendless and lonely because they are no longer accepted by their peers. Rejection of new mothers by both teachers and learners when attending school after delivery of their babies was observed by Shefer, et al (2013:5).

Peer support from friends is an important issue for pregnant teenage girls. Teenagers need support from friends during their pregnancies or as teenage mothers and respect from other

learners. This negative attitude from friends and peers causes dropout; it is unacceptable. In an era where human rights and gender equality is very much at the forefront, millions of young pregnant females are denied these rights and punished for motherhood while the male who expressed his manhood through a sperm (Elders, et al 2013:178) retain these rights. According to UNFPA (2013:4), human rights include, among others, “the right to an education, to health and an adequate standard of living”. UNFPA (2016:6) asserts for both males and females the transition from childhood into adulthood is difficult but although “risks abound for both girls and boys, gender discrimination makes these worse for girls in almost every way. "Social norms and practices may make them more severe.” (UNFPA 2016:6).

In South Africa, in Chapter 2 of the Constitution of the Republic of South Africa (108 of 1996) as amended it is stipulated that everyone has a right to basic education. In Section 29(3), the equality clause reads, “the state may not unfairly discriminate directly or indirectly against race, gender, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth” (Constitution, 1996:14). UNFPA (2013:xi) unequivocally states girls who fall pregnant “need support, not stigma.”

- **Response of teachers (support v/s rejection)**

The participants reflected support from teachers for pregnant teenagers or new teenage mothers was a profound challenge. Some teachers were supportive while others were not. According to the participants, being prevented to take part in school activities (sport), having teachers making fun of them and even getting expelled from school were only some of the obstacles they faced at school. Some participants expressed their very negative experiences as follows:

> “*I had a serious problem at school as sometimes teachers were saying that what I did was wrong and was destroying my future. It was painful the way I was treated. After few months, the principal noticed that I was pregnant and he expelled me from school. I was expelled on a Monday. Some teachers used to talk bad things about me, calling me names while some teachers advised me to ignore such talks. The most painful part was that I was not allowed to participate in some activities such as sports*.” (Participant 13)

> *“When teachers discovered that I was pregnant, I was told that my parents should come to school to see the principal. From there, I was expelled and I never returned to school with the fear that teachers will make fun of me. I was rejected*.” (Participant 1)

One of the teenage mothers was asked whether she became pregnant while still at school, and her response was:

> *"Yes! I was, teachers used to give examples about me when talking about children who are falling pregnant at school. The teachers used to talk bad things about me, saying that they were now attending school with mothers and some teachers rejected me*." (Participant 14)

All the participants admitted they did receive a little support from certain teachers (educators), but overall the majority of teachers were condescending, unsupportive and apparently extremely rude as verified by the verbatim words "*some teachers used to talk bad things about me, calling me names*" and "*teachers will make fun of me*". As a result, some of the teenage mothers never returned to school after delivery. Rural education policy (2017:21) aim to ensure that rural schools are provided with quality education for all. This appears to bring change in the life of rural school children. The implementation also appears good, however, the challenges regarding, physical resources (physical structure) teaching materials to be used, lack of qualified teachers brings doubt if ever the plan will be achieved. The researcher happens to reside at the villages where some learners are still attending classes under the tree. Rejection of pregnant learners still exist in some of the schools and the budget is not stipulated. Malahlela (2012:56) found that the relationship between pregnant teenagers, other leaners and educators was strained leading to school dropout. Teenage mothers in this study undoubtedly wanted to continue attending classes at their schools. One was extremely disappointed when she was prohibited from participating in sport activities. The current study findings confirm the argument of Shefer, et al (2013:7) that "pregnant learners themselves would rather continue until they feel it is necessary to withdraw from school" (Shefer, et al 2013:7).

Malahlela and Chireshe (2013:145) state young school-going mothers have to suffer various forms of ill treatment from teachers and principals alike. This treatment includes humiliating behaviours, threats of terminating their school-going careers (in fact, current participants were expelled from schools because they were pregnant), insensitive remarks and a lack of support in general from teachers which align with findings of the current study. Also in agreement are Chigona and Chetty (2008:276) who mention pregnant teenagers who continued with schooling were faced with numerous problems such as rejection and ridicule by their teachers in front of other learners. In fact, Modisaotsile (2012:5) reminds us the Constitution of the Republic of South Africa (Act 108 of 1996 as amended) makes provision for all children, thus also for pregnant teenagers and lactating teenage mothers, to attend school.

However, Shefer, et al (2013:3) found evidence that school authorities continue to stigmatise pregnant and parenting learners. Findings of a study they conducted in 11 schools in Cape Town and Durban respectively, revealed the principals and by far majority of teachers and learners all felt "pregnant girls and parenting learners do *not* belong in school". This notion was confirmed in the current findings by participants who shared profoundly sad and obviously degrading experiences. An example mentioned by one of the current participants was her being used as a 'model' to stand in front of a class when teachers taught learners about pregnancy. Such discriminating acts conflict directly with Chapter 2, Section 29(3) in the Constitution which plainly stipulates everyone has a right to basic education; the equality clause reads, "the state may not unfairly discriminate directly or indirectly against race, gender, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth" (Constitution of the Republic of South Africa, 1996:6).

As argued by Anyon (2008:518), a supportive and trusting school environment provides identity and security to pregnant young girls. Such an environment is created when emotional and physical support is offered by teachers; it helps pregnant girls to feel comfortable with being pregnant in class and the school environment in order to deal with stigma (Willan 2013:42). Also, counselling of teenage mothers should be done before they return to school as this will help them cope better in school (Anyon 2008:518). In the current study, a few participants mentioned some teachers were friendly and tried to be helpful, but overall the unanimous feeling among the participants was that they were unnecessarily stigmatised, isolated and humiliated by teachers.

- **Response of family (parents)**

According to the participants, anger was the general response they got from their parents. The participants of this study expressed that:

> "*I was taken to the doctor, it was discovered that I was pregnant. My parents were very devastated and could not talk to me. Home appeared to be very far from the doctor and I was so scared*." (Participant 14)

> "*My parents were very angry, especially my father who even threatened to expel me from home. A family meeting was called where I apologised to my parents for falling pregnant and they accepted my apology*." (Participant 6)

> "*My parents were very angry with me when they discover that I am pregnant. I asked for forgiveness but was said that I must learn a lesson. That is how I dropped out of*

> *school and never returned. My family took me to the boy's family to report that I was pregnant. The father of my child accepted the pregnancy. It was arranged that I must go and stay with him. I got married in that manner. I am still staying with him and he is taking care of us.*" (Participant 7)

Although the parents were initially angry, there seemed to be different responses from them as they calmed down. Molapo (2012:110) and Pricilah, Nyangan and Chang'ach (2014:136) similarly report parents become angry when they discover their teenage daughter is pregnant; Priscilla, et al (2014:136) write "parents expressed uncontrolled anger". According to Jewkes, Morrell and Christofides (2012:680), the family's reaction towards the teenage mother or pregnant teenager is usually negative. One father in the current study threatened to expel his daughter from their home. Holt, et al (2012:288) found in a study in Soweto, South Africa healthcare workers also believed that teenagers did not have sufficient information about the consequences of sex and the importance of prevention as they lacked communication with parents. This strengthens the findings of Mthobeni and Peu (2013:6) that young people often experience resistance from parents who consider it religiously or culturally taboo for older people to talk about safe sex, condom use and the transmission of HIV to younger people.

Furthermore, parents oftentimes act by arranging a trial marriage between the pregnant girl and the father of the child (Priscilla, et al 2014:136). Reaffirming forced marriage owing to the pregnancy, Beguy, et al (2014:8) found marital status was associated with unwanted pregnancy because as soon as pregnancy occurred, marriage followed which in most cases mean the teenage mother never completes her school education. In the current study, a teenage girl's parents took her out of school. She never returned to school but was instead forced to marry her boyfriend.

Forced marriages as a consequence of pregnancy seem to be especially common in patriarchal societies where gender norms and practices determine the girl-child's future life (both current and as she grows older); she remains but a bystander looking on as others (parents, partners, husbands) make decisions about her schooling, healthcare, life and future (UNFPA 2016a:26-7). Realising the urgency to increase teenager girls' educational opportunities through formal and non-formal channels, the WHO (2011:3) in 2011 already recommended interventions to inform and empower girls in combination with interventions to influence family and community norms to delay the age of marriage among teenage girls until the age of 18. Yet, UNICEF (2012:8) still indicated in the developing world (excluding China) nearly one in every four teenagers aged 15 – 19 were married or in a union – mostly against their will.

Beguy, et al (2014:8) state, support from parents is important to help teenage mothers to return to school. Family support and assistance minimised disruption in the lives of teenage mothers (Akella and Jordan 2015:48). These authors found that parents were unwilling to support their teenagers with pregnancy at first, but later after motivation, they started to support them "Mothers, grandmothers and aunties rallied around to provide childcare support and assistance to the teen mothers" which allowed them to continue with their schooling.

These older women "contacted the teachers to collect school work, dropped it off to ensure the teen mother was able to continue at her school, complete school work on time and stay on track for graduation" (Akella and Jordan 2015:58). However, there is another possibility raised by Mayosi, Lawn, Van Niekerk, Bradshaw, Karim and Coovadia, 2012:823). These authors posit that many children raised by a social mother (such as a grandmother) as opposed to the biological mother (the teenage mother who is continuing with her education) may suffer an impediment on his or her emotional development thereby increasing the likelihood for him or her to become involved in crime in later life.

3.4.1.3 Sub-theme 3: During labour

During labour was the third sub-theme identified under Theme 1: Challenges experienced before, during pregnancy and during labour. Four categories emerged, namely birth; the baby; experience (pain/kindness); and will return to school. Labour refers to a recurrent pain felt by a woman during the process of childbirth.

- **Birth**

During labour and when giving birth, problems and difficulties that are neither predictable nor preventable can happen. For pregnant teenagers to have a safe and successful birth, they must have health services that are accessible, physically available, affordable, appropriate and acceptable. Health services for the current participants were provided in the rural clinics and some voiced their experience of birth as follows:

> "*I got the baby through Caesarean section. They indicated that the baby is not well and a premature. He was placed in an incubator for a month and* [I] *started with the so-called Kangaroo care. The baby was so tiny and I was afraid to handle him at first, but gradually I had to, with the help of nurse.*" (Participant 8)

> "*I gave birth normally even though I expected to give birth in December but I gave birth on the twenty-seventh November before expected date. The baby was very tiny and was admitted in the incubator. I was afraid to hold and to bath her*." (Participant 15)

> "*I had a normal delivery but had an episiotomy with a premature baby. I was admitted at the clinic and was transferred to the hospital. The ambulance was called and it did not come*." (Participant 4)

Young teenage mothers usually give birth by a Caesarean section (C-section) or deliver a premature baby as a result of giving birth at an early age as confirmed by the participants' verbatim quotes.

The National Association of Community Health Centres (2014:15) report in South Africa approximately one in eight teenage deliveries is conducted through a Caesarean section. A C-section birth is a complicated birth for which a hospital and a multidisciplinary obstetric team are needed. As a result of their physiological immaturity, girl-child teenagers end up having a C-section because of cephalo-pelvic disproportion owing to a contracted pelvis (National Association of Community Health Centres 2014:15).

According to Fraser, Cooper and Nolte (2010:518), "an episiotomy is an incision through the perineal tissues which is designed to enlarge the valval outlet during childbirth and should be repaired as soon as possible". The authors also reflect it should be kinder to the mother to repair without delay while the tissues are still anaesthetised to ease pain. Davidson, London and Ladewig (2008:776) advise that pain relief measures should begin immediately after birth by applying an ice pack to the perineum. The Maternity Guideline (2016:42) stipulates routine episiotomy should be discouraged and could be considered only with specific reasons such as a thick and rigid perineum that prevents delivery. Indeed, this is exactly why young teenagers in the current study had an episiotomy. It was not a routine but as a result of a rigid perineum caused by early bearing down.

In support of the current study findings, the WHO (2014:1) confirms health professionals who are responsible for providing postnatal care to teenage mothers and their new-borns are primarily in areas where resources are limited and they therefore transfer the clients to the nearest hospital in case of complicated labour. McIntyre (2010 cited in Schaay, Sanders and Kruger 2011:6) reflect the distances to health facilities and the transport costs involved are major and still existing barriers to accessing healthcare in South Africa. "The overall average travelling time to a health facility for the poorest 20% of households is nearly 40 minutes and a single visit costs on average 11% of the households' monthly expenditure." (McIntyre (2010) cited in Schaay, et al 2011:6). In this study, the clinics were situated in rural areas where transport and money problems caused major problems for teenage girls who were about to give birth. Because complications arose, they were referred to the district hospital. With no transport, money or an ambulance service the lives of both the young mother and

baby are in serious danger. According to the Guidelines for Maternity Care in South Africa (2016:85), if delivery is expected for a baby of less than 1 500g, the teenage girl needs to be transferred to the hospital for further management in the neonatal intensive care unit.

Rangiah (2012:15) concur with the current findings and note with young teenage births there is an increased risk for assisted deliveries such as some C-section or forceps because the pelvis of teenager may be inadequate and may not be mature for the normal delivery of a baby. UNICEF (2009:47) confirms an elevated risk of obstetric complications such as maternal death, low birth weight and a higher risk for infant mortality can result from early childbirth. Sodi (2009:19) found that teenage mothers were physically underdeveloped and this underdevelopment was reported to pose a greater health risk to the pregnant teenager leading complications such as premature births and low birth weight of their babies thus verifying the findings of the current study.

The WHO (2015:14) advocates for the increase of skills in nurses to prevent maternal and infant death as a result of prematurity at birth. This implies to prevent complications nurses should be trained as specialists to manage the health of mother and the baby in case of premature birth. The organisation encourages Birth Preparedness and Complication Readiness (BPCR) interventions to be increased to further prevent maternal and infant death. The MDG Country Report (2013:24) states, to be prepared for birth and possible complications, women, families and communities need to know what signs indicate the onset of labour as well as what are the danger signs during pregnancy and after birth for both the mother and new-born. This statement implies the involvement of families and communities may reduce complications during delivery.

- **The baby**

Almost all participants verbalised their babies (neonates) were premature or had a very low birth weight. **Pattison (2011:60)** explains neonates are new-borns who are subdivided into two groups: early neonates defined as from birth to seven days and late neonates being from seven to 28 days. The participants expressed it was an awkward experience to have a tiny baby and to be expected to take care of him or her. They shared the following experiences:

> "*I was stressed with the result that ended up giving birth to a premature baby. I was also forced to stay long in the hospital. I was afraid of handling the baby because it was very tiny*." (Participant 10)

> "*The nurses indicated that the baby was not well and a premature. He was placed in an incubator for a month and started with the so-called Kangaroo care. It was so tiny*

and I was afraid to handle it at first but gradually I had to with the help of nurses." (Participant 8)

"*I delivered the baby normally, though it was said that the baby is light for date weighing two kilogrammes. I did not stay long in the hospital. I was taught to breastfeed the baby. It was so painful. I really learned a lesson*." (Participant 9)

One of the reasons why Ediau, et al (2013:10) emphasise the importance of antenatal care attendance (ANC), is because it is during ANC that the teenager's health and that of the foetus is checked to determine whether a healthy baby may be delivered and whether the teenage mother's body will cope with it. To prevent complications such as low birth weight or premature birth especially very young pregnant teenagers who may be poor and undernourished must be encouraged to visit clinics for ANC. It emerged from this study that teenage mothers gave birth to premature babies as a result of their very young age. A premature baby is born before the end of thirty-seven (37) weeks of gestation regardless of birth weight. Ibis Reproductive Health (2013:23) in fact confirms a higher incidence of low birth weight is not unusual among infants born to teenagers. In South Africa, the incidence of premature labour, miscarriage and stillbirth are high among teenagers who go into labour (NDoH 2013:17).

Participants who gave birth to premature babies confirmed their neonates were placed in incubators. According to Fraser, et al (2010:818), all babies are prone to heat loss because their ability to produce heat is compromised by their immaturity. Therefore, a premature neonate is placed in an incubator and, as soon as the neonate is healthy and strong enough, skin-to-skin contact (coined as 'Kangaroo care') with the mother is implemented. A participant in this study shared her baby was in the incubator for a month after which she proceeded with Kangaroo care and her tiny baby was carried close to her body for warmth and also to encourage bonding. Infections like HIV acquired from the mother in utero or intrapartum and very low birth weight (VLBW) infants minimise the prospects of survival for these neonates. Although neonates may have mothers living with HIV, it does not mean the neonates are HIV positive. HIV-exposed infants should be tested by 4 to 6 weeks and, if positive, they can immediately start antiretroviral therapy to improve chances of survival. (WHO, UNICEF and UNAIDS Global HIV Millennium Development Goals Report 2011:25).

The health risks to the infants and children of teenage mothers are profound. Stillbirths and new-born deaths are 50 per cent higher among infants of adolescent mothers than among infants of mothers between the ages of 20 and 29 (Karra & Lee 2012). About 1 million children born to adolescent mothers do not make it to their first birthday. Infants who survive

are more likely to be of low birth weight and be premature than those born to women in their 20s. In addition, without a mother's access to treatment, there is a higher risk of mother-to-child transmission of HIV (UNFPA 2013:22).

- **Experience during service delivery**

According to the participants, some nurses were kind which helped them to endure the pain during labour and the birth itself. However, the dire lack of transport to the hospital in a time of crisis was a major challenge to the teenage mothers. The following quotes attest this finding played a major role during labour:

> "*I was admitted at the clinic and was transferred to the hospital. The ambulance was called and it did not come. Nurses asked a lift for me in another transport which displayed their kindness. The reason for the transfer was premature labour. In the hospital, I was treated well. I did not experience any problems with nurses they were so kind to me.*" (Participant 4)

> "*During ANC, I was told that I must give birth at the hospital because of my age. When I feel pain, I must immediately hire the car to take me to the hospital. When I felt labour pains, I rushed to the clinic. There was no transport at the clinic and my parents hired the car to take me to the hospital*" (Participant 13)

> "*I went to hospital after feeling pains and at the clinic I was transferred to the hospital because I was swollen due to pushing before the baby was due. I gave birth through normal delivery with episiotomy and it was a full-term baby*." (Participant 14)

Timeous referral to the hospital and safe, quality treatment came up strongly as part of the birth experiences shared by the teenage mothers. All very young teenage girls delivered their babies in the hospital. One had terrible pain as a result of delivering her baby with the help of an episiotomy. Davidson, et al (2008:776) found teenagers needed to be supported during an episiotomy and repair to prevent pressure sensations and pain. These authors advise placing a hand on the woman's shoulder and gently talking to her as this distracts her from the pain and comforts her.

The participants indicated they were treated with kindness in the hospital. However, after referral, getting to the hospital caused a lot of unnecessary stress and anxiety for the teenage girls. Addressing the transport challenges, the teenage participants reiterated the lack of transport as a major obstacle and cause of fear for her life as well as the baby's life:

> "*I was admitted at the clinic and was transferred to the hospital. The ambulance was called and it did not come. Nurses asked a lift for me in another transport which was going to the side of the hospital*." (Participant 4)

> "*I then gave birth to these babies at the hospital as a transfer due to twin pregnancy. Though lack of transport is a problem and I used a taxi*." (Participant 3)

A participant indicated that registered nurses at the clinics were attentive and kind enough to assist her with finding another means of transport when the ambulance failed to collect her at the clinic. Transport was a serious problem in Muyexe village. The total lack of transport in the area and the distance the clinic was situated from the referral hospital caused a delay in teenage mothers' reaching the referral hospital. In another instance, the parents had to drive their teenage daughter to the hospital.

Ware (2013:3) states in rural settlements the distance from the clinics to referral hospitals is a major challenge to access services urgently and timeously. These authors add the unavailability of transport cause difficulties in attracting appropriate staff to work in remote areas. Poor transport resources which lead to young pregnant teenagers not being transferred from the clinics to the hospital can result in the loss of both the mother's and unborn baby's life. Ibis Reproductive Health (2013:22) inform that the teenage mothers do have serious health complications such as obstructed labour; delay in reaching the appropriate life-saving health services (the hospital) may result in maternal mortality.

The WHO (2015:27) indicates that for pregnant women and especially first-time teenage mothers seeking skilled healthcare for births or for some complications to prevent maternal and infant mortality, the unavailability of transport is unacceptable. In this regard, it is perhaps wise to be reminded of the words uttered in 1988 by the late Nelson Rolihlahla Mandela, "transport to schools are non-existent" – almost 30 years later, in the health services context, the same can be said of emergency transport to hospitals in remote areas, "transport is non-existent" as the truth thereof is proved by the currents study findings (MDG Country Report 2013:24). Indeed, the participants in this study shared transport in their rural area consisted of *one single ambulance*. (Author emphasis).

3.4.2 THEME 2: CHALLENGES TO RETURN TO SCHOOL

Teenage mothers are very likely to have an interrupted education; in fact, some simply drop out of school never to return. Having endured rejection, humiliation and stigmatisation at school, in the community and the family, many teenage mothers choose to return to school and complete their education. Although admirable, a lot of courage is needed to overcome

the challenges they face. Theme 3: Challenges to return to school consists of three categories: post-natal barriers to return to school; factors to enhance return to school; and financial challenges as shown in Table 3.7.

Table3.7: Challenges to return to school

THEMES	SUB-THEMES	CATEGORIES
3.4.2 THEME 2: CHALLENGES TO RETURN TO SCHOOL	3.4.2.1 Sub-theme 1: Post-natal barriers to return to school	• Will to return to school
		• Reaction from learners (stigma vs) support
		• Lack of support from parents (caregiver)
		• Role demands
	3.4.2.2 Sub-theme 2: Factors to enhance return to school	• Community/ parental/ personal encouragement
		• Family/partner support
		• Day care for baby near school
	3.4.2.3 Sub-theme 3: Financial challenge	• Financial limitation
		• Need for child support grant

3.4.2.1 Sub-theme 1: Post-natal barriers to return to school

'Post-natal' refers to the process of recovery from childbirth to when the teenage mother has healed physically and emotionally to continue with her life – but a new life where she has to carry more responsibility than before: adjusting to a new baby; a new routine and a new role, motherhood. How well she adjusts to this new life is highly dependent on her willpower as well as the support of partners, friends and, ultimately, the family. Therefore, the barriers that hinder her process of recovery, adjustment and return to school were identified and labelled as post-natal barriers.

Under the category 1, post-natal barriers to return to school, four subcategories emerged: will to return to school; reaction from learners (stigma vs support); lack of support from parents (caregiver); and role demands.

- **Will to return to school**

There was no doubt that all of the teenage participants indicated they were willing to return to school after delivery, but some barriers prevented them to do so. Indeed, some teenage

mothers managed to return to school the year after giving birth. The participants shared their wish to return to school as follows:

> "*I did not go back to school after delivery that year. There was no one to remain with the kid if I go back to school. The following year I went back to school. I wanted to complete Grade 12 and go to tertiary. I needed to complete education which can enable me to take care of the kids* [twins]." (Participant 1)

> "*Many people told me to return to school, such as some of my teachers and friends. I was afraid to tell my parents. I was receiving child grant and intended to use it for transport. After two years, my parents promised to stay with the baby. The boyfriend also accepted the baby and promised to take care of us. I went to collect a remove from my school at Mphambo and I was staying at N'wadzekudzeku with the boyfriend. So, I changed school, I did not go to the same school*." (Participant 4)

> "*I stayed at home and tried to go back to school but unfortunately I had to stay in marriage. Also, with us girls we think about marriage to the boyfriend and who will sometimes end up impregnating two or more girls at the same time.*" (Participant 5)

The issue of forced marriage emerged from this finding. One teenager shared she was married and forced to remain in marriage instead of going back to school. Granted, this participant admitted she fell pregnant because she wanted to keep her boyfriend. The information contained in this participant's quote touches upon three major hindrances teenage mother s face if they want to return to school: forced marriage, choosing pregnancy to keep a boyfriend, and the role of the male in pregnancy.

The latter, according UNFPA (2013: ix), points to failure in including the role of boys and men when addressing the underlying determinants and drivers of teenage pregnancy. Conversely, UNFPA declares in its latest 2016 State of World Population report despite the legacy of the deeply ingrained idea that 'manhood' means males must be "in power and control", boys must be from an early age be socialised to support the empowerment of girls (UNFPA 2016:75). Boys and men must learn to become girls' and women's allies and friends, not their enemies and rapists. Hence, engaging boys and men in programmes promoting gender equality can contribute towards both young women and men building skills, acquiring education, attaining good employment and earning sufficient money to succeed in modern economic life while building a better and sustainable future for the next generation and the world they will be living in.

Teenage girls of childbearing age are forced into early marriage and even more decisively if she becomes pregnant (WHO 2009:19). In confirmation, UNICEF (2012:10) states many teenage girls who marry or enter into union at the ages between 15 and 19 often do so against their will and with men at least 10 years older or even older. Consequently, as a married mother marriage itself is a barrier against furthering a teenage mother's school career because her life now revolves around looking after the baby, taking care of her husbands or partner and doing housework which leaves no time for school (Nkani 2012:51).

To enable pregnant adolescents or new mothers to stay in or return to school, they need supportive national and local school policies. But even with supportive policies, many may not resume their education. For example, despite progressive legislation in South Africa allowing young women to return to school post pregnancy, only around a third actually re-enter the schooling system (Grant and Hallman (2006) cited in UNFPA 2013:76). In this study, a teenage mother registered at another school, although she wanted to further her education. She did not want to return to her old school because of the heartache and sadness she endured from her friends. But, the desire to continue learning was so intense that she just enrolled in another school.

Teenage mothers in the current study setting confirmed most returned to school the following year after delivery. It seems some found it difficult to find someone to take care of the baby while the mother was at school. Adam's (2012:109) perception that teenage mothers want to have a better future for themselves and their babies is verified by the participant who stated she "*wanted to complete Grade 12 and go to tertiary*". This teenage mother's dream is a reminder that steps must be taken to transform her dreams into reality. The South African Schools Act (Act 84 of 1996) documents teenagers who fall pregnant or teenage mothers cannot be denied access to education. The ISHP (2012:10) supports improved outcomes for access to school, retention within school, and achievement at school by advocating for improvement to the general health of learners and the environmental conditions at schools which the ISHP perceives as barriers to learning. Nelson (2013:65) reports most teenage mothers choose to return to school usually a month after delivery because they do not want to miss too much school work.

The chances of going back to school were challenges for the current participants because there was nobody available to care for their babies. Shefer, et al (2013:139) note that teenage mothers do return to school but their performance was often affected, and many moved from doing well academically to becoming average or 'underachievers' once they were balancing motherhood and schooling. Nevertheless, teenage mothers' potential should be realised. Parents, families, educational institutions, governments and the world need to

investment in their health and education instead of looking on as they bear the burden of child-rearing and household duties. “Lower fertility and later marriage increase female labour force participation, another area of economic potential for both the household and the nation … policies promoting better health, education and labour-force participation for women – as well as being worthy ends in themselves—can contribute to healthier, better educated and more prosperous families and nations.” (UNFPA 2016:48-9). “Healthier girls are able to attend school more consistently and learn more effectively. In addition, healthier girls who grow to become healthier mothers give birth to healthier children who are better nourished and can grow to become more effective students and workers. (Onarheim, et al. cited by UNFPA 2016:49).

- **Reaction from learners (stigma v/s support)**

Obviously teenage pregnant girls would be recognised if they returned to school after birth. After the emotional harm they suffered through stigmatisation, being called names and losing friends, they felt scared and some feared returning to school as verified by their quotes:

> “*Some scholars did not even want to share a seat with me* [rejection] *and others used to gossip and laugh at me. My friends wouldn’t like to play with me anymore. I was lonely. They were gossiping about me.*” (Participant 4).

> “*Other scholars were very friendly and supportive towards me and even discouraged me from even considering terminating it. They gave me good advice*.” (Participant 5)

> “*When the other students discovered that I was pregnant, they started making fun of me and also claiming that I was causing them to slumber in class. Some of my friends rejected me and I turned into a loner. When the teachers discovered it, they reported me to my parents When the teachers discovered it, they reported me to my parents and I do not wish to relate that experience again, it was horrible.”* (Participant 10)

> “*I also wanted to change school because I was afraid to face teachers and students. I thought teachers and other students will continue torturing me.*” (Participant 14)

The participants still harboured the feelings of rejection they experienced from learners during their pregnancies. This was quite a big barrier for them to overcome if they decided to return to school as mothers. One said she did not “*wish to relate that experience again, it was horrible*” regarding the experience of discovering her pregnancy and involving her parents. Friends turned away from them; gossiped about them and made fun of them.

Adam (2012:109) found in schools, peers (and teachers) often fear teenage mothers will "contaminate" other learners when they return to school. In other words, they may influence other children to become pregnant. This author perceives this ungrounded fear of contamination as a reflection of pure discrimination against teenage mothers which is totally not in line with the Constitution of country. Karra and Lee (2012:3) and Rangiah (2012:47) also state younger mothers (17 or younger) are less likely to return to school after delivery for the fear of yet more rejection – which made them drop out of school in the first place

The Department of Basic Education (2010:42) reasons that teenage mothers drop out of school due to poor academic performance, few child-caring alternatives, inadequate support from peers and the school environment as well as the social stigma of being a teenage mother**.** Shefer, et al (2013:8) argue that the negative responses of schools and the very biased and powerfully gendered experiences that pregnant girls bear the brunt of simply because they are more visible, leads to rejection during pregnancy and during motherhood. Molapo et al (2012:84) also found that teenage mothers, who were always discriminated against, treated badly and ignored in class and then returned to school after delivery, tended to suffer again as their peers thought the former wanted special treatment because of their motherhood status. This could relate to the finding that friends "*did not want to share a seat with me*" although this comment was not expanded on by the participant.

Nkani (2012:49) posits the majority of pregnant teenagers and teenage mothers experience many challenges in schools; they are mostly marginalised and discriminated against by their peers and teachers as they are considered to contribute to high failure rates. Yet, this supposition is disputed by Akella and Jordan (2015:50) who observe some teenage mothers "decided to rectify their mistakes and pursue future career objectives". Participants in Akella and Jordan's study voiced, "*Being pregnant makes me want to do better and finish school. Now, I am really taking school seriously*"; "*I plan to become a registered nurse"; "I have stopped dating am concentrating on my studies and baby now";* and "*Getting pregnant is not the end. I am going to finish school and graduate. You just have to stay motivated for you and your child."* (Akella and Jordan 2015:50-1). Motherhood can and do change priorities; the lessons learnt become the reasons for wanting success and striving for a better life.

A teenage mother, who returns to school in spite of adversities, may be the girl Dr Babatunde Osotimehin, United Nations Under-Secretary-General and Executive Director UNFPA, the United Nations Population Fund, visualises when he describes a 10-year-old girl's path through adolescence to a productive and autonomous adulthood as being a girl,

> Who is able to exercise her rights, stay healthy, complete her education and make decisions about her own life, she – and everyone around her – wins. She will be healthier and, if she later chooses to start a family, her children will be healthier. She will be more productive and make a better living and in turn make the world a better place (UNFPA 2016:3).

- **Lack of support from parents (caregiver)**

Teenage mothers need support especially from parents for proper promotion of their health and welfare. The current study findings indicate some parents are willing to support their teenage daughters to return to school to become educated and have a proper career even if at first they were shocked when discovering she was pregnant. The next quotes verify this finding:

> "*My parents encouraged me to return to school and they indicated that giving birth to the child was not the end of the road for me. I took a remove to another school in order to continue with education and learn. I was told not to repeat the same mistake*." (Participant 6)

> "*I think parents should sit down with us as their daughters and encourage us to finish school before looking for men. They can use the child care grant money to pay for our children at local crèches whilst returning to school instead of rejection*." (Participant 5)

> "*My parents were very disappointed and did not want to have anything to do with the baby. I stayed for almost a year before returning to school. After a year, they did not allow me to go back to school*." (Participant 12)

> "*Some teachers used to talk bad about me, calling me names but some advised me to ignore such talks and supported me. Some students rejected me while others supportive. But I was not allowed to participate in some activities such as sports*." (Participant 13)

Parents seemed to encourage teenage mothers to return to school. According to Nkani and Bhana (2016:7), the best way to escape unemployment concomitant with poverty is to complete secondary school and either to find a job that pays well or further one's studies at a tertiary institution. A challenging situation was experienced by teenage mothers who did not have parents to take care of their babies while at school and with limited social support networks.

According to Malahlela and Chireshe (2013:145), in both urban and rural areas teenage mothers are primarily responsible for child care because families are not always willing to support and accommodate their school schedule. These authors also state teenage mothers who were attending school dropped out of school because of the pressures they experienced at school including stigmatisation from peers and teachers. Duncan (2011:1) argues that teenage mothers need support from parents, family, friends, schools and other organisations to return to school while Sodi (2009:58) emphasises parents and other people should be supportive towards the pregnant and teenage mothers. The participants of this study stated parents and the community should be supportive to teenagers and encourage them to return to school. Thobejane (2015:274) confirms parents play an important role in the lives of their children. In case where parents fail to provide their children financially, it contributes to the situation of teenagers falling pregnant at an early age. The author adds the lack of parental support leads teenagers to be trapped in substance abuse.

According to Panday, et al (2009:130), poor support from families result in teenage mothers' non-return to school. These authors concur with the findings of the current study as the participants reported both parents were working and there was nobody to remain with the baby when attending classes. According to Chigona and Chetty (2008:271), parents of teenage mothers were reluctant to support their daughters due to stigmatisation. It seems as if parents do not understand what the teenage mothers go through during their pregnancy and they failed to provide support when their daughters needed it most. According to Nelson (2013:4) the responsibilities of being a teenage mother and a scholar at the same time are difficult. The author also indicates that in order to assist them to fulfil their demands of being a mother and a scholar, service providers need to come up with a strategy to accommodate young mothers in a variety of ways. The phenomenon of not attending school because of lack of parental support was seen as a concern in general which needs mechanisms in place that will support teenage mothers in their desire to complete education.

Hence, there was a need for parental intervention as far as teenage pregnancy is concerned. According to IRH (2013:2) teenage pregnancy and early childbirth are concerning public health problems, and they deserve unbiased attention from health professionals, policy makers, educators, and community members.

A challenging situation was experienced by teenage mothers who did not have parents to take care of their babies while at school and with limited social support networks. According to Malahlela and Chireshe (2013:145), in both urban and rural areas teenage mothers are primarily responsible for child care because families are not always willing to support and accommodate their school schedule. These authors also stated that teenage mothers who

were attending school declined due to pressures experienced at school including stigmatisation from peers and teachers. Duncan (2011:1) argues that teenage mothers need support from parents, family, friends, schools and other organisations to return to school while Sodi (2009:58) emphasises parents and other people should be supportive towards the pregnant and teenage mothers. According to Nelson (2013:20) the responsibilities of being a teenage mother and a scholar at the same time are difficult. The author also indicated that in order to assist them fulfil their demands of being a mother and a scholar, service providers need to come up with a strategy to accommodate young mothers in a variety of ways. There was therefore a need for parental intervention as far as teenage pregnancy is concerned.

- **Role demands**

The role demand in this study meant multiple duties to be done by the teenage which could hinder progress of going back to school. The participants verbalised it was difficult **to** fulfil a dual role of being a learner and a mother and consequently they left school. Their remarks in this regard were as follows:

> "*I was slumbering in class because I was always tired when the baby cries at night. Sometimes it was difficult even to write homework, but as the time went on, there were no longer problems. My parents encouraged me to return to school and they indicated that giving birth to the child was not the end of the road for me. I took a remove to another school in order to continue with education and learn. I was told not to repeat the same mistake*." (Participant 6)

> "*Yes, but it was difficult at first because I had to get someone to look after the baby when I was at school and I could not. Both my parents are working and I was forced to take care of the baby until he was old enough to go to a day care centre whilst I returned to school*." (Participant 10)

> "*I am currently staying with the father of my child. It was tough to be a mother and staying with another family. You cook; fetch water and other house chores. You are always tired and sleep in class. I was annoying teachers because I was always tired and I failed*." (Participant 6)

The participants in this study reflected that the main problem of being a teenage mother was tiredness which led to sleeping in class. Doing school work such as home work was difficult. The school performance was very poor which resulted in failure**.** Shefer, et al (2013:7) reflect on the possibility of bringing the parenting role into the school grounds by taking the baby to school. However, strong arguments against the possibilities of children being cared for at

school were made by Willan (2014:57) stating that a school role can be expanded to support a mother both as a learner and a mother as such, if she chooses to breast feed exclusively for the first 6 Month.as recommended by Department of health and WHO in Maternity Guidelines.

Ibis Reproductive Health (2013:57) states teenage mothers need parental support and advice, especially if they are uninformed and battling to be parents. The author also mentions due to the dual demands of being a learner and a parent led to teenage mothers failing to go back to school. But whether they stay at home or go to school, advice on how to care for their babies is much needed by young mothers. These authors' opinion concurs with that of the participant of study who indicated that she was always tired because of the multiple roles she had to fulfil as a learner, wife and a mother. The implication is thus that the main reason for teenage mothers not returning to school may be ascribed to having to take care of the baby. The findings of Macleod and Tracey (2010:20) further signified the main motive for teenage mothers to leave school before passing matric was poverty, absence of parents at home, the need to care for siblings, sick family members and the baby. Malahlela and Chireshe (2013:146) also indicate reasons for poor performance if teenagers return to school is the responsibilities of caring for the infant and devoting time to school work. This reaffirms Kyei (2012:137) opinion that children born to teenage mothers are often left in the care of ageing family members when the mother returns to school. If the family life is not stable, the baby could be exposed to violence.

It emerged from this study that one of the participants verbalised cooking, fetching water and doing other chores made her tired; she fell asleep at school which annoyed the teachers. In support, Molapo et al (2014:1270) reflect that teenage mothers have no time to do their school work at home because of their babies and house chores which are not conducive for learning. According to Thobejane (2015:274), teenagers that fall pregnant under 18 years are unlikely to return to school because they must look after their babies and can only continue with schooling when the child is older. A participant mentioned that both her parents were working and she was forced to take care of the baby until he was old enough to go to a day care centre and she could then return to school.

According to Taylor et al (2014:10), pregnancy and motherhood does not necessarily end a teenage girl's schooling; however, for many who remain in school or return following childbirth it does affect their grades and academic progression. Yet, they do not always drop out of school but show exceptional perseverance. A further challenge was related to the baby's health. Chauke (2013:17) states it is very common for infants to fall ill, especially if they were premature babies. The teenage mother then has to take the baby to the hospital

and, if admitted for a long period of time, the mother would miss classes. This could accelerate school dropout. Yate (2011:25) argues that dropping out of school due to pregnancy may help the teenager avoid stigma and judgment by peers, it may give them time to prepare for parenthood, it may give them time to be there and look after their child once it is born. Once older and more settled, the mother can resume her school career.

3.4.2.2 Sub-theme 2: Factors to enhance return to school

Under category 2, factors to enhance return to school, three subcategories emerged, namely community/ parental/personal encouragement; family/partner support, and day care for baby near school.

- **Community/ parental/personal encouragement**

Encouraging teenage mothers to continue with their schooling after delivery was a delicate issue for the teenage mother participants from the two rural villages. Strict cultural and traditional rules applied to teenage girls' sexual behaviours while boys apparently went scot-free. Parents and teachers were inclined to avoid talking about sexual and reproductive health and gave incorrect information. Despite many challenges, the teenage participants showed great determination to complete their schooling as the following verbatim quotes verify:

> "*I think I should be serious with my studies and continue to take the contraceptives so that I do not fall pregnant again before I am ready. But the problem was that, both of my parents were working and I was forced to take care of the baby until he was old enough to go to a day care centre whilst I returned to school*." (Participant 10)

> "*As a teenage mother, I must make a decision about my education and future and also takes contraceptives. We as teenagers, we should learn to communicate with our parents so that they can allow us to return to school*." (Participant 15)

> "*As teenagers, we must learn to communicate and to listen. I must use contraceptives especially the new one of implants as it will sustain me for long. I will be able to complete my studies and have a profession. Employment will be possible*." (Participant 13)

Regarding personal encouragement, participants indicated that they wanted to return to school to complete their studies. Some said they had started to use contraceptives to prevent another pregnancy. However, the problem was that they needed someone like their parents to remain with the baby while they attended classes. Basch (2011:616) supports the

development of future aspirations such as completing high school and college in order to better a mother's life and future and at the same time contribute to the community and society. As reiterated by a participant who said she "*will be able to complete my studies and have a profession*". Mahlalela and Chireshe (2013:140) also indicate that teenage mothers' pregnancy made them realise they had to think and work for a better future for them and their children and they therefore took education seriously when they returned to school immediately after delivery.

But, the findings showed even though young mothers were determined to return to school, the obstacles they faced in their communities and families were immense. There was the general feeling that educators at both schools did not approach teaching learners on sexual and reproductive health correctly; the traditional tenets that talking about sex is taboo, abstaining from sex is compulsory and boys are viewed as worthier than girls, these upset the participants. The following quotes verify this:

> "*The teachers should deal very deeply with the subject in Life Orientation especially the reproductive system. They teach light information because talking about sex is a taboo. The community should also be involved in teaching us about health, not calling us prostitutes when having a boyfriend.*" (Participant 12)

> *"In the community, they will say that a child will become barren because the contraceptive she takes is in her bloodstream or body and she will never fall pregnant. The term taboo should be eliminated*." (Participant 11)

> "*Families, churches, chiefs and community developers should work together to groom children from early stage. The term taboo should be eliminated and parents start teaching us the truth about sex. Lack of knowledge makes us to be pregnant. The boys have no problems because only girls are considered to be responsible for pregnancy but they [*all teenagers] *should be told about the dangers of unprotected sex such as sexual transmitted infections.*" (Participant 15)

The communities of Muyexe and Homu 14C villages strongly object to pregnancies among teenagers before marriage since as a community, most families seem to promote the traditional culture of abstinence. In a community where misconceptions about using contraceptives ("*the contraceptive she takes is in her bloodstream or body and she will never fall pregnant*"); being judged as a "*prostitute*" for having a boyfriend and parents and teachers failing to communicate correct information to the teenagers regarding sex ("*They teach light information because talking about sex is a taboo.*") prevail it is likely for girls to be

regarded as inferior to boys. This supposition is confirmed by the verbatim quote that the "*boys have no problems because only girls are considered to be responsible for pregnancy".*

Thobejane (2015:274) reflects that teenagers receiving inaccurate, inappropriate and confusing information about sexuality and reproductive health remain a problem in South Africa – particularly in remote areas. Bana, et al (2015:154-5) fully agree in economically poor rural populations young people's knowledge of preventing HIV and STIs and condom and contraceptive use is alarming.

In a rural area in the Eastern Cape (population approximately 36 000), these authors discovered many 15- to 24-year-old learners were unaware of what STIs were but believed it was a "female disease"; they had "some vague idea about other STI syndromes like discharge and ulcers"; had only heard about HIV and AIDS; and were unclear about the different methods of contraception and how it linked to STIs including HIV prevention (Bana, et al 2010:154-5). According to UNFPA (2013:50) parents may "impart information about sexuality and prevention of pregnancy or they may withhold vital information".

Parents' roles and how they view the roles of their sons and daughters in the family and in life itself play a pivotal part in whether girls grow up believing their destiny is to marry, have children and look after their husbands or whether they have the right as individuals to have equal rights as boys to education and developing life skills to become autonomous and take control over their own future. Sadly, parents "who succumb to community pressures usually force their girls into marriage and a lifetime of dependency" (UNFPA 2013:50). The current participants verbalised again and again discussing sexuality is "*taboo*" whether in the household, school, church or with peers.

This indicates networking on sexuality (vertically with parents) and horizontally (with community-based structures like school teachers, nurses, church and tribal leaders) is non-existent or not utilised properly (Modiba, Schneider, Weiner, Blaauw, Gilson, Zondi, et al 2002:i). In early the early 2000s Caldwell and Caldwell (2002:para 1-2,5) found urbanised single young women already replaced traditional postpartum sexual abstinence with contraception in sub-Saharan countries such as South Africa, Lesotho and Botswana but in most rural areas life was still lived according to traditional customs prescribing abstinence as the only way to prevent young girls to become pregnant. In the current study setting, abstinence only was promoted by educators in schools and in churches; parents at home and the community at large. It was only after having unprotected sex and falling pregnant that participants who were sexually active realised the importance of using contraceptives.

The participants verbalised again and again their dismay with the fact that discussing sexuality was "*taboo*" whether in the household, school, church or with peers. This indicates networking on sexuality (vertically with parents) and horizontally (with community-based structures like school teachers, nurses, church and tribal leaders) is non-existent or not utilised properly (Modiba, et al 2002:i). Therefore, participants pleaded for "*families, churches, chiefs and community developers should work together to groom children from early stage,*" and for parents to start telling both sons and daughters "*the truth about sex. Lack of knowledge makes us to be pregnant … [all children] should be told about the dangers of unprotected sex such as sexual transmitted infections*".

According to Chigona and Chetty (2008:274), the communities in which teenage mothers live have a significant impact on their lives. These authors assert that instead of being supported to complete their schooling, teenage mothers in traditional communities are discouraged and often treated as a girl with low morals – being stigmatised as a "prostitute" was mentioned in this study. Gender-bias was also observed. This is in stark contrast to the standpoint of UNFPA (2016:76) that from young age boys should be educated to respect girls and acknowledge them as human beings and vice versa.

Teachers failed to inform teenagers about safe sexual practices; sexual and reproductive health was not properly discussed or addressed by teachers in schools although in the subject Life Orientation these issues form part of the curriculum (National Department of Education 2002). Clearly, there was a lack of giving teenagers correct knowledge about reproductive health and safe sexual practices in the schools and households in the Muyexe and Homu 14C villages. Gyan (2013:59) recommends for teenage mothers to be subjected to an integration and skill development programme which will support and help them to complete their education. In support, Willan (2013:58) cites the provision of proper counselling to teenage mothers before they return to the school system is important in order for them to cope with their difficult situation.

The author adds extra lessons should be available for teenage mothers at times that are convenient to them to enhance the completion of their education. Malahlela and Chireshe (2013:147) indicate that schools need educators skilled in counselling to assist pregnant teenagers and teenage mothers to overcome the psychological issues surrounding their physical and emotional conditions during pregnancy and after delivery. To assist with this task, Gyan (2013:59) asserts the Department of Education should initiate teacher training programmes to assist teachers in eliminating their prejudices against pregnant teenagers and young mothers who return to school after delivery. In this regard, the view of Makiwane, Desmond and Udjo (2006:4) is that raising the standard of education in poor communities

and having youth-friendly services for teenagers could reduce pregnancies and school dropout.

“Parents and communities play an important role in achieving gender equality.” (UNFPA 2016:75). The aim of the modern parent needs to be to raise sons to become men as “responsible, caring and non-violent partners or peers” (UNFPA 2016:76). According to Macleod and Tracey (2010:21), not sharing SRH information publicly because it was culturally taboo could be one of many reasons why the denial of paternity by the male partner in unenlightened rural communities was ‘okay’.

Because Karra and Lee (2012:7) believe in the importance of policies and programmes that encourage teenage mothers to continue with their studies, they assert all teenagers should be allowed to access reproductive health advice and receive free contraceptives without parental permission to prevent pregnancies. The NASRHRF (2014-2015:34) recommends for areas where taboos, myths, misperceptions regarding contraception, stereotyping and discrimination on sexuality are challenged by cultural and traditional practices, any approach and/or attempt to curb teenage pregnancy should be done in a positive, open manner where the dire situation is backed by facts strengthening the reality and truth as it is.

- **Family/partner support**

For teenage girls and mothers who had an unplanned baby but desired to complete school or further her education and career, support by family members and partners is a critical factor for realising this dream. Unfortunately, as the participants’ verbatim quotes signify, not all parents realised how much their daughters needed their love and support as the latter suffered emotionally or physically while being pregnant or as a teenage mother. On the other hand, some teenage mothers were fortunate to have support from boyfriends and their families who accepted the pregnancy and helped the young mother to return to school. These findings are confirmed by the next quotes of the study participants:

“*My family took me to the boy’s family to report that I was pregnant. The father of my child accepted the pregnancy. It was arranged that I must go and stay with him. I got married in that manner. I am still staying with him. He is the one taking care of us.*” (Participant 7)

“*I am currently staying with the father of my child. It was tough to be a mother and staying with another family. You cook, fetch water and other house chores*.” (Participant 6)

"*I am staying with the baby's father at his home together with his parents. He is maintaining me and the child.*" (Participant 2)

"*The following year I went back to school. I wanted to complete Grade 12 and go to tertiary. I needed to complete education which can enable me to take care of the kids* [twins]. *My parents allowed me to go back to school and I managed. My kids were staying with parents from both families*." (Participant 1)

"A family meeting was called where I apologised to my parents for falling pregnant and they accepted my apology, hence they were telling me to return to school after delivery to complete my matric." (Participant 6)

"*But the problem was that, both of my parents were working and I was forced to take care of the baby until he was old enough to go to a day care centre whilst I returned to school*." (Participant 10)

Malahlela and Chireshe (2013:147) state through sex education learners could be encouraged to abstain from having sex until completion of their studies and those who fail to abstain should be encouraged to use condoms, injections or pills to prevent an unwanted pregnancy at an early age or when still in school. In this study, teenage mothers mentioned the challenging outcomes of unplanned pregnancies such as arranged marriages. ("*I got married in that manner*") and the biological father distancing himself from the teenage mother and his baby ("*both of my parents were working and I was forced to take care of the baby*"). Conversely, positives were that both sets of grandparents offered support in the form of taking care of the grandchild.

("*My kids were staying with parents from both families*.") and own families who wanted their daughter to complete her education ("*they were telling me to return to school after delivery to complete my matric*").

It emerged from this study that some parents forgave their daughters and were willing to care for the baby to let the mother return to school. This is positive support. Adam (2012:110) confirms the importance of parental support for the benefit of both the new mother and the baby. Teenage mothers are often financially dependent on their parents and/or family. When she has a baby, their financial responsibility is doubled. For parents who are already struggling financially, providing for the mother and baby can become a major challenge; therefore, parents often rely on assistance from the community (Rangiah 2012:15).

Ibis Reproductive Health (2013:26) agrees that teenage mothers' intervention with parents are helpful in terms of providing better health outcomes if they have consistent family support

and they can go to their parents for advice on family planning. The authors assert that communication among parents and their children should be encouraged through community programmes because communication could help teenage mothers to return to school and also to use contraceptives without fear. The Department of Basic Education (2010:42) reports that teenage mothers' decision to leave school altogether may stem from inadequate support from parents, partners and/or a school environment where teenage mothers feel unwelcome and cannot cope with the workload. Teenage mothers' recovery and motivation to return to life and school is very much dependent on the teenage fathers' attitudes, behaviours and decisions regarding her and the baby. Getting financial support from the child's father is important for their survival. The current teenage mothers, except for a few, had been left by their baby's fathers thus leading them to disillusionment.

"Parents and communities play an important role in achieving gender equality." (UNFPA 2016:75). The aim of the modern parent needs to be to raise sons to become men as "responsible, caring and non-violent partners or peers" (UNFPA 2016:76). According to Macleod and Tracey (2010:21), not sharing sexuality and reproductive health information privately (at home) or publicly (for example, by teachers and nurses) because it is culturally taboo could be one of many reasons why the denial of paternity by the male partner in unenlightened rural communities was viewed as 'okay'.

However, the age, attitude and views of the biological father "on marriage, sex, gender roles, contraception, pregnancy and childbearing" (UNFPA 2013:46) greatly influences the overall financial, physical and mental wellbeing of the teenage mother. Men and boys who father the children of teenage girls need to learn to take responsibility, not only financial responsibility but also as a father. In this study, some participants voiced the behaviours and decisions of their babies' fathers and their families were somewhat positive. Some of the children's fathers were supporting their babies while others were disillusioned as the fathers took no responsibility for the baby or reject them.

Forced marriage, biological fathers distancing them from the young mothers' plight and a community that ostracises a young mother is, indeed, taboo. Simply stated, "Girls who have become pregnant need support, not stigma." (UNFPA 2013:97). They need parents who uphold their daughter's basic human right to achieve her full potential and they need husbands/partners who "challenge gender norms, stereotypes and harmful practices" (UNFPA 2013:95) because they recognise women/girls as equal counterparts.

- **Day care for baby near school**

Having a day care centre near the school was identified as a motivational factor to encourage teenage mothers to return to school. The participants of this study advocated for a day care centre to be erected near the school. The participants further suggested the centre could be funded by the government. Below are some verbatim quotes from the participants regarding the necessity to have a day care centre close to their schools:

> "*I think a communal centre, similar to a crèche, can be erected so that they can leave their children there when attending school, without paying any fees, because people do not have money. The place should be funded by the government who will pay the salaries of the child-minders*." (Participant 3).

> "*I think parents should sit down with their daughters and encourage them to finish school before looking for men. We can use the child care grant money to pay for their children at local crèches whilst they* [mothers] *return to school. Children centre in local areas of the community where we can put our children when attending classes should be built*." (Participant 5)

> "*Maybe if as teenage mother, I can be knowledgeable regarding family planning and have some crèches nearby, can go back to school."* (Participant 6)

> "*But the problem was that, both of my parents were working and I was forced to take care of the baby until he was old enough to go to a day care centre whilst I returned to school."* (Participant 10)

In this study, the participants requested for the building of a child care centre or crèche as close to the schools as possible. The government could fund the scheme and pay the employees. Having their babies close enough for feeding and knowing they were safe would help the teenage mother to concentrate in class. The issue of being taught about family planning was once again mentioned while discussing with parents the possibility of using their child grant as money for the teenage mother to pay for school fees was mentioned.

MacCleod and Tracey (2010) state the major reason for not returning to school was the need for someone to care for the baby. In the opinion of Shefer, et al (2013:8), if appropriate support from the community and government departments involved in teenage health and education (the NDoH and NDoE, for example) want to ensure teenage mothers and their children have better future life opportunities, the mothers' voices should be heard.

Teenage mothers in this study wanted to return to school, but lack of care for the baby, scarcity of money and feeding their babies were obstacles to overcome. Having a day care centre close to the school would be a major step towards supporting teenage mothers to fulfil

their parenting role and complete schooling. Taylor, Jinabhai, Dlamini, Sathiparsad, Eggers, and De Vries (2014:6) assert many babies are left with grandparents, other relatives or friends to allow teenage mothers to attend school. These authors concur with the participants' view that providing crèche facilities close to schools will make it easier for them to access school and further their education while still being able to take care of their babies.

Willan (2013:58) states educators (teachers) also need to be trained on how to support teenage mothers in their schools. In fact, this author supports the idea that the school itself should consider providing crèche facilities for teenage mother learners. This author's suggestion makes perfect sense if one considers Bhana, et al (2008:83) found that some schools would not allow teenage mothers to breastfeed at school. According to these authors, their study findings indicated there were instances where family members would bring the infants to the school where the mothers breastfed in front of other learners.

Obviously, this is not suitable behaviour in a learning environment and therefore schools in areas where challenges for teenage mothers are complex should perhaps take the lead in finding a way to accommodate the needs of teenage mothers who have to take care of infants but at the same time focus on their lessons. For a breastfeeding mother, it is best if there is a day care centre near the school where she can go to feed the baby (Ibis Reproductive Health 2013:26). Keeping teenage mothers in school is possible if adequate efforts are made by organisations and sectors in the community and country to include the voices of teenage mothers when attempting to remove the barriers that keep them out of school.

3.4.2.3 Sub-theme 3: Financial challenge

Under category 2, financial challenge, sub-theme 1, namely the financial limitation and need for Child Support Grant:

- **Financial limitations**

In this study, financial constraint was referred to limitations of having money for survival by teenage mothers and their kids. Limitation of funds led parents to encourage their teenagers to become pregnant. The participants displayed that they did not return to school because of insufficient money.

The expressions of the participants were:

> *"Some parents are unemployed and they do not have money to let their children go back to school whilst taking care of the child. Due to poverty, some parents*

encouraged us as their teenage children to fall pregnant. Getting more than one child because of the Child Grant they receive. Some of them feel that giving birth is far better than going back to school." (Participant 7)

"My parents did not have money for transport. I also wanted to change schools because I was afraid to face teachers and students. I thought teachers and other students will continue torturing me. Unfortunately, I dropped out from school." (Participant 14)

"Money was not enough at home for me and the baby and I also stayed long in the hospital. I can go back to school if I can get a job or study privately. I passed my matric through ABET, but I cannot proceed due to lack of money." (Participant 8)

In this study, the participants stated that they have a will to return to school, but suffer from financial constraint. One of the participants indicated that parents were poor and unemployed. Teenage mothers were willing to return to school, either study privately or get a job. Financial state was not good for the participants and their babies. Anyanwu, Goon and Tugli (2013:927) indicated that teenage pregnancy had some financial implications, especially if the pregnancy was unwanted as lack of education could lead to lack of job that lead to poverty.

Similarly, to this citation, the participants also indicated that their parents were not employed and this led them not to go back to school. Chigona and Chetty (2008: 273) indicated that, many teenage mothers who grew up in poor areas (informal and rural) cannot return to school as they already come from financially challenged families and parents cannot afford babysitting for grandchildren. Molapo, et al (2014:14) reflected that, financial barriers perpetuate itself from generation to generation and increase the opportunities that may affect them in their life time. These needs to be overcome by teenage mothers by finishing school and finding employment in South Africa. These authors concurred with the participants under study who wanted to pass matric through ABET and look for a job. The findings of this study imply that there are some very serious problems in rural areas regarding money.

Molapo (2012:110) indicated the importance of parental support for the benefit of both mother and the baby. The Department of Basic Education 2010:42) reported that teenage mothers who dropout from school increase opportunities that may occur out of school due to inadequate support from peers and the school environment, as well as the social stigma of being a teenage mother. Willan 2014:58) reported that, finances often prevent teenage mothers to be able to pay fees for childcare at the centre, preventing their return to school. The participants in this study confirm that the teenage mothers experience financial

constraints which prevent them to return to school. Thobejane (2015:274) documented that, the teenagers that fall pregnant are unlikely to return to school because poverty may lead to prostitution in a way of compensating their patents.

Parents are expected to look after their children when attending school and the parents. Chohan and Langa (2011: 91) stated that, many teenagers who remained at school while pregnant and returned after childbirth was through their own motivation, believing that at the end of their schooling they will find jobs to benefit both the mother and the baby including the family. Provincial Health Research (2012:42), reported that teenage mothers needed money, wanted to access the child support grant and having multiple partners in order to be assisted financially. Karra and Lee (2012) have also shown that teenagers tended to drop out of school earlier than boys as a result of numerous factors, such as pregnancy, lack of access to safe transport, domestic responsibilities, financial constraint and being orphaned as a result of their parents dying of HIV and AIDS.

- **Need for Child Support Grant**

Financial constraints caused immense survival problems for teenage mothers. The lack of money prompted some parents to encourage their teenage daughters to have a baby because the child grant would assure some income for the family. Participants said they could or did not return to school because of insufficient money. The participants shared the financial challenge they encountered as follows:

> "*Some parents are unemployed and they do not have money to let their children go back to school and taking care of the child. Due to poverty, some parents encouraged us as their teenage children to fall pregnant and get more than one child because of the child grant they receive. Some of them feel that giving birth is far better than going back to school*." (Participant 7)

> "*My parents did not have money for transport. I also wanted to change schools because I was afraid to face teachers and students. I thought teachers and other students will continue torturing me. Unfortunately, I dropped out from school.*" (Participant 14)

> "*I don't know what to say, because most of teenage mothers have more than one child because of the child grant they receive. Some of them feel that giving birth is far better than going back to school. Some parents are unemployed and are not yet at a pensionable age that is why they encourage their teenage children to fall pregnant*." (Participant 2)

> "*Money was not enough at home for me and the baby and I also stayed long in the hospital. I can go back to school if I can get a job or study privately. I passed my matric through ABET, but I cannot proceed due to lack of money*." (Participant 8)

> "*I think parents should sit down with their daughters and encourage them to finish school before looking for men. They can use the child care grant money to pay for their children at local crèches whilst they return to school*." (Participant 5)

> "*I realised that the only way of taking good care of my child was to go back to school and be educated. I can use child support grant to pay for the school fees of my child.*" (Participant 10)

The findings of this study imply there are some very serious problems in rural areas regarding money. Anyanwu, et al (2013:927) state a teenage pregnancy has financial implications which are especially problematic if the pregnancy was unwanted and unplanned; its financial consequences are not favourable for a teenage school-going girl who comes from a gender-based, impoverished home environment where there is a constant lack of money. Molapo, Molapo, and Zulu (2014:14) posit for a teenage girl an unwanted teenage pregnancy can become a barrier to education which leads to joblessness which, in turn, forces her to live in poverty for the rest of her life. This cyclic lifestyle of illiteracy, joblessness and poverty can perpetuate itself from generation to generation as implied by the statement of a participant who said her "*parents are unemployed and are not yet at a pensionable age*".

Many teenage mothers who grow up in informal areas – usually impoverished, remote areas – cannot return to school as they already come from financially challenged families and cannot pay parents or caregivers for babysitting (Chigona and Chetty 2008:273). Although it may be the wish of many to complete their schooling – or at least develop some other skills that would assure them an income – some parents will not allow it. They want their daughters "*getting more than one child because of the child grant they receive*" as the whole family lives on the child grants. This is confirmed by Macleod and Tracey (2010:22) who found that the older female relatives (usually the teenagers' mothers) who took over the care of the baby were often the beneficiaries of the child support grant – in most of these cases the teenage mother was too young to qualify for the grant. According to Chohan and Langa (2011:91), many teenagers who remain at school while pregnant and return after childbirth do so through their own motivation and belief that at the end of their schooling they will find jobs to benefit both them and their baby as well as the family.

Living in a community where the "so-called diseases of poverty" prevail (according to UNFPA (2016:32), violence is included in the list of diseases attributed to poverty), a girl may be

forced or coerced to begin bearing children as soon as she goes through puberty (UNFPA 2016:32). It was found in this study that the child support grant was needed to support poor families. Besides supporting poor families, the South Africa's child support grant also contributes to parents' positive attitudes towards teenage pregnancies (Taylor et al. 2014:255). Chauke (2013:10) states teenage birth and motherhood is seen as a blessing in some families because it proves the girl's fertility.

A poor family may therefore encourage a daughter to have more children at an early age because they receive and survive on the child grant. Making school attendance more affordable and manageable for girls' families is a further option to help teenage mothers financially. In Malawi, e.g., the government provides scholarships, stipends and cash transfers for poorer families. Girls also receive school meals and food to take home with them. Studies from as early as 1999 have shown that better nutritional outcomes ensure better school outcomes (UNFPA 2016:65).

The child support grant is a key programme for alleviating child poverty in South Africa. The beneficiaries are also entitled to free health care services and education (ISHP 2012:35). Southern Africa Labour and Development Research Unit (SALDRU), (2011:4) reflects that teenage mothers would benefit from getting the child support grant as soon as possible after the birth. Social grants are linked to improved nutritional outcomes for children, yet uptake is low for young children 0 – 2 years and particularly babies born to teenage mothers. The introduction of alternative forms of identification should make it easier for teenage mothers who are not yet 16-years-old to get access to the child grant. This could be helpful to teenage mothers who want to return to school, but find the CSG is used to support the family. If the grant is paid to her directly, she may be able to pay the local crèche during school hours while she attends classes. Hence, the child grant is associated with increased school attendance and improved child health and nutrition (Macleod and Tracey 2010:22).

Rangiah (2012:15) indicates that a teenage mother is often compelled to be financially dependent on her family or on public assistance. Conversely, the families of these teenagers are burdened with the responsibility of physically and financially supporting the teenager and her infant. In families who are already struggling financially, provision becomes a major challenge or threat.

3.4.3 THEME 3: CHALLENGES EXPERIENCED TO ACCESS SERVICES

Challenges to access service delivery in this study referred to hindrances preventing teenagers from obtaining contraceptives to prevent unwanted pregnancies. Two sub-themes

categories were identified under Theme 3, namely access to contraception before pregnancy and contraception after pregnancy as illustrated in Table 3.8.

Table 3.8: Challenges experienced to access services

THEMES	CATEGORIES	SUBCATEGORIES
3.4.3 THEME 3: CHALLENGES EXPERIENCED TO ACCESS SERVICE DELIVERY	3.4.3.1 Category 1: Access to contraception before pregnancy	• Fear of parents
		• Fear of nurses' response
		• Teenage ignorance (insufficient information)
		• Wanted to keep boyfriend/relationship challenge
		• Sexual abuse

3.4.3.1 Sub-theme 1: Access to contraception before pregnancy

To be effective, contraceptives as a method to prevent not only pregnancy but also the transmission of STIs including HIV needs to reach all young people, with more intensive prevention for those at greatest risk, i.e. young teenagers are prone to participate in sexual risk behaviours. Teenage participants in this study seemed not yet emotionally mature or self-assured enough to make a concrete decision on contraceptive choices and many lacked information about access to modern forms of contraception. Five subcategories emerged from this category, namely, fear of parents; fear of nurses' response; teenage ignorance (insufficient information); wanted to keep boyfriend; and sexual abuse.

- **Fear of parents**

As mentioned before, the participants lived in a community where the discussion of any sexual topic was taboo. Thus, to hear the teenage mothers say they were afraid to communicate with their parents about their sexuality was not surprising. The participants expressed their fear of talking to their parents about contraceptives as follows:

> "*I did not expect to fall pregnant and I was not forced to have sex, but I did not know what I was doing. I was afraid of my parents to talk about sex, knowing that they will be angry with me."* (Participant 6)

> "*I was afraid that my parents will not allow me to do that* [for getting contraceptives from the clinic nurses] *because even my mother never said anything about sex or sex education or female growth* [reproductive health]." (Participant 1)

> "*I used to take an injection privately in order to hide from my parents. I was afraid that with a pill they may suspect and stop me. I skipped once and did not go for the next one because I came late from school.*" (Participant 5)

In protecting the teenagers from becoming pregnant, the Children's Act (Act 38 of 2005:17) documented that children have rights to access contraceptives. These rights documented in this act, are embraced as legal document governing children's rights. Despite the availability of the Act (Act 38 of 2005) teenagers continued to be pregnant because they failed to use contraceptives that were available at all clinics. Mnyanda (2013:17) revealed that, teenagers who were knowledgeable about contraceptives were ignorant and did not use contraceptives and those who used, kept contraceptives a secret. The same author stated few reasons for not utilising the contraceptives. These reasons include among others, reluctance to take contraceptive, failure to take precautions, fear of complications and parental detection.

Despite their knowledge about the importance of the use of those contraceptives; teenagers become pregnant at an early stage. UNFPA (2016:50) confirms many "as they enter adolescence, many girls may not have a safe forum in which to ask questions about these topics, which in many communities are still considered taboo". As previously explained, this is certainly true about the settings where the current teenagers came from – mentioning or communicating about any topic of a sexual nature was indeed taboo in their communities and homes. It was also attested by Mthobeni and Peu (2013:6) when the community at large in Hammanskraal and religious people had resistance to their health talk when given to young people about HIV since talking about safe sex, condom use and sexual transmitted infection was a taboo in adult people.

Among the reasons Mnyanda (2013:17) provides for teenagers' reluctance to use contraceptives, is the fear of side-effects as well as parental detection. This was confirmed by a participant who was very scared of being seen by her parents if she used a contraceptive pill. She opted for monthly injections – but trying to plan the time to visit the clinic for it caused stress and fear of being seen by her parents.

According to Taylor, et al (2014:10) parental guidance and open communication about sexuality with children as they grow up are central to the latter making healthy lifestyle choices. Oyedele, Wright and Maja (2013:95) places the blame for the lack of communication between parents and teenagers and the latter's continuous engagement in unprotected sexual intercourse – even if the teenagers are aware that contraceptives prevent pregnancies – on the parents' unwillingness to talk about sexual issues. This outlook is similar to that of Panday, et al *(*2009:35) who reflect that for a parent not to talk to an

adolescent child about sexual risk behaviour if the teenager is willing to do it and wants to listen, is really a missed opportunity for parents to educate their children on sexual health and wellbeing. A participant touched on the topic of missed opportunities when she shared "*because even my mother never said anything about sex or sex education or reproductive health*".

Beguy, Mumah and Gottschalk (2014:8) concur with Panday, et al (2009:35) by stating poor communication between teenagers and parents contribute to teenage pregnancy despite receiving health education at school. Bana, et al (2010:157) observed in their study on the knowledge, attitudes and behaviours of adolescents in relation to, among others, contraceptive utilisation in the rural Mhlakulo region in the Eastern Cape the knowledge the participants had about STIs and HIV came from sources other than parents, namely "health care workers/nurses/doctors/clinics, the media, educators, the school (teachers, classmates or in the classroom) and friends".

- **Fear of nurses' response**

A nurse is a person trained to care for the sick; their care encompasses prevention and promotion of health to all people in all healthcare and community settings. Nurses' attitudes undoubtedly contributed to the reluctance of the teenage participants in this study to access the available contraceptive services. The finding that the participants did not use contraceptives or condoms and subsequently became pregnant raises the question; why not make use of contraceptives if they are freely available and accessible. According to the participants, they feared the nurses would scold them as their verbatim quotes show:

> "*I was not preventing* [using contraceptives]. *I did not want to use either condoms or contraceptives. I believe that I had an attitude towards nurses, fearing that they will scold me. Some of our peer group told us that nurses need us to have permission from our parents. I was afraid that my parents will not allow me to do that because even my mother never said anything about sex or sex education.*" (Participant 1)

> "*We are afraid to go to the clinics because we are afraid of nurses. After school, some of the nurses refuse to offer contraceptives indicating that it is late. We must come in the morning. At school, we must not miss classes.*" (Participant 3)

> "*I did not attend family planning because I thought nurses will scold me like what other children who tried to go there. I thought I better stay away.*" (Participant 9)

The participants reflected that they were afraid of the attitudes of nurses when accessing contraceptives. The participants said, "*some of our peer group*"; "*we are afraid to go to the*

clinics because we are afraid of nurses"; "*like what other children who tried to go there*". Not using first person only in their discussions, the teenage participants very clearly signified that they were influenced by their peers to expect, e.g., to be scolded or treated with disrespect. However, it does seem from the verbatim quotes as if the nurses' attitudes were indeed not caring, respectful or considerate – all attributes of youth-friendly healthcare service delivery contained in the WHO's Quality Assessment Guidebook (2009:2-3).

It is also documented in the National Contraception Policy Guidelines (2012:15) that the nursing staff working in clinics seemingly creates barriers for teenage girls to access contraceptives. These barriers include the hours during which clinics open and close; waiting times at clinics; concerns around confidentiality; staff showing a judgmental attitude or lecturing teenagers; and some staff members having limited knowledge regarding implants and other contraceptives. Moreover, only about one-third of clinics provide contraceptive options to anyone seeking contraceptives (National Contraceptive Guidelines 2012:16).

Quotes from the current study disclose some of these barriers were also experienced by the participants themselves. Nurses refused to offer them contraceptives because it was late and advised them to return in the morning; but the timing did not suit the teenagers because they had to be in school the next morning. Naturally, this behaviour from the nurse's side can contribute to teenage pregnancies. The participants' quotes show similarities with the study of Mnyanda (2013:17) who found teenage mothers complained that the services rendered at the clinics were not youth-friendly and accused staff of being judgmental and cruel. Further complaints from the participants included waiting in long queues and clinic hours that are not flexible to the clients' times and needs. This is evidenced in the current quote, "*the nurses refuse to offer contraceptives indicating that it is late*". Time allocated for the provision of contraceptives to teenagers was not conducive to attend to the teenager's need for contraceptives.

Beguy, et al (2014:8) agree the attitudes and bias of service providers towards teenagers regarding contraceptive use discourage the latter to make use of reproductive health services. Kyei (2012:137) further notes that nurses' attitudes are the major barriers experienced by teenagers when attempting to access contraceptive services. Conversely, this author also pays attention to the fact that nurses may feel uncomfortable about providing contraceptives to teenagers because it may be the formers' belief that young girls are not supposed to have sexual intercourse. Whereas the girls may view this situation as highly judgmental and unhelpful to teenagers, the nurse on the other hand may believe she or he is educating the girl to abstain and maintain a healthy lifestyle. Clearly, this means there is a huge communication gap between the teenager and the nurse indicating the nurse is not

aware how to approach the girl in a youth-friendly way. To Oyedele, et al's (2013:104) way of thinking, healthcare providers are not willing to provide contraceptives to teenagers because in their personal capacity the nurses have a negative attitude towards sexual behaviour among teenagers.

Ibis Reproductive Health (2013:23) confirms that upon arrival at a healthcare facility, teenage mothers do encounter judgmental attitudes from health professionals, especially if the teenagers are unmarried. Ndlebe's (2011:44) view is that reproductive health education at the clinics is lacking. This author states when a woman experiences some side-effects from the pill or monthly injection and does not know what to do as a result of a lack of knowledge, contraceptive intake is terminated.

- **Teenage ignorance (insufficient information)**

Some of the participants in this study revealed they had some knowledge about family planning clinics, but had little knowledge about its purpose. Others feared the clinic nurses' attitude while various participants lacked knowledge of how to use contraceptives and wished their parents (mothers mostly) would openly communicate with them at home about sexual and reproductive health rights. The next verbatim quotes express the participants' experiences in this regard:

> "*I did not know that I may fall pregnant because I thought you become pregnant after you started with menstruation. I thought I was still young to use contraceptives. So, I did not have knowledge about contraceptive use*." (Participant 7)

> "*As a teenager, I did not like to use contraceptives. I believed that our parents should be open enough to talk to us about such things* [sex education] *and we need to be taught. I thought that having sex was just part of fun until I fell pregnant. Lack of information is the cause of unwanted pregnancies among us. I also had* [thought] *that I will gain weight or become wet when using contraceptives.*" (Participant 13)

> "*I believe that some teenagers are just like me. We do not have knowledge about family planning or contraceptives. To help teenagers I personally think there must be workshops to teach us about preventing* [use of contraceptives] *and teenage pregnancy*." (Participant 4)

Some of the participants in this study revealed that they were aware that contraceptives exist, but did not know that they could prevent pregnancy. Some did not want to use either condoms or contraceptives while others indicated to have insufficient information. Lack of knowledge, insufficient information and inconsistent use of contraceptives are viewed as

contributory factors to unwanted pregnancies. Poor knowledge and ignorance are cited by many authors the main reason for ineffective or non-use of contraceptives (Bana, et al 2010:158; Willan 2013:28; Tayler 2014:7). In the 2017 South African Health Review, according to the framework adapted from the Western Cape Burden of Disease Reduction Project (2007), the non-use of contraceptives is indicated as one of the major behavioural determinants of HIV in young girls and women in South Africa (Scott, et al 2017:81).

Participants stated they chose not to use contraceptives for various reasons: perceiving it as bad, making one wet and weight gain (Mnyanda 2013:17); knowing contraceptives should be used to prevent pregnancy but not knowing how to use it effectively or correctly (NDoH 2010:19); trusting their partners and being submissive to the male partner due to culturally related issues (Holt, Lince, Hargey, Struthe, Nkala, McIntyre, et al 2012:288). Wishing for parents who were "*open enough to talk to us about such things* [sex education] *and we need to be taught*" and for "*workshops to teach us about preventing* [use of contraceptives] *and teenage pregnancy*" are confirmed by Holt, et al (2012:288) who emphasise parents do not talk to their children about sex; therefore, teenagers end up getting incorrect information from other sources such as peers, classmates, the media (Bana, et al 2010:155-6) resulting in a lack of accurate knowledge about sexuality and contraceptives.

Parents must know one of their roles is that of a sex educator to their children, while the responsibility for "educating parents and their children about sexuality must be shared by churches, civic organizations, work sites, schools, and communities" (Elders, et al (1999:177) cited in Berkeley Journal of Gender, Law and Justice 2013:Art.5). According to UNFPA (2016:66), "Comprehensive sexuality education is a critical source of age-appropriate information for millions of girls around the world." UNFPA (2016:66-9) makes it clear in many countries access to sexual and reproductive health services for adolescents old enough to require it and *want to make use of it,* is blocked. Laws prohibiting access, community norms, judgmental service provider attitudes as well as traditional parents living according to cultures where the belief that sexuality education hastens sexual activity are challenges to teenagers' safer sexual behaviours and delayed sexual debut. Dhavanna-Maselesele, Lalendle and Useh (2007:18) conducted a study on the knowledge, attitudes and practices related to HIV/AIDS amongst learners in the Vhembe district of Limpopo and similarly found teenagers rarely consulted not only their parents but also church leaders on sex-related issues. Reportedly, church leaders "do not create an environment that allows for free discussion of sex-related issues, including HIV and AIDS" (Mthobeni and Peu 2013: 6).

Bana, et al (2010:157) found the experience of older teenagers (18 to 24) was that parents would talk about what was "right and wrong" when communicating about sexual behaviours.

They would advise their daughters to delay sexuality and practice abstinence, they "talked about birth control and preventing STIs respectively" but communication was not open, honest and detailed. These authors concluded that "parents were a poor source of information as compared to clinics and the media" which could point to a lack of knowledge on the part of the parents themselves. This lack of knowledge could probably be addressed by greater health education for the parents as well." (Bana, et al 2010:157). Similarly, Macleod and Tracey (2010:23) found both teenage girls and boys were receiving clashing information regarding sexuality and contraception from parents, community and church elders advocating abstinence only and peers and the mass media encouraging sexual intercourse when 'in love'. These different messages are confusing particularly for vulnerable, poor and oppressed young female teenagers.

- **Wanted to keep boyfriend/ Relationship challenges**

In this study, the participants verbalised the main reasons for them to want to have a child included keeping their current boyfriends, to not compete with other girls anymore for the attention of a boy but to win him over by having his child, and clinging onto the ideal of marrying their boyfriends. Interestingly, the participants were negative about the role of boys in their lives. Supporting these findings are some verbatim quotes from the teenage participants:

> "*With us teenagers we think about marriage to the boyfriend and who will sometimes end up impregnating two or more girls at the same time. Young girls should be discouraged about competing for a boyfriend by falling pregnant instead of concentrating* [and instead concentrate] *on their studies.*" (Participant 10)

> "*Girls should be encouraged to go to family planning clinics in order to prevent unwanted pregnancies. Boys should also be educated about the importance of family planning and avoid staying with girlfriends as their wives at home. They should also stop the practice of piercing the condoms in order to let the semen or sperms to leak out and into the vagina and cause pregnancy*." (Participant 12)

> "*The boys have no problems because only girls are considered to be responsible for pregnancy but they should be told about the dangers of unprotected sex such as sexual transmitted infections.*" (Participant 15)

It was the ultimate goal for many teenage girls to become pregnant to keep boyfriends; some hoped the boyfriend would marry them. These reasons contribute much towards causing unwanted pregnancies and teenage girls leaving school before completing their studies. On

the other hand, positive utterances such as girls "*should be encouraged to go to family planning clinics in order to prevent unwanted pregnancies*" and encouraging girls to "*concentrate on their studies*" were welcomed as it proved some teenage girls were mature enough (or had become mature through surviving the reality and hardship of a teenage pregnancy) to realise the personal and economical value of at least finishing school; that is, education must be viewed as more important than marriage. As in mentioned in Chapter 1, compared with other districts in Limpopo, at the time of study the incidence of teenage motherhood continued to be disproportionately high in the Mopani District, Limpopo which was the setting for this study. Approximately 90.8% teenagers had experienced first-time motherhood by the age of 16 (Mopani District Integrated Development Plan 2011/16 2012:19).

Teenagers engage in sex and they resist prescriptive guidance Millennium Development (2015:65). They do not want to be told what to do and what not to do (Burns and Porter 2007:234) but want to be allowed to make their own decisions or at least be involved in decision making. Peer pressure, alcohol abuse and coercion seem to be the main drivers of teenagers' willingness to participate in sexual activities. Many also desire to feel a sense of 'belonging' – belonging to a peer group makes teenagers experience the importance of a self-worth. Girls particularly would appeal not to do anything to jeopardise their acceptance in the group and thus they participate in sexual activities to please friends – particularly boyfriends – due to pressure and not out of their own free will. A survey conducted in the USA in 2008 revealed that seven per cent of high school children had sex before the age of 13 and two thirds of the children in Grade 12 were sexually active (Kim, 2008:1).

Furthermore, evidence from 54 developing countries (UNFPA 2013:13) reveals that recent global observations and statistical information on adolescent pregnancy show adolescent pregnancies are occurring more and more among girls under 15 years of whom approximately 2 million are living in sub-Saharan Africa today. The life conditions of these girls seem to follow a similar pattern: they are from lower-income households, have lower education levels and live in rural, remote areas (UNFPA 2013:14) or are "ethnic minorities, immigrants, or marginalized sub-populations" (UNFPA 2013:15). Retrospective data on the pregnancy rates of girls between 15 and 19 is readily available and up-to-date because household surveys reach them directly. Unfortunately, data on 10 to 14-year-old girls and their pregnancy status is scarce – owing to various ethical and human rights reasons. This is a critical shortcoming because what is needed for governments, communities and families to help such young girls to "prevent pregnancies or support those who have already become pregnant or given birth" is an unprejudiced and definite deeper understanding of "the

determinants of pregnancies among this group, their challenges and vulnerabilities, the impact on their lives" (UNFPA 2013:14-5).

An important remark which gave a little more insight into the highly patriarchal and gender-based cultural environments the girls came from was that "*boys have no problems because only girls are considered to be responsible for pregnancy*". UNICEF (2009:54) documents males generally report earlier sexual debut than females; but, they are also more prone to frequent partner changes thus concurring with the findings of this study where it was voiced that boys often ended up "*impregnating two or more girls at the same time*" because of unprotected sex. This also links to Chopra et al. (2008:1) who ascribe the non-use of condoms to the excessive use of alcohol which also leads to the youth having multiple sexual partners exposing them to STIs including HIV and AIDS as well as early marriage-related behaviour where teenage girls are at risk of early child marriage practices where parents accept offers of marriage for girls as soon as they reach childbearing age at around 10 years old (UNFPA 2016:2).

Holt, et al (2012:286) point out teenage girls should not be having sex before marriage for cultural purpose. The culture of submission to male partner who do not wish to use condoms leads to teenage girls also not to use as they trusted their partners and therefore became pregnant and being exposed to sexual transmitted infections. It further emerged from the findings that boys are not considered to be responsible for the pregnancies they cause, but the blame should be placed squarely on the shoulders of the young teenage girl. In traditional African regions where everyday life in communities is lived according to prescribed and inherited age-old norms and values, an unwed teenage mother is prone to be ostracised by her family and the community (Bana, Bhat, Godlwana, Libazi, Maholwana, Marafungana, et al 2010a:154).

In remote areas, registered nurses who work with reproductive health and pregnancy care oftentimes come across situations where girls as young as 10- or 11-years-old are pregnant. Participants voiced that young teenage girls from about 10-years-old until the onset of menarche (which differs in every girl) were ignorant about their sexuality. In the opinion of the participants, pregnancy and motherhood in very young girls is an extremely complicated issue because the girl may have been a victim and not a partner in the sexual encounter which resulted in a pregnancy. What needs to be done is for male adults (parents as well as other adults) to not be afraid of going against oppressive patriarchal traditions. As the other person involved in the pregnancy, the young male "must learn that being a father involves nurturing, supporting, and providing something more than a sperm. And they must be given

opportunities to succeed in ways other than making a young girl pregnant" (Elders, et al 1990:178).

- **Sexual abuse**

The participants in this study indicated that as a result of poverty and/or being orphans, they were sexually abused which led to unplanned pregnancies and unwanted babies. Some teenage participants admitted to being abused in the family. Forced marriages and forced sex left physical, emotional, financial and educational scars on teenage girls which would never heal but changed their lives forever. Following are the voices of these vulnerable young mothers' experiences:

> "*Some parents are unemployed and are not yet at a pensionable age that is why they encourage their teenage children to fall pregnant. Some are orphans, they are sexually abused in exchange of money therefore have unplanned pregnancies and also receive child grant.*" (Participant 2)

> "*Problem of family sexual abuse should be stopped. Social workers should be involved. Care group motivators should be paid in order to go around teaching teenagers about prevention of pregnancy.*" (Participant 12)

> "*Some parents are unemployed and they do not have money to let their children going back to school but taking care of the child. Due to poverty, some parents encouraged their teenage children to fall pregnant. Some orphans are sexually abused sometimes by their uncles and have unplanned pregnancies*." (Participant 7)

The participants shared poverty was seemingly the main contributory factor to sexual abuse resulting in an unwanted teenage pregnancy. Female orphans (ages were not specified) also seemed to be easy victims of forced sex – a more acceptable term for 'rape' perhaps, because of the former's impoverished circumstances. A disgraceful finding was that own male family members – uncles were specifically mentioned and were the perpetrators of abusive acts with orphaned female teenagers ("*some orphans are sexually abused sometimes by their uncles*"). Another shocking discussion centred on the issue of biological parents who encouraged their teenage daughters to become mothers, e.g., parents did not work and "*due to poverty, some parents encouraged their teenage children to fall pregnan*t". The participants wished for "family sexual abuse to be stopped" and urged for social workers to intervene.

In 2009 over 8 000 women between the ages 15 to 49 were interviewed in a gender survey done in urban and rural areas of seven regions in Ethiopia. Findings in UNFPA (2010:1) revealed high rates of early marriage for girls (during early adolescence or by their 15th birthday) leading to early sexual initiation and early first birth. An alarming finding was that

marriage often took place by abduction “where an unmarried girl is forcefully taken, often followed by rape by her future husband or gang rape by her husband and friends” (UNFPA 2010:61).

National strategy for prevention of child abuse, neglect and exploitation as an intersectoral strategy provide guidelines for the prevention and protection of children all forms of abuse. The strategy facilitates implementation of the Children’s Act (Act No 38 of 2005), which made provision for the mandatory reporting of all suspected forms of child abuse, neglect and exploitation (ISHP 2012:35) According to Engebretsen (2012:2), teenage girls faced serious challenges around the time of puberty including withdrawal from (and lack of safety in) public spaces, sexual abuse, leaving school and pressure for marriage. Kathree, et al (2014:4) also indicated that the situation of sexual abuse was aggravated by challenges because of poverty. This author also reflected that the teenage mothers depended on an abusive partner and be unable to extract themselves from the abusive relationship as they were the one bringing money at home.

It was emerged from this study that some orphans are sexually abused by their uncle due to poverty which concurred with that of Thobejane (2015 273) which indicate that teenagers are vulnerable to be sexually abused as a result of lack of money. This author also revealed that in developing world, teenagers experience a series of human rights abuses such as threats to bodily integrity, lack of education, and young age at marriage and childbearing. Furthermore, in this study, poverty in rural communities increases the opportunities for sexual abuses where women and children have unequal power relations if a man is a breadwinner a specially to orphans. These findings are similar to that of Mothiba (2012:4) who identified that In South Africa rape and sexual coercion often take place at school and in family homes, where abusers are peers, family members, and sometimes teachers and are not reported.

Partners may force to have a baby or refuse to use condoms. WHO (2013:24) indicated that teenage mothers should be observed for any risks, signs and symptoms of domestic abuse and also be made aware of whom to contact for advice and management as well as to report rape. The participants emphasised that teenagers are sexually molested by their family members and are become afraid to report these pregnancies. In confirming the expressions of participants, (NSPCC 2013:6) noted that perpetrators of sexual abuse and rape are more likely to be family friends or acquainted with the child rather than being a parent or strangers. In supporting the debate, Thobejane (2015 273) also mentioned that teenagers are vulnerable to be sexually abused. The author also revealed that in developing world, teenagers experience a series of human rights abuses such as threats to bodily integrity,

lack of education, and young age at marriage. Engebretsen (2012:2) also reflected that teenagers face serious challenges during the time of puberty including sexual abuse, leaving school and pressure related to marriage. All the above authors concurred with the current study that teenagers are sexually abused by the relatives and end up being pregnant thus hinder their education. It shows that among certain families, teenagers are sexually molested or abused and later become pregnant without access to contraception and also unable to obtain their education.

3.4.4. THEME 4: SUGGESTIONS TO OVERCOME CHALLENGES

Table3.9: Teenage mothers' suggestions to overcome challenges

THEMES	SUB-THEMES	CATEGORIES
3.4.4: THEME 4: SUGGESTIONS TO OVERCOME CHALLENGES	3.4.4.1: Sub-theme 1: Teenage-friendly services to be accessible	• Contraception after pregnancy
	3.4.4.2 Sub-theme 2: Information dissemination including males	• Nurses to promote non-judgemental and accessible teenage family planning service
		• Peer group driven information/campaigns
		• Community-driven information
		• Parent driven information

3.4.4.1 Sub-theme 1: Teenage-friendly services to be accessible

When a teenage mother is not breastfeeding, the *combination* contraceptive pill, vaginal ring and patch could be used within 21 days after giving birth. However, in the case of breastfeeding, she should wait for six months to use these contraceptive methods as they could affect milk supply (Guidelines for Maternity Care 2016:47).

- **Contraception after pregnancy**

Contraception after pregnancy is therefore quite challenging in order to prevent further unwanted pregnancies. To continue with schooling was seen to be important. Insertions of implants under the skin such as implanon and the use of condoms were promoted by participants to prevent unwanted pregnancy. These were reflected when participants said:

> "*You as nurses should promote family planning* [contraceptives] *at schools especially at the primary schools where you will find 10-year-olds who had just started experiencing their menstrual cycles. They should be advised to go for family planning in order to prevent unwanted pregnancies*." (Participant 1)

> "*Nurses should teach the teenagers about the correct use of contraceptives that they should take. The use of implants should be promoted. Door-to-door campaign is necessary. Condoms should be used*." (Participant 9)

> "*Health professionals especially nurses should go out to schools and communities to teach teenagers about the importance of family planning and that unprotected sex can lead to sexual transmitted infections.*" (Participant 13)

The participants revealed that nurses should teach teenagers about contraceptives at an early stage; when they were about 10 years or when they started experiencing their menstrual cycle. According to participants, these could prevent teenagers from early pregnancy. The participant in this study confirmed that the use of contraceptives was necessary to prevent further pregnancies and some started to use them after delivery of their babies. They therefore commended nurses to teach teenagers about the correct use of contraceptives at an early stage and also do "*door-to-door campaigns*" to motivate teenagers to use contraceptives. Proposals to use contraceptive implants (implanon) and condoms were also made by the participants. Implanon is a hormonal implant that is convenient, highly effective, long-acting and reversible form of progestin and is the only contraception which inhibits ovulation and thickens the cervical mucus. It is inserted beneath the skin on the upper arm to prevent pregnancy for three years and is only administered by some trained personnel (USAID 2013:3).

The National Contraceptive Guidelines (2015:15) indicates South Africa's liberal policy allows pregnant teenagers to remain in school and to return to school post-delivery. This policy protects teenage mother's educational attainment and helps them to delay a second pregnancy. Beguy, et al. (2014:9) state reaching teenagers at an early stage of development while they are still at school will have the potential of reducing unintended fertility and pregnancies which will have a significant impact on their wellbeing.

UNICEF (2009:37) also indicates that services that are convenient in terms of opening times will prevent teenage girls and boys to stand in long queues waiting to obtain free condoms or other contraceptives. The participants of this study indicated that the use of implants and condoms should be promoted among teenagers. This is supported by Polaneczkym, Slap, Forke, Rappaport and Sondheimer (2016:3) who reflect that Norplant is usually used post-

delivery to delay a second pregnancy in teenage girls. The authors also indicate that the implant cannot be used alone due to the risk factor of sexual transmitted infections. They therefore recommended using both the implant and a condom. The implant works similarly to oral contraceptives but does not have to be taken every day. Taylor, et al (2014:855) confirm that programmes providing sex education that are implemented at school do not increase sexual activity. Malahlela and Chireshe (2013:46) indicate that sex education should include the use of condoms, abstinence and also introduce other forms of contraceptives and also include making the youth more aware of HIV and AIDS. Shefer, et al (2013:8) state there is still a need among learners for more effective education regarding sexuality and safe sexual practices since it is imperative to halt the spread of HIV and AIDS. Elaborating and sharing information and knowledge on life skills related to parenting further need to be included in these campaigns.

3.4.4.2 Sub-theme 2: Information dissemination including males

Information dissemination is vital to both teenage girls and boys. Registered nurses as participants highlighted that family planning should be promoted to enhance its accessibility. They should provide non-judgemental services to the clients. It was also expressed that peer group and community driven information or campaigns should be conducted.

- **Nurses to promote non-judgemental and accessible teenage family planning service**

Nurses are leaders in the area of health promotion and are found working with teenagers in a variety of practice setting such as schools, community health centres, youth centres and in family practice. In this study, teenage mothers were the focus area. Nurses need to develop and promote non-judgemental, accessible and youth-friendly teenage family planning services to accommodate the younger clients. The participants expressed themselves by stating:

> "*Teenagers should go for family planning upon experiencing their first menstrual cycle without fear of nurses. Contraceptives should be accessible to teenagers. Life skills should be given from childhood at home. The female parents should take their daughters for family planning in order to prevent unwanted pregnancies. Education of young girls about the dangers of unprotected sex at a young age is needed.*" (Participant 5)

> "*Health professionals especially nurses should go out to schools and communities to teach teenagers about the importance of family planning and that unprotected sex*

can lead to sexual transmitted infections. Both boys and girls should access the same venue to clarify issues of contraceptive. Normally boys are not taught about the prevention of pregnancy." (Participant 13)

"*Nurses should teach the teenagers about the correct use of contraceptives that they should take. The use of implants should be promoted. Condoms should be used. Teenagers should have accessible youth-friendly services*." (Participant 15)

The participants in this study reflected that teenagers should visit the clinic as soon as they start menstruation with their parents to prevent unwanted pregnancy. Teenage girls and boys should be taught about the dangers of unprotected sex that can lead to sexual transmitted infection at an early stage. The participants also indicated that both boys and girls should be taught in the same space about the prevention of pregnancy. They further promoted use of condoms and implants. According to James, Rall and Strümpher (2012:7), health education and advice related to family planning and sexuality could be conducted by nurses and other health professionals as a means of empowering the teenager for future prevention pregnancies.

The findings of this study concurred with that of the above authors in that nurses were chosen by the participants to give health talk as a way to intervene in the provision of reproductive health as well as sex education. However, researchers have noted a lack of empowering health education as described by James et al. (2012: 7). National Contraceptive Policy Guidelines only reported that only around one third of clinics providing contraceptive option to people seeking contraceptives. The guidelines also stated that clinic opening hours, waiting time at clinics and staff judgement limited teenagers to visit the clinics. Beguy, Mumah and Gottschalk (2014:8) highlighted that targeted programs are needed to reach teenagers with a range of sexual reproductive health information at different stage including youth friendly services.

Malahlela (2012:45) indicated awareness campaigns; net-working or inviting other community stakeholders like social workers, nurses or well-trained health workers, educational psychologists and religious leaders to be involved in addressing learners regarding pregnancies, its effects as well as the importance of contraceptive use was essential. Campaigns are rendered at Limpopo, but mainly are done for HIV and AIDS, neglecting the issue of use of dual contraceptives. Stakeholders such as churches and teachers need to be empowered with knowledge as they always encounter with teenagers.

Willan (2013: 28) stated that teenagers are knowledgeable regarding contraceptives and sexual health. This author believes that in South Africa, the knowledge that the teenagers

acquired is insufficient to enable them to use contraceptives correctly to prevent pregnancies. Teenagers could not realise the importance of using both contraceptives and condoms. Malahlela and Chireshe (2013:46) stated that through sex education, learners could be encouraged to abstain from having sex until completion of their studies. Those who fail to abstain could be encouraged to use condom, injections or pill. The participants in this study indicated that nurses at the clinics, should be non-judgemental in promoting the use of contraceptives. They therefore suggested special services for teenagers only.

It was indicated in the study that nurses should not be judgemental to the teenage mothers who come for contraception at the clinics. Some of the participants reflected the goodness of nurses and commended to continue with their action. They also proposed that nurses should advise on family planning at an early stage in primary school to prevent unwanted pregnancy. The participants in this study proposed free communication and the employment of young nurses who will understand their needs. Rangiah (2014: 51) stated that health care providing services for teenagers should not be judgmental and should be more constructive in the professional relationship with good communication. This was supporting the participants in this study since they also indicated that nurses should not be judgemental.

James, Rall. and Strümpher (2012:4) emphasised that, in a clinic environment that is non-judgemental and stress-free to teenagers, it is possible to have as many of the teenagers as possible coming to the clinic. These authors further stated that health education and advice related to family planning and sexuality could be conducted as a means of empowering the teenage mothers for future pregnancies. Ibis Reproductive health (2013:4) also revealed that teenage pregnancy and early child birth are causing concern as public health problem. The authors also stated that teenagers deserve unbiased attention from health professionals, policy makers, educators and community members. If all these stakeholders could be involved in education of teenagers about pregnancy working together to fight with the issue, the goal could be reached and teenage pregnancies be reduced.

Malahlela and Chireshe (2013:46) indicated that sex education should include all types of contraceptives through campaign. These researchers also suggested that nurses should train school educators in guidance and counselling, equipping them with knowledge on how to address pregnant teenager and teenage mothers overcome the psychological issues surrounding their conditions. According to the participants of this study, door to door campaign should be made to disseminate information to the teenagers. Beguy, Mumah and Gottschalk (2014:27) found that the service providers are often well aware that high teenage pregnancy rates but this may be uncertain on how to move beyond a sexual health education framework in order to address the root causes of these higher rates of teenage

pregnancy. Nelson (2013: 87) indicated that nurses' awareness programme on teenage pregnancies and support should be presented to teenage mothers, their families and community about factors that contribute to teenage pregnancies.

The Ibis Reproductive Health (2013:4) in support to this endeavour advocate for promotion of structural interventions regarding teenage pregnancies instead of interventions that focus on individuals that may change an increasing contraceptive uptake. It is important according to Department of Health (2010:33) that all professionals be responsible in providing support for vulnerable teenagers and play a full part in action that will have a direct impact on reducing teenage conceptions through campaigns and lessons on sexual activities should start before children become sexually active.

This author also reflected that guidance counsellors and social workers at schools should be teenager/child friendly and easily approachable so that teenagers can seek their advice regarding sex and report sexual abuse whatever the case may be. Furthermore, the author argued that the introduction of family planning education in schools could be a good start to educate teenagers and young girls on the availability of contraceptives and the consequences of being sexually active at a young age. Seekoe (2005:20) in support of nurses 'role on sexuality education stated that information regarding contraceptive practices should be imparted early in socialization process for boys and girls at homes, schools and community places in order to equip teenagers with better skills to protect themselves against unplanned pregnancies.

Nkani and Bhana (2016:7) indicated that both the Department of Health and the Department of Basic Education must make sure that a range of contraception methods are available in every public health facility, easily accessible to teenagers in general and teenage mothers as they have a tendency to forget to use contraceptives that are administered daily. The authors also advocate teenagers should be motivated to think most of their own health and future and forget about pleasing their boyfriends, therefore protection should be used to prevent STIs.

- **Peer group driven information/campaigns**

Peer driven intervention for teenagers is designed to improve the sexual health and rights of marginalised community. Peer group driven information/campaigns was the second sub-category emerged from the category.

The participants said:

"Youth development programmes should be implemented such as love life which was keeping teenagers from the street. It was educative but does not exist anymore." (Participant 5)

Boys and girls should be taught together about sex education in order to have same understanding. Life skills from childhood at home should be taught. Peer group training for HIV/ AIDS and contraception should be done". (Participant 4)

"Peer group training for HIV and contraceptives should be done. I think a place should be introduced where teenage girls can be called together on a particular day of the week, where they can be taught and discuss about the facts of life in order to prevent unwanted pregnancies and school dropouts." (Participant 11)

The participants in this study proposed that youth development programmes be implemented in rural areas to prevent unwanted pregnancies as well as HIV and AIDS. They also wanted parent to communicate with them about sexuality and contraceptives. The participants suggested that boys and girls be trained together in order to have the same understanding. The study of Thobejane (2015: 276) found that peers take a major and active role in each other's sex education followed by media therefore it is viewed as the most influential factors affecting teenager's sexual decision making. The author recommended workshop to be conducted for teenagers to express their feelings and how to use contraceptives to prevent pregnancies.

Oyedele, et al (2013:106) recommended to support peer group programmes in all clinics and encourage all teenagers to join the groups with focus on protection, nurturing and stimulation of pregnancies to enhance balance of their different behaviours. These could act as protective factors for both internal and external attributes that help to prevent youth from becoming involved in at risk behaviours. Molapo (2012:106) argued that life orientation at schools were not taken seriously as a subject because if it was taught properly, it could alleviate many problems such as STD's, HIV and AIDS.

Willan, 2013:46) indicated that teenage parents face an overwhelming number of difficulties. The authors also reflected that peer pressures are far more common than support and understanding about contraceptives therefore matured, adult decisions are required of emotionally pressured teenagers. According to Alli et al. (2012:288) gender dynamics in relationships also play a role in determining teenager's risk. Peer pressure to have sex was seen as a contributing factor to unprotected sex in the communities. It emerged from this study that peer group training for HIV/ AIDS and contraception should be done as well as youth development programmes such as love life should be implemented. It is a fact that

teenage pregnancies are on the increase therefore stakeholders should be taught the dynamics of school going mothers.

- **Community-driven information campaigns**

Community driven information in this study refers to the approach nurses should take to address teenage pregnancies by forming some programmes that could empower people and communities in rural villages of Mopani with knowledge on reproductive health and prevention of sexual exploitation of girls. This was the third sub- categories that emerged from the category information dissemination (interpersonal influence).

Community involvement as community driven activity was found to be important regarding empowering the community with knowledge of open communication with their children about reproductive health at an early age for the prevention of sexual exploitation. The participants proposed learner ship and skills development programmes.

The participants mentioned that:

> *"Chiefs, indunas, teachers and families should also be involved in making their children aware of the danger of pregnancies and not to allow any men to touch their private parts from early childhood, even relatives (va fanele va ala ku khoma khomiwa hi vavanuna hambi kuri maxaka). Cinemas and parks can prevent lot of mischief because teenagers will entertain themselves there".* (Participant 14)

> *"I think learner ship and skills development programmes can be utilised in all communities because such programmes are not available in rural areas. Teenagers must also abstain from sex."* (Participant 8)

Another participant noted that:

> *"I think a communal centre, similar to a crèche, can be erected so that they can leave their children there when attending school, without paying any fees, because people do not have money. The place should be funded by the government who will pay the salaries of the child-minders."* (Participant 3)

The participants of this study suggested that learnerships and skill development programmes should be made available within the communities. The participants noted that community involvement including indunas and family members are needed. The participants further mentioned that nurses, pastors, teachers, school governing body and parents should work

together in a youth friendly manner that respect the sexual and reproductive rights of young people, that is non-judgemental and accessible.

Additionally, the participants suggested that there was a need for crèches to be erected and funded by the Government for the children of teenage mothers when teenagers are attending school. Therefore, teenagers should be taught about sexuality at an early stage. Based on these debates and concerns the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2024/2015:34) recommended that the family and community should be considered key stakeholders in the intervention programs related to teenagers. Engebretsen (2012:2) in support of the concern suggested that investments in teenagers could reduce early childbearing while increasing their productive capacity, benefiting them, their families, communities, the greater economy and society.

Pricilah, et al (2014:138) stated that community, families and parents should be encouraged to forgive and reconcile with their daughters and consider taking care of their babies to allow them to return to school 'therefore an effort to improve adult education is paramount. According to Taylor et al. (2014:856), lack of youth- friendly service in South Africa reduces access to contraceptives of which contributes to teenagers becoming pregnant. This author also put emphasis in that these require community initiatives by involving different stakeholders to encourage teenagers to use available services on promotion for the use of contraception then it will be successful. Scrimgeour (2014:28) advocate that when teenage mothers got to the facilities, should also be allowed to consult for other problems that they may be having and be given information about current issues on health through building good relationship with them.

- **Parent-driven information**

Parent-driven information in this study means information that is expected to be provided by parents to teenagers regarding reproductive health and sex education. Some parents expect their children to learn and finish their education without becoming pregnant while others with low economic status need their daughters to become pregnant in order to have source of income in a form of child grant.

The participants expressed that:

> ***"****My parents encouraged me to return to school and they indicated that giving birth to the child was not the end of the road for me. I should go back to school and learn. I was told not to repeat the same mistake."* (Participant 2)

> *"After two years, my parents promised to stay with the baby. The boyfriend also accepted the baby and promised to take care of us. I went to collect a remove from my school at Mphambo and I was staying at N'wadzekudzeku with the boyfriend. I expect parents to take care of our babies while we go and further our studies."* (Participant 4)

> *"The parents should also be opened to their children and be in a position to give them the necessary advice about sex and contraceptives. The mothers should be in a position to check their daughters if they are on regular periods so that if she misses her periods, the necessary tests could be made and a termination can be done where necessary."* (Participant 11)

It was revealed in this study that parents need to see their children completing studies. They therefore do not need to see their children becoming pregnant or getting married before completing their studies. They need their parents to be open and be supportive in case of pregnancies. Ibis Reproductive Health (2013:26) supported that parents could be helpful in terms of providing better health outcomes if they have consistent support to their children, Children are willing to talk to their parents, but they are afraid. The author also cited that teaching programmes could be arranged to achieve communication.

Rangia (2012:51) also was in agreement with the findings of this study because the author noted that there was insufficient communication about sex in home environment between the parents and their teenagers. This author concurred with the participants in that parents should also be open to their children and be in a position to give them the necessary advice about sex and contraceptives. Thobejane (2015:277) added to the debate and alluded that parents may play important role in discussing sexuality with their children for them to become responsible. Anyanwu, Goon and Tugli (2013:2) also revealed that pregnancy at an early age was high and teenage mothers faced fear, shame and embarrassment when pregnancy revealed to family but at this point, they also needed support. It emerged from one participant of this study that confirmation made where parents were not kind in such a way that they wanted to chase her away. One of the participant further confirmed the bitterness of her father complaining of his wasted money for a person who did not need school.

The Department of Health (2010:19) further reported that the myths about sex, fertility and abortion still exist among various teenagers while significant number of parents lack the knowledge and/or confidence to talk to their children about sex and relationships. My opinion is that really, the awareness campaign is needed to empower parents and educators with knowledge of sexuality and contraceptives. Hamdela et al. (2012:5) pointed that in order to

address unwanted pregnancy, reproductive health programs and promotion of communication about family planning among parents and teenagers and how to access health services as well as empowering teenagers should be done immediately.

Anyanwu, Goon and Tugli (2013:927) also revealed that pregnancy at an early age was high and teenage mothers faced fear, shame and embarrassment when pregnancy revealed to family but they needed parents' support during this stage. Seekoe (2005:20) also suggested that sex education and contraceptives should be taught at an early stage of their lives for both boys and girls which concurred with the one under study that sex education be taught from homes, schools and communities. The author also argued that it was difficult for parents to convey sex education to their children as their own values about sexuality could not always help their children into sexual responsible individuals. The department of Health (2010:20) indicated that it was clear and consistent that message to teenagers through media campaign could impact positively on young people's attitudes and behaviour. It was also indicated that this strategy could be used to access advice and support from all stakeholders. The researcher therefore viewed that there is a need for teenagers to be knowledgeable about sexuality, use of contraceptives and to promote abstinence to prevent pregnancies.

3.5 FIELD NOTES

Field notes in this study refers to qualitative notes recorded during observation of a specific phenomenon under study that enabled the researcher to provide the evidence that gave meaning and aided in understanding the phenomenon. Observation was made amongst registered nurses and teenage mothers in rural area of Mopani District, Limpopo province.

Table 3.10: Field notes

NO	OBSERVATIONAL NOTES	THEORETICAL NOTES
1.	Entrances to the facilities were security guards. Some had good relationships with clients but others not.	In all areas where data was collected, securities were found to be at the gates. They were searching clients as we enter and leave the gates. All securities were from private sectors. Some reflected knowledge of Batho Pele principles whereas few securities reflected to lack knowledge of the principles because they were bully to clients. The differences in relationships reflected that some people abuse power in their working area because some of the securities wanted clients to feel that they have power

2.	The staff in all heath facilities welcomed and supported the researcher warmly regarding all the needs she required.	The warm welcoming was the result of pre-arrangements made between the staff and participants. All of them were ready for my arrival.
3.	The accommodation and environment were very clean and spacious. Empirical results are The area was conducive for the interviews to take place because it was quiet and private.	This indicated good planning by the management of the institutions and also reflected good understanding regarding the purpose of doing a research that it does not need some interruptions.
4.	The time allocated for the interviews occurred as per arrangement	Time allocated was convenient to both the researcher and the participant
5.	The participants: These included the registered nurses working at the clinics and teenage mothers living in the nearby villages who visit the clinics for comprehensive health.	The data from participants were evidence of their experiences and reflection of the situations that they meet in those villages
6.	All participants were available as planned in the clinic and no one disappointed me	This meant that the explanation regarding the purpose of the study was clear and well understood by the participants. Trustworthy was also reflected.
7.	A meeting was held with the participants to explain everything about the study prior the actual collection of data in order to ask permission for their participation	Information dissemination regarding the study was done
8.	Building a rapport though greetings and welcoming the participants	Building a rapport/ relationship was to put participants at ease and to motivate for free participation. They were made aware that confidentiality will be maintained.
9.	Explanation of the instruments to be used	The participants were informed about the availability of field notes and audiotapes to be used.
10.	Maintenance of confidentiality was emphasised	This indicated that the data collected was voluntarily and informed consent was freely given. Participants were aware that they could terminate if feel like
11.	Reminded about what was in the consent forms provided to sign	Reinforcement of the permission given and expectations
12.	Communication with the participants: Registered nurses were free to communicate while regarding teenage mothers, some were free from the beginning of interview while others	This reflected that registered nurses were used to be public speakers. The teenage mothers were not free to communicate because some feared victimization, some were sexually abused or of their status of

	gained momentum as we proceeded with communication	being HIV positive. In their culture, speaking about sex with an adult is a taboo.
13.	During the process of interviews, some of the participants lowered their voices during communication while others were high to capture all information	These meant that as indicated above, culture, age and fear of judgement may be the contributory factors that led the observation by the researcher that some participants had confidence while others were not and needed probing them during interviews.
14.	Facial expression and non-verbal communication	The researcher was able to read what the participant is clarifying through non-verbal communication.
15.	During discussion, some of the participants were giving insufficient information that resulted in probing in order to get more information the researcher needed	These reflected that some of the participants are more confident than the other and probing assisted the researcher in getting more information for analysis
16.	Withdrawal from participation	All invited participants managed to come for interviews. No withdrawals made by participants
17.	The field notes writer's remarks were that he enjoyed and affected by information given	These meant that the field notes writer also realised the important of doing this research as he heard all the problems the teenagers are experiencing.

3.6 CONCLUSION

The findings of the study indicate that some of the participants reflected eagerness to return to school after delivery of their babies in order to complete their education. However, some teenage mothers in the rural areas in Mopani District of Limpopo province were unable to return to school after delivery for various reasons, including arranged marriage following the pregnancy or birth of the child.

Others could only manage to return to school in the year following the delivery of their babies. Many challenges were experienced that disrupted their vision to return to school. Pregnancies continued to have detrimental effect amongst teenagers, as pregnant teenagers and teenage mothers were expelled from some of the schools, or they were treated in various un-dignifying ways that lead them to either drop out or not return to school.

Financial constraint associated with non-receipt of the Child Support Grant, poverty and early marriage are some of the findings that emerged from the current study. It was suggested by the participants that Nurses and other health professionals who are involved in the teaching of teenagers about sexual and reproductive rights and health should do this at an early stage of their schooling. Both boys and girls should receive same instructions on the use of contraceptives including community involvement and the use of campaigns. The researcher viewed these as a good opportunity to change the way of thinking and understanding of social and technological change where nurses should invest in the sexual health of all teenagers instead of judging them. Nurses and other stakeholders should focus on both boys and girls. Also taking into consideration that children mature earlier than expected.

CHAPTER 4

DISCUSSION OF EMPIRICAL FINDINGS OF RESEARCH WITH REFERENCE TO HEALTH PROMOTION MODEL

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4.1 INTRODUCTION

In chapter 3, the empirical research results are presented, discussed and justified with literature. The results were presented as the description of the challenges experienced by registered nurses regarding the promotion of health and wellbeing of teenage mothers as well as the barriers experienced by teenage mothers to return to school after delivery of their babies at Mopani District in Limpopo Province. In this chapter, the results of the empirical study were matched with the core elements and the components of Pender's Health Promotion Model, to build a holistic picture of how registered nurses, parents, educators and stakeholders in the villages could be involved in the promotion of the health and wellbeing of teenagers in general and teenage mothers who dropped out of school. Also, to motivate their return to school. Fasoranti and Adeyeye 2015:226) believed that to achieve all these variables, individuals should play an important role upon their own health through health education. This process enabled teenagers and teenage mothers to increase control over, and to improve their health by actualizing their human potential. The role and the responsibilities of nurses (health professionals) in practice were to provide support to vulnerable teenagers regarding promotion of health and their wellbeing by providing health education on ways in which their behaviour and lifestyle could impact their own health and to ensure that the information is well understood. This will help them to change their previous behaviours and be able to manage or cope with significant adversity of life (Willis, 2014:260). These formed the bases of chapter 4.

In this chapter, the synopsis of the Pender's health promotion model will be discussed in conjunction with the themes and categories that emerged from the previous chapter of the empirical study. The guidelines will be formulated in this chapter and developed in chapter 5 directed by the model. The reasons for choosing the model, as well as discourses about the

model helped the researcher in applying the model and drafting the guidelines. The Health Promotion model describes the multidimensional nature of persons as they interact within their environment to pursue health. Health as a positive dynamic state rather than simply the absence of the disease, directed at increasing a patient's level of well-being. Registered nurses should play an important role in the integration of health promotion into the fabric of a community (Rimmer 2016:498).

Pender's model in Pender el al. (2006:61) was proposed as complete predictive model of health promotion behaviours for the use in nursing practice. For the purpose of this study, these behaviours should result in improved health, enhance functional ability and better quality of life at all stages of resilience and teenage mother's development. All stakeholders in health and the society in general should be involved in the development of both teenage boys and girls.

4.2 DESCRIPTION OF PENDER'S MODEL

4.2.1 Overview of Pender's health promotion model with the alignment to the study

The Pender's Health Promotion Model (HPM) put emphasis to the increase of wellbeing and actualizes human health potential motivated by desire the model has given to a new direction. The model looks at steps in which a person can pursue better health or ideal health. The Health Promotion Model was designed by Nola J. Pender to be complementary counterpart to models of health protection reference needed. The model was revised in 2002 and in 2008 by Pender, Murdaugh and Parsons to be used in practice for health promotion (Pender et al.2006:56). This model defines health as positive dynamic state rather than simple absence of disease, directed at patient's/client's level of wellbeing.

The purpose of the health promotion model was to assist registered nurses in understanding factors that affect health behaviours. The researcher in this current study believe that teenage mothers need the understanding of nurses to transform and therefore see Pender's model as the basis for behavioural changes in order to promote healthy lifestyle (Pender 2011: 2). The role of nurses in using health promotion model is to facilitate collaboration with clients in order to assist them in changing their behaviours to achieve ideal healthy life style. It focuses on explaining health promoting behaviours using a wellness orientation. Polit and Beck (2012:135) define Pender's model of health promotion as activities directed toward developing resources that maintain or enhance well-being and embodies a number of

theoretical propositions that can be used in developing interventions and understanding of health promoting behaviours.

Peu (2008:10) view health promotion as an effort that enhance, support or promote health and wellbeing of individuals, families, groups, communities and societies focussing on maintenance and improvement of general health. Health promotion support individual development through health education. Teenagers are able to learn and develop skills in order to maintain their own health, whereas McQueen and De Salazar (2011: ii195) view health promotion as enabling people to learn throughout life, to prepare themselves for all its stages and to cope with pressures of life. According to these authors the focus should be at schools, home, work and community settings.

Guedes, et al. (2009:774), state that promoting health depends on giving attention to integral development, contemplating the following aspects attention to the quality of interpersonal relationships and access to healthcare services, access to information and formal professional education and doing leisure to promote healthy life style. School is one of the space acknowledged for promoting health and lifestyle of teenagers. Guedes, et al (2009:774) argue that health care professionals need to become aware of habits of teenagers in schools so that they implement strategies to promote their health and well-being. They further indicated that Pender developed theoretical nursing model of health promotion that may be used to have knowledge and understanding to execute and assess health promotion in practice.

George (2011:548) indicated that the theory noted that each person has unique personal characteristics and experiences that affect subsequent actions. The author also stated that the set of variables of behaviour specific knowledge and affect have important motivational significance and the variables can be modified through nursing actions which makes it the end point in the health promotion model. Petersen, et al (2012: 411) noted that health promotion and the prevention of illness in South Africa need to be addressed such as maternal depression, and to strengthen attachment and psychosocial stimulation during infancy, strengthen families, promote health during infancy, promote health and enhancing school environment. The behaviours should result in improved health, enhanced functional ability and better quality of life at all stages of development. According to George (2011: 550) the final demand is also influenced by the immediate competing demand and preferences, which can derail intended actions for promoting health.

Pender's model includes three major concepts namely:

- Individual characteristics and experiences.
- Behaviour- specific cognitive and affect.
- Behaviour outcome (Pender 2011:3).

In the figure 4.1 below, the key concepts of Pender's Health Promotion Model are summarised.

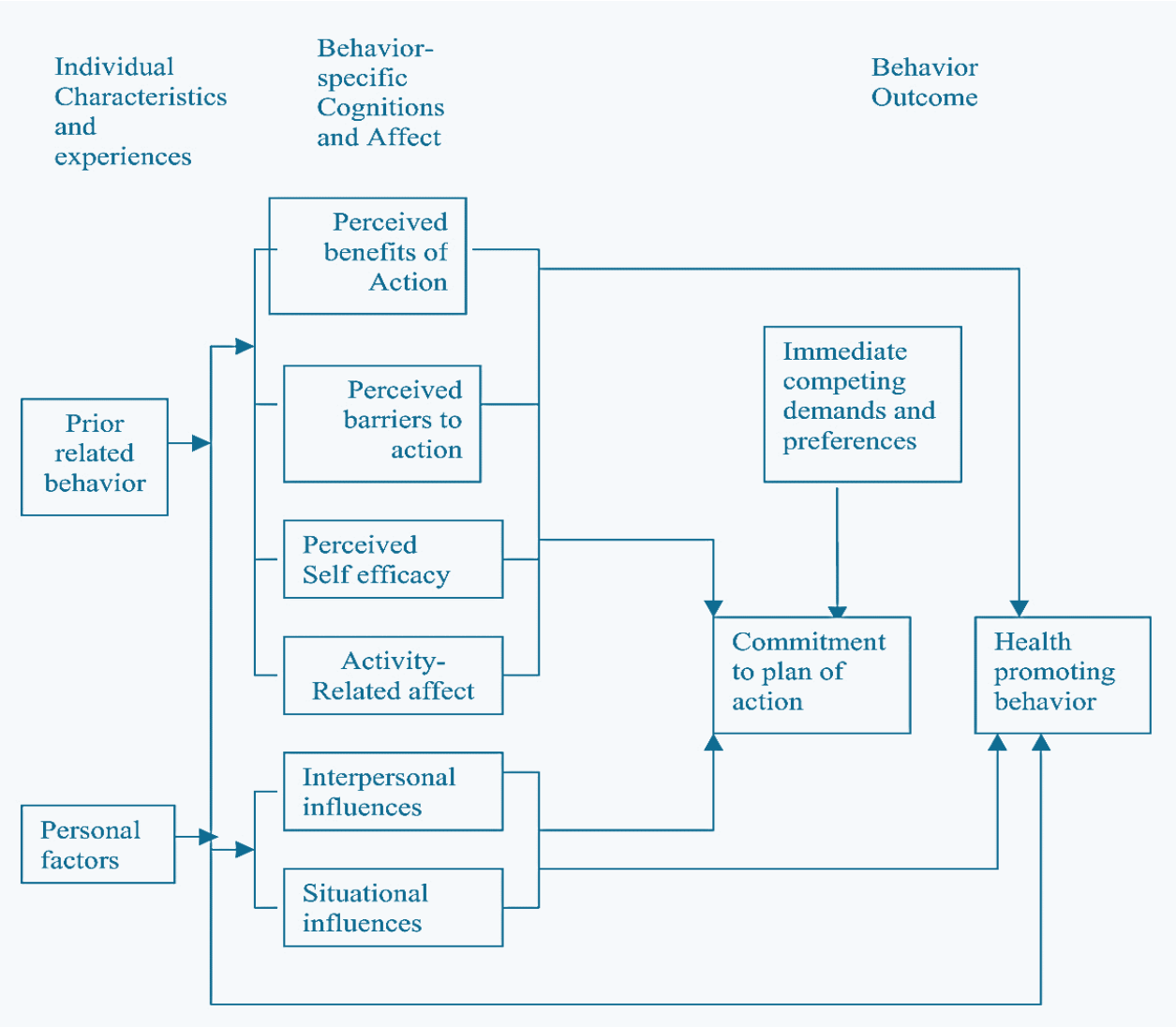

Figure 4.1: Pender's Health Promotion Model

4.2.1.1 Individual characteristics and experiences of Pender's health promotion model.

The individual characteristics and experiences are divided into prior related behaviours and personal factors. Prior related behaviours referred to the frequency of the same behaviours or similar health behaviour that are habit forming since each time a behaviour is performed, the habit is strengthened. These behaviours can be positive or negative and are the best predictor of future behaviour with the frequency of the same or similar behaviours characteristics in the past (George 2011:458). In applying Pender's model, teenagers need a successful transition into adulthood, including completion of schooling, attainment of economic self-sufficiency and engagement in healthy family and community relationships to achieve wellness. This also correlate with the assumption that the individual seeks to actively regulate their own behaviour. Teenagers may also have the ability to manage or cope with significant adversity or stress in ways that are not only effective, but may result in an increased ability to respond to future adversity (RNAO 2010:14). The human rights of teenage mothers are protected in the bill of rights in the constitution of South Africa. The Constitution of South Africa (Act No. 108 of 1996) as amended states that everyone has a right to basic education. Subsequent statutes allow pregnant teenagers irrespective of early symptoms experienced to attend school during pregnancy and lactation. In this study, the researcher argues that lack of recovery period is dramatically holding back collective ability to be resilient and successful.

Prior related behaviours were displayed in this study by the teenage mothers who indicated that rejection by other learners in class forced them to stop returning to school. The participants (teenage mothers) further indicated that the reason for leaving school was fear of other learners who made fun about them, as well as their experiences of loneliness due to marginalisation. Some of these participants indicated that they were accused of being pregnant because they were blamed of causing sleep while others would say that they attend classes with mothers. These hindered their development and resilient to be successful as a result of rejection. Mahlalela, and Chireshe (2013:141) supported the participants in this study reflected that dropout from school was mostly caused by rejection from peers and teachers at school. They also indicated that child headed young individuals are not supported at home and at school, yet with many responsibilities that lead to dropout from school.

The participants (registered nurses) stated that prior related behaviour was displayed by teenagers due to forced sexual activity. The forced sexual activity started early sometimes as young as 10-12 years of age, usually without the knowledge of parents or family members. They become pregnant not knowing what they are doing. Their parents and other men

commit sexual offences against them. However, the Constitution of the Republic of South Africa (1996) underscores the legal framework for all legislation in South Africa which covers the rights of the child, including adolescents, to equality, education, health, nutrition, social security, a safe environment, water and shelter, and identity, amongst others but their rights are violated because they are still young to make own decisions. They also fail to report the abuse. Beguy, Mumah and Gointtschalk (2014:8) stated that early sexual debut increases young women's exposure to the risk of pregnancy. These could affect their future of completing school as teenagers and lead to unemployment and poverty which could also affect the future of their children.

They also indicated that, while attending school during pregnancy, they had challenges of pregnancy related conditions such as nausea, vomiting, headache and swollen feet and fainting. These symptoms were associated with pregnancy among teenagers. These pregnant related conditions led them to terminate schooling. One participant reflected that, entering the classroom triggered vomiting and therefore could not stay at school but to quit schooling. Health professionals in this stage are required to intervene as part of interpersonal environment to exert influence on the teenagers in order for them to return to school and complete their studies. Health talk regarding sexuality, reproductive health and use of contraceptives could transform teenagers in general to better adults and becoming pregnant when ready to do so (Nkani and Bhana 2016: 2).

Personal factors are described as biological (age), psychological (self-esteem) and sociocultural (education) factors by Pender's model who also indicated that only those factors that are theoretically relevant to the desired behaviour that need nursing intervention (George 2011:548). Personal factors were displayed by participants who indicated that unwanted pregnancy occurred at a younger age, had more negative experiences such as pain in labour, experience more mental problems in early postpartum period, shame and withdrawal from society. One of the participant (teenage mother) confirmed that she relocated from the original village as arranged by parents to stay with the boyfriend at another village and was bound to change school after two years of stay at home as she was afraid to be humiliated by other leaners if she decides to return to the original school. Parents should teach their children about reproductive health and sexuality while they are still young (Anyanwu, Goon and Tugli 2013: 927). Pender encourages healthy preventative activities during the process of growth and development therefore; the researcher believes that nurses could provide interpersonal influence in helping teenage mothers to be committed in the transformation of their behaviors (Sanchez, Rowles and Dube, D. 2011:8).

Psychological factors include self-esteem, self-motivation, and perceived health status (George 2011: 548). In this study, some of the participants reflected that teenage mothers lacked guidance from parents and community at large regarding the use of contraceptives as talking about sex was a taboo. They were also labelled to be prostitutes. As a result, they lacked self-esteem, motivation and poor health status. It was found that most families revealed that it was difficult to talk openly or to discuss about sex with their children (Rangiah 2012:48).

4.2.1.2. Behaviour- specific cognitive and affect

Pender (2011:4) define behaviour-specific cognitions and affect as the anticipated positive outcomes that will occur from health behaviour. These outcomes are viewed as major motivational importance and considered to be the core for intervention since they are the most amenable to change through nursing intervention (George 2011:548). The participants in this study (both teenage mothers and registered nurses) indicated that youth friendly services that cater for teenagers only should be available and be adequate in all communities (DH 2010:47). They also suggested that teenagers form their own support group in order to discuss freely about contraceptives and also have special suitable services for teenagers to discuss issues on their health promotion and also campaigns (The National ASRHR and Framework Strategy 2015:27). This could motivate teenage mothers to attend health services without fear of adult people.

Perceived benefits of action are the anticipated positive outcomes that will occur from health behaviour. These outcomes according to (George 2011:548) received moderate support in the research conducted on the HPM as may moderate the behaviour directly or indirectly. The participants (registered nurses) in the current study indicated that perceived benefits may moderate behaviour both directly and indirectly. They also proposed that mobile clinics should be available in villages where they are not available and offer family planning workshops. They further suggested that the services from mobile clinics be provided after school for teenagers to have access (Clarke 2014:33). The teenagers in general may benefit from the mobile clinic. Pender ascertains in her theory that “individuals are responsible to create healthy choices for their own human health potential”. These persons must be able to look at their own unacceptable actions and improve their environment that could change and maintain their ideal health (Sakraida 2010: 434).

Perceived barriers to action are activities that hinder the progress of individuals. An individual may wish to progress with furthering education but because of poverty that person fail to fulfil her goal (Shahroodi, et al. 2013: 55)**.** These factors have been supported by HPM as determinant of participation in health-promoting behaviours. In this study, the participants

(registered nurses) displayed that teenage mothers could not face the attitudes of the parents and that of the peers if they become pregnant. These teenagers therefore refrained from going to school and also felt that they disappointed their parents. These actions caused barriers for teenage mothers to go back to school. According to the participants, some teenage mothers were forced to stay with their boyfriends due to lack of support from teachers, parents and community (Thobejane 2015:274). The barriers were also displayed by teenage mothers when they have high levels of knowledge about contraceptive methods, but gaps and ignorance appeared to exist in the accuracy of their knowledge or skill regarding correct use of contraception. They therefore fell pregnant and terminate schooling. The issue was also supported by (Mahlalela and Chireshe 2013:140) in that gaps exist amongst teenage mothers regarding use of contraceptives. Perceived barriers may influence actions that are perceived by teenage mothers.

Perceived self- efficacy or one's judgement of one's ability to carry out an identified action relate not to a person's skills but to that persons about what can be accomplished with those skills (George 2011:549). According to LoBiondo- Wood and Haber (2010:485), self-efficacy is a major factor in decisions to adopt health behaviours among people with varying health states, ages and ethnic groups. LoBiondo- Wood and Haber (2010:485) also argued that self-efficacy engaging in one health behaviour does not guarantee self-efficacy when engaging in another but the specific health behaviour correlate strongly with actual enactment of that behaviour. Thobejane (2015: 274) supported self-efficacy when indicated that teenage mothers put their trust and listen to adult people when they advise them and ignore what they really need in the environment in which they leave. Motherhood was perceived to be a connection and an avenue for their parents to accept a partner they would otherwise not accept; however, these communities may share beliefs about their health and ill health and the ways in which they make their health decisions (Wills 2014:311).

The researcher in this current study found that nurses were judgemental to the teenage mothers who come for contraception at the clinics. Some of the participants reflected the goodness of nurses and commended to continue with their action. The participants (teenage mothers) also suggested that nurses should promote family planning by providing health education at an early stage of development in primary school to prevent unwanted pregnancy. Pricilah, et al (2014:138) encouraged parents to forgive their teenage mothers, reconciling with their daughters and consider taking care of their babies in order to return to school while believing that they have the ability to achieve education. They also proposed free communication among nurses, teachers and teenagers. Teenage mothers further proposed that young nurses be employed who could understand their needs.

Activity related affect is defined as the subjective feeling state or emotion occurring prior to, during and following after a specific behaviour while prior behaviour reinforces strength of client and build on past success and failures (Ibis Reproductive health 2013:17). These behaviours influence self-efficacy, which means that the more positive the subjective feeling, the greater the feeling of efficacy (Pender 2011:4))**.** These feelings may vary from mild to quite strong and may be cognitively labelled, remembered and continue to be associated with thoughts about the particular behaviour (George 2011:549). It was found in this study that the participants (teenage mothers) were so young when they had sex for the first time. Some indicated that they were not forced to have sex but they did not know what they were doing when having sexual contact. Ibis reproductive health (2013:17) attested that pregnancy during one's school-going years can have significant negative effects such as poverty, which also limits future opportunities for the child. At the same time, positive effect may also be imparted in teenage mothers and build the future out of it by learning from previous mistakes of becoming pregnant.

They further confirmed that they were immature to make a concrete decision because falling pregnant was not on their minds but they did. It also emerged from this study about the confirmation made by the participants that they were inspired by what they saw in a media and thought making love was an easy thing. While teenage mothers have high levels of knowledge about contraceptive methods, gaps and ignorant appear to exist in the accuracy of their knowledge or skill regarding correct use of contraception. In protecting the teenagers from becoming pregnant, the Children's Act (Act 38 of 2005:17) documented that children have rights to access contraceptives. The rights documented in this act, are embraced as legal document governing children's rights. Despite the availability of the Act (Act 38 of 2005) teenagers continued to be pregnant because they failed to use contraceptives that were available at all clinics.

Interpersonal influences are the person's thoughts or beliefs about behaviours, attitudes and beliefs of others and may not accurately reflect those behaviours, attitudes or beliefs (Innstrand 2012:10). The participants (registered nurses) in this study reflected that teenagers should visit the clinic as soon as they start menstruation with their parents to prevent unwanted pregnancy. They also indicated that teenage girls should be taught about dangers of unprotected sex that can lead to sexual transmitted infection at an early stage. The participants (Teenage mothers) projected that both boys and girls should be taught in the same area about the prevention of pregnancy, use of condoms or implants doing door to door campaign.

The participants (teenage mothers) in this study indicated that peer group training should be conducted together with youth development programmes to prevent unwanted pregnancies and also HIV and AIDS. They also wanted parent to communicate with them about sexuality and contraceptives. The participants suggested that boys and girls be trained together in order to have the same understanding. It came up very strongly from the participants that the community misled teenagers when saying that if contraceptives are used, a person will become a barren and will never give birth (Mothiba and Maputle 2012:4). The participants also alluded that the community failed to accommodate teenagers who have boyfriends and call them prostitutes. They further failed to teach them sexual health and led them falling pregnant as a result of lack of knowledge since talking about sex was regarded as taboo. Boys were found not to be involved. The community should teach teenagers about sex (Thobejane 2015:274)

Situational influences include the options that are perceived as being available, demand characteristics, and environmental features. These are personal perceptions and cognitions of any given condition that can either facilitate or inhibit activities. Situational influence can promote negative or positive attitudes depending on the maturity of an individual (Sakraida 2010: 434). In this study, participants (nurses) indicated that some teenagers became pregnant before starting menstrual cycle or possess an identity document and terminate schooling. The child support grant was found to be perceived as a barrier to contraception before pregnancy among teenagers in this study by the participants. Some teenage orphans are sexually abused in exchange of money and some of the parents who were not working and not yet on pension also depended on the child support grant or married to some elderly men (Nkani and Bhana 2016:7). Other participants in this study argue that Child Support Grant is helpful to those who are lacking and are in need such as orphans. They also indicated that they use the money to pay for local crèches for their babies and allow them to go back to school. These will allow them chances of returning to school after giving birth to their babies. Their future will be enhanced (Willan: 2013: 58).

Commitment to a plan of action initiates the behaviour. The underlying cognitive processes are a “commitment to carry out a specific action at a given time and place and with specified persons or alone, irrespective of competing preferences and identification of definitive strategies for eliciting, carrying out, and reinforcing the behaviour (George 2011: 548). The researcher of this study found that learner ship and skill development programmes should be utilised. The participants (teenagers) noted that community involvement including indunas and family members is needed. The participants also mentioned that nurses, pastors, teachers, school governing body and parents should work together to teach children about reproductive health at an earlier stage of their lives. Additionally, it was agreed that

teenagers must abstain from sex. The participants concluded that there was a need for crèches to be erected and funded by the Government for the children when teenagers are at school (George 2011: 551). Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2024/2015:34).

4.2.1.3 Behavioural Outcome

Behavioural outcome is a health promoting behaviour, an action or endpoint directed toward attaining positive health outcome such as optimal well-being, personal fulfilment and productivity (Guedes, et al 2009:777). According to Armad, et al (2013:53) it is a health promoting behaviour where a person has some intentions and identified a planned strategy that could lead to the implementation of a health behaviour. It was emphasised in this study by participants (teenage mothers) that health professionals should teach both boys and girls about contraceptives in the same venue because boys are normally not involved regarding contraceptives. They also stated that nurse driven information activity should be done in schools and communities, teaching about the importance of the use of contraceptives. They further reflected that unprotected sex could lead to sexual transmitted infections and they reflected that boys are reluctant to use condoms (Malahlela and Chireshe 2013:46). The participants (teenage mothers) revealed that parents did not tell them about menstruation as teenagers and acquired information from peers which led them to insufficient knowledge. They also indicated that they needed their parents to be open with them and support them during their pregnancies or if they choose to terminate the pregnancy. They further stated that parents should sit down with their daughters at an early age and encourage them to finish school before looking for men and that teenage mothers can use the Child Care Grant money to pay for their babies at local crèches whilst they return to school in order to complete their studies (Rangia 2012:51).

4.3. RATIONALE FOR EXCLUDING COMPETING DEMAND ON THE REFINED MODEL

George (2011:548) defines competing demands as behaviours over which the person has little control, such as work or family responsibilities, and are situations in which a failure to respond may affect the life of significant others. Teenage mothers are still young to make their own concrete decision as they are not yet matured and are still developing. They are found to be some victims of sexual abuse by relatives and other people in general who decide for them and threaten them in case they report. They have lower control over environment exigencies such as work and or family (Holt, et al 2012:286). The participants in this study displayed poverty as contributory factor of sexual abuse to teenagers which led to

teenage pregnancy. They further stated that uncles were found to be the cause of sexual abuse and also elderly men in exchange of money (ISHP 2012:35).

According to Taimoori, et al. (2008: 5), competing preferences were viewed as alterative behaviours with powerful reinforcement properties over which individuals exert relatively high level of control based on one's preference to alter a plan of action for positive health action and requires capabilities. These researchers also indicated that HPM competing preferences are proposed to directly affect the probability of occurrence of behaviours as well as moderating the effect of commitment. In this study, teenagers are not yet having those capabilities. These were reflected by participants (teenagers) who noted that marriage seemed to be important to the family since arrangement was made for the teenage mother to go and stay with the boyfriend. These participants were also afraid to handle tiny babies after a premature delivery. These implied that babies needed special care while the teenage mothers could not handle the babies because of fear and being young and still developing (NACHC 2014:1).

4.4 THEORETICAL STATEMENTS

According to Pender (2011:5 thirteen theoretical statements that come from the model were quoted. These statements provide the basis for investigative work on health behaviours of individuals and her quotes are as follows:

- "Prior behaviour of an individual may be an inborn one or influenced by other people in the environment such as norms and values".
- "Individuals may commit to engaging in behaviours through learning from other which they anticipate deriving personally valued beliefs".
- "Perceived barriers can constrain commitment to action, a mediator of behaviour as well as actual behaviour as well as actual behaviour".
- "Perceived competence or self-efficacy to execute a given behaviour increases the likelihood of commitment to action and actual performance of the behaviour".
- "Greater perceived self-efficacy results in fewer perceived barriers to a specific health behaviour".
- "Positive affect toward a behaviour results in greater perceived self-efficacy, which can in turn result in increased positive affect".

- “When positive emotions or affect are associated with behaviour, the probability of commitment and action are also increased”.

- “Persons are more likely to commit to and engaged in health promoting behaviours when significant others model the behaviour, expect the behaviour to occur, and provide assistance and support to enable the behaviour”.

- “Families, peers and health care providers are important source of interpersonal influence that can increase or decrease commitment and to and engagement in health promoting behaviour”.

- “The greater the commitments to a specific plan of action, the more likely health-promoting behaviours are to be maintained over time”.

- “Commitment to a plan of action is less likely to result in the desired behaviour when competing demands over which persons have little control require immediate attention”

- “Persons can modify cognitions, affect and the impersonal and physical environment to create incentives for health actions”.

4.5 PHILOSOPHICAL ASSUMPTION OF PENDER’S MODEL

The health promotion model makes four philosophical assumptions (Pender 2011:5)

4.5.1 Explanation of the philosophical assumptions

4.5.1.1 First assumption

- “That the individuals seek to actively regulate their own behaviours” (Pender 2011:5).

This assumption demand participation of role players to ensure improves and maintains the lives of people by improving the available resources. In this study, it is essential that teenage mothers change their own behaviours. The assumption provides an appropriate strategy which can be used in this study to a great advantage to promote health of teenage girls and teenage mothers who dropped out of school in their immediate environments, including schools, families and community. The participants of this study are found to be dropping out of school as a result of pregnancy and child birth related issues. The model uses the proposition that people follow the behaviours in which they believe they will benefit and

assume that they will learn skills from others in order to be competent or self-efficacy relating to a given behaviour that increases the likelihood of actual performance (Pender 1996). Self-efficacy depends on the health providers as well as family in helping the teenage mother to be committed. The concept of self-efficacy was developed by Bandura's in 1997 and is still utilized (Bandura 2013). The model incorporates interpersonal and situational influences on person's commitment to health promotion action. The self-efficacy model is based on the "belief that what people think, believe, and feel affects how they behave" (Petersen, Bhana, and Swartz 2012:412).

To enforce self-efficacy, the participants (teenage mothers) revealed that nurses should teach them about contraceptives at an early stage of about 10 years when experiencing menstrual cycle. According to participants, these could prevent teenagers from becoming pregnant at an early age. They also confirmed that the use of contraceptives was necessary to prevent the occurrence of pregnancy and some started to use after delivery of their babies. One of the participants considered the pregnancy to be a lesson learned as she suffered a financial constraint such as lacking money for napkins. They therefore commended nurses to teach teenagers about the correct use of contraceptives at an early stage of their lives and also to do door-to-door campaigns in order to motivate teenagers to use contraceptives. Proposal to use implant and condoms were also made by the participants. All these could benefit the teenagers from becoming pregnant and to complete schooling.

4.5.1.2 Second assumption

- "Individuals in all their bio-psychosocial complexity, interact with the environment, progressively transforming the environment as well as being transformed over time" (Pender 2011:4).

In this study, the community, families and parents could be transformed over time to be able to be open and communicate with their children regarding reproductive health, sexuality and use of contraceptives. The participants (registered nurses) of this study pointed out that family members, the communities, and parents should sit down with teenage mothers and discuss about the advantages of going back to school and what they are going to benefit by doing so in future. Also, that having a baby is not the end of the road for them, but they must just be courageous and go back to school. This could help in changing the behaviour of teenage mothers in becoming keen to return to school in that environment. On the other hand, the participants (teenage mothers) also indicated that community involvement as community driven activity should be empowered by registered nurses with knowledge of open communication with their children about reproductive health, sexuality at an early age

(home environment) for the prevention of pregnancies. They therefore proposed learnerships and skill development programmes to empower them with knowledge that could change their behaviour and reduce the occurrence of pregnancies. This is supported by The National Contraceptive Guidelines (2015:15) indicated that South Africa's liberal policy allowed pregnant teenagers to remain in school and to return to school post-delivery. This policy protected teenage mother's educational attainment and helped them delay a second pregnancy. Beguy, Mumah and Gointtschalk (2014: 9) stated that reaching teenagers at their early stage of development while they are still at school will have potential of reducing unintended fertility and pregnancies which will have significant impact on their wellbeing.

4.5.1.3 Third assumption

- "Health professionals, such as nurses constitute a part of the interpersonal environment, which exert influence on people through their life span" (Pender 2011:4)

In this study, health professionals are the key role players in providing care to teenage mothers. The participants revealed that nurses should teach teenagers about contraceptives at an early stage of about 10 years when experiencing menstrual cycle at their home environment. According to participants, these could prevent teenagers from early pregnancy. The participant in this study confirmed that the use of contraceptives was necessary to prevent further pregnancies and some started to use them after delivery of their babies. They therefore recommended that nurses should teach teenagers about the correct use of contraceptives in an early stage and also to do door-to-door campaigns to motivate teenagers to use contraceptives to prevent pregnancies. Proposal to use contraceptive such as implants (implanon) and condoms were also made by the participants who will take three years before the teenager worry about becoming pregnant. These could be achieved through health education to teenagers and parents and the community at large. In support of the issue, Taylor, et.al (2014:855) confirmed that, the information that are provided to teenagers in schools are not sufficient to improve the occurrence of teenage pregnancies. Shefer, et al (2013:8) stated that there was still a need among learners for more effective education regarding sexuality and safe sexual practices.

4.5.1.4 Fourth assumption

- "Self- initiated reconfiguration of the person-environment interactive patterns are essential to changing behaviour" (Pender 1996).

In this study, the participants (teenage mothers) are the major role players in reshaping themselves by changing their behaviour of becoming pregnant and have willing to return to school with the aim of completing their education and become employed. The participants displayed that they wanted to return to school to complete their studies. This is the reflection that teenage had strong will to return to school. However, they had some challenges of being married and forced to remain in marriage instead of going back to school. Some of these participants reflected that, teenagers do become pregnant for the purpose of marriage while some were willing to return to school to complete their studies. They also indicated that some hindrances that made teenage mothers not to return to school were the fact that no one would remain with the children when attending classes. This is supported by the South African Schools (Act 84 of 1996) documented that teenagers who fall pregnant should not be denied access to education. The ISHP also put emphasis on the improvement of the general health of school- going children by addressing health barriers and allowed pregnant teenagers to remain in school for learning purpose and furthering their studies (ISHP:10). These implied that pregnant teenagers and teenage mothers have the right to be at school regardless of their pregnancies. Nelson (2013:65) reported that most of the teenage mothers returned to school a month after delivery to further their studies. The author also stated that a reason for returning to school was that, teenage mothers did not want to miss school work.

4.6 RATIONALE FOR USING PENDER' HEALTH PROMOTION MODEL

The main purpose of Pender's model was to empower nurses with knowledge and skills about the lives of people and learn their lifestyle in order to be empathetic when counselling them or giving health education. Pender believed that using the model and working in collaboratively with clients, the nurse can assist clients in changing their behaviours to achieve health lifestyle (Heydari and Khorashadizadeh (2014:1067). The researcher in this study viewed the health promotion model as relevant to the study as it aims to represent ways of changing the approach to health promotion of teenagers as well as teenage mothers, helping them in decision making that would benefit their health, wellbeing, development and resiliency whereas Wills (2014:50) views health promotion as a guide to theoretical framework through which a nurse should look at different perspectives of health considering philosophy, values and beliefs influencing the development and implementation of strategies. According to Somerall (2010:3), Pender's Health Promotion Theory would serve as an excellent foundation for guiding the chosen population in actively participating in the promotion of activities that will lead to improved health.

George (2011:548) indicated that health care providers can develop a systematic problem-solving approach to improve and develop strategies to promote good health of individuals

through research. According to Pender, Murdaugh and Parsons (2014:35), the HPM was a frame work for integrating nursing and behaviour science perspectives on factors that influence behaviour. Hence, Nola Pender's HPM was shaped to serve as a "multivariate paradigm for explaining and predicting health promotion component of lifestyle (Pender, 1990:326).

4.7 RELEVANCE OF THE STUDY

The researcher views HPM as relevant to the study as it aims to represent ways of changing the behaviour of teenage girls and teenage mothers for them to consider education as important. The model guided the researcher to explore and describe their behaviour in bringing up their babies and returning to school (Pender 1996). According to Pender, et. al (2011:2), people are not static, but social being capable of changing behaviours depending on the circumstances in which they find themselves in order to meet their needs and goals.

The teenage mothers were viewed as dealing with individual characteristics and experiences which are divided into prior related behaviours and personal factors. The prior related behaviours were important as the best predictor of their future. Personal factors were described as biological, psychological and sociocultural which included self-esteem, self-motivation, and perceived health status. Pregnant teenagers were found not to be ready for becoming pregnant. They were either abused or forced to have sexual relationship. Men took advantage that they cannot decide on their own since they are still young to make decision

Teenagers need a period of development during their youth for positive and successful transition into adulthood, including completion of schooling, attainment of economic self-sufficiency and engagement in healthy family and community relationships. They needed to be guided regarding reproductive health by adult people especially in the primary level where parents were expected to be involved in their development. Most of the parents are still reluctant to talk about sex with their children as it is regarded as a taboo (RNAO 2010:14).

In this study, teenage mothers were expected not to fall pregnant at an early stage by their parents but they did. A positive youth development included specific focus on the role of family, community, educators and registered nurses in the interpersonal environment of teenage mothers. The researcher therefore found that the integration among participation in Positive Youth Development program and self was enhanced. Teenage mothers had the ability to manage or cope with significant adversity or stress in ways that resulted in an increased ability to respond to future adversity (Molapo and Iseler 2014:175). These were displayed when some of the teenage mothers managed to complete their education despite the fact that peer groups, parents and community at large were rejecting them.

They recuperated from their pregnancies, labour and delivery. Their strained bodies were able to recover its size and shape after deformation caused especially by the stress of pregnancies and deliveries. They therefore managed to return to school. The researcher of this study argued that lack of recovery period may hold back collective ability to be resilient and successful in their entire lives. The researchers also stated that there was a direct correlation between lack of recovery and increased incidence of health and safety problems. Youth development programmes were found to be necessary for teenage mothers for self enhancement and to build their self-esteem. The participants (teenage mothers) of this study also cited that nurses should teach them about sexual health at schools because teachers are afraid to tell them about sex, yet they have life orientation. They suggested that boys and girls be taught together in the same venue in order to have the same understanding about sex. They also proposed that life skills from childhood at home should be taught by their parents.

4.8 DISCOURSES ABOUT THE MODEL

Pender's Health Promotion Model is a framework for integrating nursing and behavioural science perspectives on factors that influence nurse and client behaviour. The model can assist us as health promoters to design interventions based on the commonalities observed in the experiences of others. The model has been used extensively as a framework for research aiming at predicting health promoting lifestyle as well as specific behaviours.

According to Innstrand (2012:26), the model on the relationship between job resources and individual resources influenced people's experiences and attitudes regarding organisational outcomes such as absence of sickness, wellbeing and productivity. It was found that the more people are satisfied at work the more the productivity. Glanz (2011:8) viewed health behaviour "at an interpersonal level where individuals exist within the environment where other people's thoughts, advice, examples, assistance and emotional support affect their own feelings, behaviour and health". These entails that people who leave in the same vicinity influence one another to behave in similar manner and the behaviour such as peer group influence. This behaviour can either be negative or positive.

Shahroodi et al (2013:51) in a survey conducted at Mashhad viewed Pender's health promotion model assisted in predicting the employee's physical activity and found that it was efficient in identifying and predicting physical activity or behaviour and could be used as a framework for planning and implementing educational interventions in order to improve the health. The study conducted in the United Kingdom looked for new ways of improving health promotion of individuals through training of practitioners and it was found that the

practitioners who participated in training were inherently more innovative to try new initiatives that they considered qualities. Therefore, health promotion could benefit the primary health care sector and assist continuity of care across entire health care system (McManus 2013: 15).

Fasoranti and Adeyeye (2015: 226) define health education "as a process of persuading people to accept measures which will improve their health through primary health care and to reject those that will have an adverse effect". These entailed changes occurred when health education was understood as a factor for promoting and protecting the health of people. It involves changing unhealthy behaviours through education activities in collaboration with other stakeholders. The current study presented positive results in increasing the teenager's knowledge on issues of contraceptives and sexuality (Viero et al 2015:485).

Glanz (2011:7) noted that guidelines, contemporary health promotion included educational activities, advocacy, organizational change, economic supports, policy development and multi- method programs. The behaviour was viewed as being affected by and affecting multiple levels of influence. Glanz identified five levels of influence for health related behaviours namely intrapersonal/ individual factors, interpersonal factors, institutional factors, community factors and public policy factors. This multi-level intervention was found to be successful. From Pender's model point of view, only the concepts of interpersonal and individual factors are utilized (Glanz 2011: 7). In this study, individual characteristics and experiences, behavioural- specific cognition and affect and behavioural outcome was utilised for teenage mothers.

Goodstadt (2005:1) referred logic model as an initiative conceptual framework with the purpose of providing action flow related to planning, development, implementation and evaluation of initiatives such as programs, policies or services. The researcher stated that the model can be used in planning and evaluating the health promotion initiatives. The researcher further indicated that the logic model can be applicable in the health promotion behaviour by partaking initiatives to influence change set goals considering values and develop strategies in order to achieve expected outcome by nurses or health professionals.

McQueen and de Salazar (2011:195) took a task to interpret as to what extent the charter has influenced current health promotion. One of the components of charter was that health promotion support personal and social development. This could be achieved through the provision of information about health and life skills to maintain teenager's environment. This will enable them to cope with stress of illness and injuries which can be facilitated in schools,

home, and community settings by health professionals such as educators, nurses and voluntary bodies within the institution.

In this study, the researcher views HPM as relevant to the study as it aims to represent ways of changing the behaviour of teenage girls and teenage mothers in order for them to see education as important. The model will assist the researcher to draft and develop guidelines to motivate individuals to change their behaviour and focus on health improvement (Pender, Murdaugh and Pearson 2008: 50).

The researcher also viewed the model relating to the study as pregnant teenagers and teenage mothers were actively seeking to regulate their behaviours in all their bio-psychosocial complexity and to interact with the environment while progressively transforming the environment as well as being transformed over time. Health professionals such as nurses, constituted part of the interpersonal environment, which exerted influence on people through their life span and self-initiated reconfiguration of the person-environment interactive patterns that are essential to changing behaviours since pregnancy continue to prevail.

The three major concepts and how concepts of Pender's health promotion model are related to this study were discussed. The application of the model will be discussed below.

4.9 APPLICATION OF THE MODEL

Nola J Pander revised the Health promotion model in 1996. It was assumed to be a useful guide to nursing care in relation to assisting those receiving nursing care in choosing and carrying out the behaviours to increase wellbeing. Assessment could be guided by the individual characteristics, experience and behaviour- specific cognition and affect (George 2011: 551). Planning occurs by developing plan of action to which the client commits. Implementation would draw upon the entire model. Evaluation would be based upon the performance of the targeted health promoting behaviour. However, nursing diagnosis and the process of the planning is not directly reflected in the model. The model was successfully utilized in England (George 2011: 551).

The major concepts of the model are applied in this study. The individual characteristics and experiences as well as perceived self-efficacy were displayed by teenage mothers regarding pregnancy and child birth that lead to school dropout. The participants (teenage mothers) confirmed receiving kindness in the hospital however had problems of pain as a result of episiotomy done. Lack of transport was also another challenge that affected the individuals. The distance caused the delay of the pregnant teenagers to reach the hospital from the

village of which even the ambulance also failed to reach the clinic on time until picked up by a private vehicle assisting her to reach the hospital. They also indicated that health professionals assisted them in giving birth to premature babies. The babies were placed in the incubator and had kangaroo care. Some participants were done caesarean section to deliver the babies for they were young to deliver normally which would not be possible to perform at the clinic. The participants were afraid to handle tiny babies. These implied that babies needed special care while the teenage mothers could not handle the babies because of fear and being young. In this study, the above information was the reflection of health promotion as it guided the nurses to choose and carryout behaviours to increase wellbeing of teenagers by transferring the client in case of emergency (pregnant teenager. and their experiences of teenage motherhood (Cinar and Manekse 2017:22).

Health promotion model helped nurses to execute health promotion to individuals, groups and families in schools and community at large. It enhanced client's capacity for self-care through education and development (Willis and Ewen 2007). According to National institute of health (Pender 2011:5), Health promotion was adapted with ideas from the behavioural and social sciences to fit the concerns of public health workers. These adaptations are based on what is learned over the years. Pender argued that health promotion proposed a framework for integrating nursing and behavioural science perspectives on factors influencing health behaviours (Pender, et al 2002: 47). In this study, teenage mothers are motivated to change their attitudes through health education. The motivation for conducting this study was to develop guidelines in order to promote health and wellbeing of teenage mothers after delivery of their babies in Mopani District, Limpopo Province with a view of supporting their return to school. The participants were registered nurses as well as the teenage mothers with the age between 18 and 21. The use of Pender's health promotion model formed the basis to answer the question, how will the guidelines for nurses assist in the promotion of health and wellbeing of teenagers. Refer to table 4.1 for clarity.

4.10 INTEGRATION OF RESEARCH FINDINGS IN RELATION TO PENDER'S MODEL LEADING TO DRAFTING OF PRELIMINARY GUIDELINES

The themes in Table 4.1 are grouped into three major concepts of Pender's health Promotion model namely individual characteristics, behaviour-specific cognitive and affect as well as behavioural outcome. These are the level of health promotion that needed to improve the health and wellbeing of teenage mothers by developing the guidelines. The three concepts are harmonized with Pender's model to inform the development of preliminary guidelines.

The first two themes are collaborated with personal, psychosocial factor and situational influence emerged from individual characteristics which affect teenagers before pregnancy, during pregnancy, labour and post-delivery and are the following:

Themes 1 regarding challenges of health service provision during pregnancy, labour and postnatal including follow up as prior related behaviour.

Theme 2 provision of health education to parents, family and community about support to teenagers regarding reproductive health including sexuality.

The third, fourth and fifth themes are collaborated with perceived barriers to action, activity related affect and interpersonal factors in which influence the behaviours of teenage mothers. These themes emanated from behaviour-specific cognitive and affect. These are**:**

Theme 3 post-natal barrier to contraceptives which collaborated with perceived barrier to action which can be influenced by interpersonal factor.

Theme 4 registered nurses to provide accessible, affordable and free service on contraception to teenagers.

Theme 5 registered nurses support and encourage teenage mothers to return to school in collaboration with parents, educators and other stakeholders in the villages thereby promoting health and wellbeing of teenage mothers.

The sixth and seventh themes were collaborated with situational influence which can affect teenage mothers and can remedy the problems behavioural outcome (health promoting behaviour) which could improve the health of teenagers emanating from Behavioural outcome which are:

Theme 6 Registered nurses to prepare plan of action to collaborate with the government to expand friendly health services for teenagers.

Theme 7 Registered nurses to empower and enhance information dissemination to both boys and girls in the same venue.

Table 4.1 contains a summary of the integration of the model and the themes.

Table 4.1: Summary of application of Pender's Health Promotion Model

THEME	MAJOR CONCEPTS I	PRELIMINARY GUIDELINES
	1.Individual characteristics	
1. Challenges of health care service provision during Ante-natal, labour, post-natal and Ensure follow up	1.Prior related behaviour	1. Provision of health promotion to antenatal, labour, postnatal care and follow up.
2. Lack of support for child care and need for child support grant	1. Personal and psychosocial factor 2. Situational influence	2. Provision of health education to parents, family and community about support to teenagers regarding reproductive health including sexuality.
	2. Behaviour-specific cognitive and affect	
3. Post-natal barrier to contraceptives **2. Post- natal challenge to return to school** **3. Proposed intervention**	1. Perceived barriers to action 2. Activity related affect 3. Interpersonal factor	3. Registered nurses to provide accessible, affordable and free service on contraception to teenagers. 4. Support and encouragement of teenage mothers to return to school. 5. Registered nurses to develop collaboration with parents, educators and other stakeholders in the villages in the promotion of the health and wellbeing of teenage mothers.
	3. Behavioural outcome	
4. Plan of action **(Health promoting behaviour)** **.** **5. Information dissemination including boys and Accessible friendly service**	1. Perceived self-efficacy 2. Interpersonal factor Perceived self -efficacy 2. Interpersonal influence	6. The registered nurses to prepare plan of action to collaborate with the government to expand friendly health services for teenagers. 7. Registered nurses to empower and enhance information dissemination to both boys and girls. 8. Registered nurses should initiate programmes which include families, communities, managers and other stake holders who respect human rights in collaboration with social

		workers to disseminate information through health education among teenagers regarding their legal rights of identifying and reporting of all forms of sexual abuse in the prevention of, and protection against, child abuse, neglect and exploitation.

4.10.1 INTERGRATION OF THE MODEL AND THE THEMES

4.10.1.1 Individual characteristics

- **Health service provision (Health promotion)**

The registered nurses to write motivational letter to the government to provide human and material resources to improve the provision of care during antenatal period and labour to deliver live baby, post-natal care to prevent complications and also initiate follow up after discharge to ensure health promotion of the mother and the baby.

- **Personal factors (Personal and psychosocial factor)**

The teenagers had a will to return to school (educational influence) and need for child support grant which could improve their low socio- economic status and also prevent receiving gifts from elderly males who end up abusing them. The negotiation for child support grant by social workers could enhance return to school and the teenage mothers could send the child to day care centre while attending classes in order to continue with their studies. The participants emphasised that early marriages should be prevented.

4.10.1.2 Behaviour-specific cognitive and affect

- **Post-natal barriers (Situational influence)**

In order to counteract post-natal barrier, registered nurses should provide quality care after the birth of the baby to prevent maternal and infants' mortality.

- **Need for support and role demand (interpersonal influence)**

The registered nurses and other health professionals should inform parents, family and community about supporting teenagers regarding reproductive health at an early stage of their lives. Knowledge of reproductive health should be provided during their growing stage from childhood.

- **Perceived barriers to contraceptives**

Initiation of accessible, affordable and free service of contraception to teenagers. The goal for nurses should be to counsel teenagers to abstain, use condoms and some other forms of contraceptives. The registered nurses and other stakeholders should give information to teenagers regarding advantages and disadvantages of different methods of contraceptives these may help teenagers to change their behaviours and learn to be independent and self-reliance. These may help them in making their own choices.

Regarding barrier to return to school, parents, educators, families and communities should be educated to support teenagers in returning to school by showing child parent relationship such as love and affection for better communication (Viero et al. 2015:485).

4.10.1.3 Behavioural outcome

- **Plan of action (health promoting behaviour)**

Health promoting behaviour is defined by Pender (2011:4) as the behavioural end point or outcome of health decision making and preparation of action. In this study, it refers to the motivations made by teenage mothers on ways in which they can be assisted in changing their own behaviour. The participants in this study motivated for accessible health services for teenagers and employment of young service providers for better understanding of their needs. They also pointed out that information regarding sexual health and contraceptives should be enhanced through information dissemination in a venue where both boys and girls could be together. The information should be regarding reproductive health, sex and contraceptives. Educators, parents, and community at large should also be encouraged to teach sex education to their children.

Address interpersonal influence leading to pregnancy through empowerment of teenagers both boys and girls and also enhance return to school through personal encouragement including parents, families and community and encouragement. Social workers should be involved to stop the issue. The National Adolescent Sexual and Reproductive Health and Rights Framework Strategy (2015:9) planned to draw some action plan involving stakeholders to inform, support and encourage teenagers about their sexual and reproductive rights. Emphasis was put to facilitate the implementation of the Children's Act (Act No 38 of 2005), which made provision for the mandatory reporting of all suspected forms of child abuse, neglect and exploitation as a result of poverty and being orphaned.

4.11 CONCLUSION

This chapter illustrated the results of the research conducted matching with the Health Promotion model of Pender, supported by literature control that was relevant to the study. This progression formed the foundation of the study and assisted the researcher in the formulation of the guidelines to promoting the health and wellbeing of teenage mothers in Mopani District, Limpopo Province. Table 11 displays the chosen model and Table 12 provides a summary of Pender' model relevant to the development of preliminary guidelines. The actual guidelines will be formulated in chapter 5.

CHAPTER 5

DEVELOPMENT OF GUIDELINES FOR PROMOTING HEALTH AND WELLBEING OF TEENAGE MOTHERS

5.1 INTRODUCTION

In Chapter 3, the discussion illustrated the findings of the study matching with the health promotion model supported by relevant literature control. Seven (7) themes from the analysis of the empirical study were identified. In Chapter 4, the synopsis of the Pender's health promotion model was discussed in conjunction with the themes and categories that emerged from the previous chapter on the empirical phase. The preliminary guidelines were formulated in Chapter 4 and will be developed in this chapter, directed by the model. The themes were matched with Pender' health promotion model which also formed the base of the development of guidelines. The chapter ended with a brief summary.

This chapter concentrates on the process of developing guidelines for professional nurses to promote the health and wellbeing of teenage mothers in Mopani District, in Limpopo, one of the provinces in South Africa. Pender's health promotion model was used in the formulation of eight guidelines. Below, the discussion will focus on the description of the modified model that emanated from Pender's health promotion model.

5.2 BRIEF DESCRIPTION OF PENDER'S MODIFIED MODEL ALIGNED WITH RESULTS

The modification of Pender's health promotion model led the researcher in the process of developing guidelines supported by a literature control that was relevant to the study. The findings of the study with the integration of the model formed the basis of the study which assisted the researcher in the formulation and the development of guidelines to promote the health and wellbeing of teenage mothers in Mopani District, Limpopo. The three major concepts of Pender's model guided the collection of information, analysis and established the findings of this study.

The first concept was individual characteristics which matched with the themes challenges of health service provision (health promotion), personal factors (personal and psychosocial factors) and lack of support for a child and need for child support grant. The second concept was behaviour-specific cognitive and affect which matched with post-natal barriers (situational influence), post-natal challenges to return to school, need for support and role demand (interpersonal influence) and perceived barriers to contraceptives. The last concept of Pender to match with the findings was behavioural outcome matched with the theme plan of action (health promoting behaviour) and information dissemination. These themes as aligned with Pender's health promotion model and the major concepts are discussed below.

The three major concepts of Pender's health promotion model are discussed fully in chapter 4. These major concepts are described individually below:

- **Individual characteristics and experiences**

The personal factor and prior related behaviours are referred to the frequency of the same behaviours or similar health behaviour that are habit forming. These behaviours can be positive or negative and are the best predictors of future behaviour with the frequency of the same or similar behaviours characteristics in the past (George 2011:458).

The researcher connected prior related behaviour to challenges experienced by registered nurses during service provision and the experiences of teenage girls before pregnancy, during pregnancy, labour and post-delivery. Personal and psychosocial factors were matched with challenges of teenage mothers to return to school, access to health services, unpreparedness for pregnancy, and HIV contact. Individual characteristics were displayed by participants who indicated that unwanted pregnancy occurred at a younger age. They had more negative experiences such as pain in labour, mental problems in the early postpartum period such as puerperal psychosis, shame and withdrawal from society. Yet, teenagers need time for transition into adulthood. One of the teenage mother participants confirmed that she relocated from the original village to another village as arranged by parents to stay with the father of her child. After two years she changed schools since she was afraid to be humiliated by other leaners and teachers if she decided to return to the original school. Parents should teach their children at an early stage – at primary school level already – about reproductive health, sexuality and sex education (Anyanwu, et al 2013:927). Teenagers may also have the ability to manage or cope with significant adversity, but may result in an increased ability to respond to future adversity (RNAO 2010:14)

The participants verbalised the Child Support Grant as helpful to those who are poor such as orphans. The child support grant is a key programme for alleviating child poverty in South

Africa and the beneficiaries are also entitled to free healthcare services and education (ISHP 2012:35). In confirmation, in South Africa there is significance reliance on the child support grant (CSG) as it is an initiative of the state social assistance programme to combat poverty and hunger. The beneficiaries are poor children under the age of 16. Usually, the grant is received by their mothers or caregivers (Kathree, et al 2014:4). Nelson (2013:70) confirms that teenage mothers receive the child support grant as a source of income. Chauke (2013:10) argues that teenage birth and motherhood is seen as a blessing to some families, because it is a proof of fertility and therefore motivates girls to give birth at an early age to receive the child grant if not financially healthy. In contrast, Thobejane (2015:275) found that child support grants contributed to a high incidence of pregnancies among teenagers.

- **Behavioural-specific and cognitive affect**

Behaviour-specific cognitions and affect refer to the anticipated positive outcomes that occur from health behaviour. These outcomes are viewed as major motivations and considered to be the core for intervention since they are the most amenable to change through nursing intervention (George 2011:548). The themes used in this study were perceived barriers to action with sub-themes related to post-natal barriers, lack of support and role demand, perceived barrier to contraceptives and barriers to return to school. Pender refers to them as situational influence and interpersonal influence, perceived benefit of action, barriers to action and perceived self-efficacy. The perceived benefit was displayed when the participants in this study (both teenage mothers and registered nurses) indicated that youth-friendly services that cater for teenagers only should be available and be adequate in all communities (Department of Health, 2010:47). They also suggest for teenagers to form their own support group in order to freely discuss issues about contraceptives and also have special suitable services for teenagers to discuss issues on their health promotion and also campaigns (NASRH&R 2015:27). This could motivate teenage mothers to attend health services without fear of being judged by adult people. Barriers to action was displayed when participants stated that teenage mothers drop out of school as a result of the attitudes of parents, peers and teachers as well as that of the community. They also feared nurses' attitudes to attend health services for antenatal care and contraceptive services (Malahlela and Chireshe 2013:140).

- **Behavioural outcome**

Health promoting behaviour refers to the behavioural end point or outcome of health decision making and preparation of action (Pender, et al 2011:4). In this study, it referred to the motivations made by pregnant teenagers and teenage mothers on ways in which they could be assisted in changing their own behaviour. Committed to plan of action was used as a

theme related to Pender's behavioural outcome. The participants in this study were motivated to assure accessible health services for teenagers and employment of young service providers for better understanding of their needs. They also pointed out that information regarding sexual health and contraceptives should be enhanced through information dissemination in a venue where both boys and girls could be together to receive information regarding reproductive health, sex education and contraceptives. Educators, parents, and the community at large should also be encouraged to teach reproductive health and sex education to their children (Cinar 2015:22). Table 2 (in Chapter 3) represents the themes, sub-themes and categories identified from the data collected from the participants as challenges, matched with Pender's concepts. The framework in Figure 5.1 is the design of how Pender's model was merged and led to the formulation and development of guidelines, the illustration is done below.

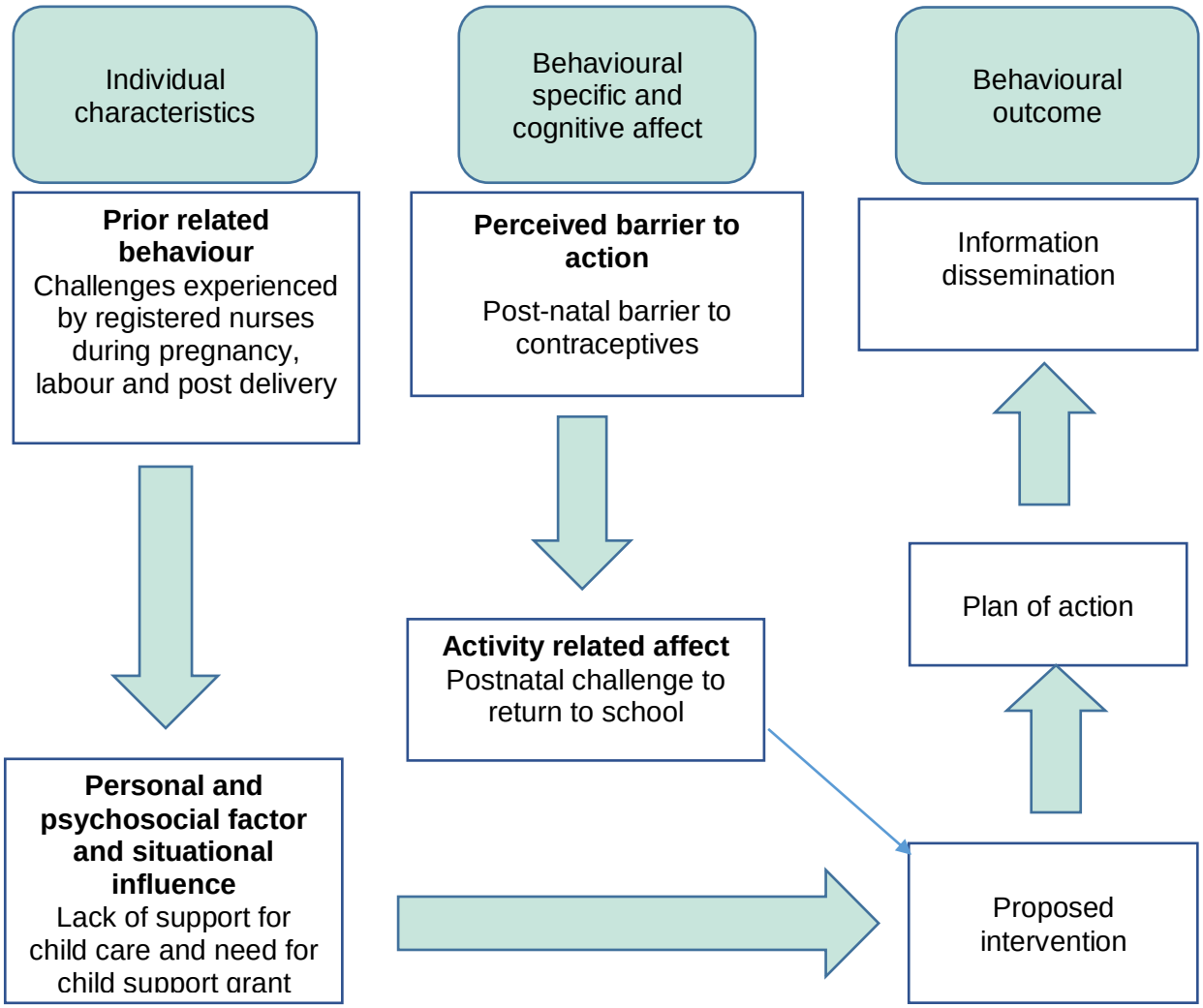

Figure 5.1: Hlongwane's model for promoting the health and wellbeing of teenage mothers, adapted from Pender's Health Promotion Model

This design was to outline the incorporation of Pender's model and the application of the concepts in service provision. The health service provision was placed in the level of the individual characteristics and experience according to Pender's model as registered nurses experience challenges during service provision to teenage mothers while teenage mothers also experience challenges during receiving the service. Challenges related to health service provision before pregnancy, during pregnancy, labour and post-natal care of teenagers were raised by the participants (registered nurses). The researcher believed that non-judgmental services by the health workers, the availability of resources including mobile clinics and the employment of younger nurses who will understand teenagers better may change the attitudes of both registered nurses and the teenagers themselves to improve the health and wellbeing of teenagers together with the involvement of the government and other stakeholders.

The challenges of teenage mothers to receive contraceptives and to return to school were placed on the level of behaviour-specific and cognitive affect which are characterised by personal factors and perceived barriers to action. The interpersonal influence and perceived self-efficacy also played a role. Regarding self-efficacy, the researcher believes the personal motivation from deep inside herself will encourage the teenage mother to return to school. This inner self-motivation and encouragement is pivotal as it will indicate to her and the world that she is ready to be a scholar and complete her studies. The researcher also deems it extremely important and necessary that teenage mothers need unconditional and loving support from parents, families, teachers and community members to encourage them to return to school.

Regarding interpersonal influence, the provision of health education to parents, families and the community as a way of empowering them with knowledge and information about the importance of supporting teenagers regarding reproductive health is of further significance. This information could be taught to their children at a younger age i.e. when still at primary school level. Obviously, the information shared at this level should be age appropriate in detail. The researcher further believes that registered nurses must develop a collaborative and friendly relationship with parents, educators and other stakeholders so that they can work together towards the promotion of teenage girls' health and also come to an agreement about the allocation of the child support grant.

Despite the fact that in this study, participants indicated that most teenagers are reluctant to use the available services. It was shown that they either do not report to the clinics or report late after circumstances. In case of pregnancy, participants reported that they only visit the clinics when problems arise such as bleeding and if found to be HIV positive, some never

return. The researcher also has confidence that the action plan will remedy the situation. The plan of action was placed on the level of behavioural outcome. This level is characterised by a plan of action for the benefit of both the healthcare providers and the teenagers. The researcher believes the registered nurses should initiate programmes in which families, communities, managers, and other stakeholders who respect human rights collaborate with social workers to disseminate information through health education among teenagers regarding their legal rights, to identify and report any form of sexual abuse to prevent and protect young teenagers becoming victims of child abuse, neglect and exploitation. In the case where a girl-child becomes pregnant, the registered nurses should provide health promotion and report her suspicions during antenatal, labour, and post-natal care.

5.3 FORMULATION OF GUIDELINES

Guidelines are “systematically developed statements that assist members of the healthcare team and their patients or clients to make appropriate decisions about a specific condition” (Robertson 2007:2). Guidelines are developed as a result of the identified disturbing detailed problem that need to be addressed by health professionals in their environment. Therefore, in the current study the guidelines were systematically developed and participants were allowed to make relevant and appropriate decision.

Mahtani (2015:2) views guidelines as systematically developed designed to help healthcare providers and patients decide on appropriate healthcare for specific circumstances. The author further indicates guidelines enable individuals with diverse backgrounds to come to an agreement about healthcare and a diversified quality framework against which such care can be measured. The author asserts guidelines can assist policymakers with informed decision making to use as a framework for assessing healthcare costs.

In this study, guidelines were systematically developed to serve as a tool to assist members of the health team in decision making regarding the promotion of the health and wellbeing of teenage mothers and their motivation to return to school after delivery of their babies in Limpopo Province. Department of Health (2006:8) describe the purpose of guidelines formulation being to “provide South Africa with clearly articulated standards of good clinical practice in research that are also relevant to local realities and contexts, and to ensure that clinical trials conducted on human participants are designed and conducted according to sound scientific and ethical standards within the framework of good clinical practice”.

Guidelines should assist in delivering the service competently. In this study, the health care providers were encouraged to provide non-judgmental, accessible services suitable for teenagers. These services must be run by young nurses for better understanding of the

former's needs. Guidelines are any document containing recommendations about health intervention, whether they are clinical, public health or policy recommendations (WHO 2012:2). According to the WHO, guidelines implies a choice between different interventions that have an impact on health and that have implications for the use of resources intended to assist providers and recipients of healthcare and other stakeholders to make inform decisions. In this study, guidelines were developed to assist all stakeholders especially registered nurses and midwives to improve the health and wellbeing of teenagers by providing services that will meet their needs. Suitable programmes specifically for teenagers will be developed involving teenage fathers to improve their health and wellbeing through information dissemination about

SIGN 50 (2011:43) states guidelines act as a tool to help health professionals to improve clinical effectiveness as well as providing an opportunity to share clinical decision making, increase team work, expand knowledge and bridge the gap between development and implementation of guidelines. In this study, the guidelines may also improve the health and wellbeing of teenagers and teenage mothers in general by sharing information among registered nurses and other stakeholders who, as a team, are directly involved with them. The guidelines developed will bridge the gap between the planning and implementation phase.

The Guidelines for Maternity Care in South Africa (2016:20) indicates that all health workers and not only midwives and obstetric doctors who care for a woman in the reproductive age group need to consider the possible effects of pregnancy on all the females they care for. The guideline supports the current study in that participants indicated that collaboration among families, parents, teachers and stakeholders who are involved with teenagers, and knowledge sharing about reproductive health and sexuality is important in order to realise the effects of teenage pregnancy. These could prevent recurrent pregnancies among teenage girls.

Mahtani (2015:2) explains guidelines assist policymakers to make decisions about useful frameworks for assessing healthcare service delivery. In this study, the guidelines will assist in informed decision in policy regarding day care centres that need to be built near schools for the purpose of teenage mothers to attend schools. Policy will also be created in relation to the reporting of any form of abuse in relation to teenage girls.

5.4 PURPOSE AND BENEFITS OF GUIDELINE DEVELOPMENT

The purpose of the guidelines was to provide Limpopo Department of Health with clearly articulated standards of good clinical practice in research that are also relevant to local

authorities and context, and to ensure that clinical trials on human participants are designed and conducted according to sound scientific and ethical standards within the framework of good clinical practice (Department of Health 2006:8).

Guidelines assist in identifying the best way of formulating intervention and noticing gaps in the information about the service (The British Psychological Society 2011:8). This society also states the guidelines increase transparency by making explicit choice and decisions to determine criteria for success. These ideas may also give contribution in South Africa if applied. In the current study, the guidelines will be transparent as the researcher made explicit choices and had an obligation to honestly report the findings.

Guidelines are addressed to investigators including ethics review committees. This provides the scientific and ethical integrity of research involving topics subjected to humans for generating valid observation and sound generation of the findings. The guidelines serve the interest of the parties actively involved in the research process. It protects the rights and safety of participants and ensures that investigations are directed at the advancement of public health objectives (DoH 2006:2). In this study, the researcher asked permission from ethics committees of the Department of Health to conduct a study in order to prevent harm and protect the participants involved. This forms the bases of scientific and ethical integrity.

In this study, the guidelines will help to improve the health outcomes familiar with the current research study. They will also affirm the role of registered nurses and reduce practice variation. The guidelines influence public and hospital policies based on gaps discovered (Fleming et al. (2015:2). In this study, the guidelines will improve the roles of registered nurses and all stakeholders involved with teenagers including those in private clinics and private hospitals prior to pregnancy, during pregnancy and post-delivery. This will improve and benefit the life of teenagers by preventing the delivery of premature babies because when reporting early at the institutions, early management will be done.

5.5 GUIDING ATTRIBUTES TO BE FOLLOWED WHEN DEVELOPING AND EVALUATING THE GUIDELINES

Guidelines are considered “essential instruments to improve the quality, appropriateness and cost-effectiveness of healthcare”. Guidelines are an authorized document which is designed to be utilised in a specific environment determined by the developer or developers. For the validity of the guidelines, other stakeholders should be involved in order to conclude their relevance and acceptability in the area of utilization. According to Fleming et al. (2015:1)

guidelines are rated by health professionals to determine their validity and relevance in the nursing practice to improve the life of the users and prevent malpractice.

In this study, the objective of Phase 2 was to develop guidelines based on the empirical phase, using Pender's revised health promotion model to promote health. The population were all experts in various health sectors. Sampling included nurse educators, registered nurses with midwifery, advanced midwives, and obstetrics that deal with mother and child health, social workers and anyone involved with teenagers in this phase (Linstone and Turoff 1975:3). This technique gathered opinions from a group of experts within their domain of expertise without meeting physically. Emails were used to collect data. A series of questionnaires were used to aggregate experts' opinions in an anonymous fashion from the responses received, thus building consensus on the guidelines for registered nurses. (Aigbavboa, 2015:8; Hsu and Sandford 2007:3). Criteria such as validity, reliability, clarity, applicability and relevance were used as a tool to evaluate the guidelines (Brouwers, et al 2013:10).

Table 5.1: Attributes used to evaluate the developed guidelines

CRITERIA	EXPLANATION
Validity	The guidelines have a strong research evidence base from participants themselves emanating from the empirical research results which will assist the healthcare professionals in making decisions about promotion of health and wellbeing of teenage mothers. In this study, validation of the instrument was done using the empirical findings of the study and validated by experts as participants where multiple consideration of the tool was done (Kuechler and Vaishnavi 2011:128). A pilot study was done prior to collection of data to check the appropriateness and quality of the instrument with the aim of testing and adjusting the Delphi questionnaire to improve comprehension and to work out any procedural problems (Polit and Beck 2012:195). The researcher selected three experts to be used as a panel to participate in the pilot study. The developed questionnaires from preliminary guidelines with the criteria were distributed to the participants. These questionnaires were distributed to the participants. After receiving participants' responses, the researcher converted the collected information into a well-structured questionnaire. This questionnaire was used as the survey instrument for the first round of data collection. The pilot study was analysed in the form of statistics regarding the promotion of health and wellbeing of teenage mothers. The purpose of the pilot study was to pre-test the questionnaires to assess whether the tool would be well understood by all participant. It was also done to judge possible flaws, validity and the time it would take to return the questionnaire. In this study, participants were expected to return in it in seven days. Further, the reason was to improve the instrument before

	involving all experts and to obtain some knowledgeable opinions. The participants were from various institutions, did not know each other and received the same tool (Browers, et al 2013:33).
Reliability	Polit and Beck (2012:741) define reliability as the "degree of consistency or dependability with which an instrument measures an attribute". The preliminary guidelines emerged from the process where seven themes were identified and integrated into Pender's health promotion model. This was supported by relevant literature which guided the researcher in the formulation and the development of guidelines. Also, the preliminary guidelines were appraised by the experts using the Delphi technique. Reliability was achieved when using the Delphi technique as an instrument to collect data. The preliminary guidelines were e-mailed to the experts in various institutions and geographically dispersed, without meeting, to critically analyse the instrument as well as the guidelines for three rounds until consensus was reached about the guidelines on the third round. All experts used the same instrument in this study to ensure its reliability. An agreement was established to discover diverse perspectives among the experts. The researcher chose the participants who have knowledge, skills, experience and expertise about the topic under study by assessing their qualifications and area of employment (Polit and Beck 2012:267; Habibi, et al 2014:10).
Clarity	Jamaloodiene (2014:21) indicates that the guideline should be easy and specific to the situation and population to which it will apply. In this study, the guidelines were considered to be clear, simple and unambiguous. An international English language was used and understood by all experts who participated. The questionnaires were clearly written in simple language and in clearly defined terms. Fourteen participants who met the criteria were selected for the study. (One dropped out during the second round; thus, a final number of 13 experts took part). The sample was obtained from experts who were communicating via emails with the researcher being the coordinator to prevent ambiguities.
Applicability	Brouwers, et al (2013:10) describe applicability as ensuring that the guidelines will be understood and utilised by all users to improve the health and wellbeing of target group during implementation. The target population of the guidelines was clearly stated in the study. The guidelines would be applied to teenage mothers by all relevant health professional groups and stakeholders and can also be implemented in another context (Robertson, (2007:30). The current population in this study was teenage mothers. Registered nurses and other health professionals should easily apply the guidelines as end-users. The guidelines were developed to improve the health and wellbeing of teenage mothers and to motivate them to return to school after delivery. The guidelines can be used in another area of the nursing field as evidence of applicability. Consensus was reached using Delphi technique in three rounds when experts were involved in the review of the statements used in the guidelines as well as its improvement (Brouwers et al 2013:38).

Relevance	The guideline is purposeful and current. The findings can be used in similar settings to improve health and wellbeing outcomes of teenagers (Pen Brooke 2015:22). The researcher in this study believed that the improvement of youth-friendly health services will benefit teenagers in general. Guidelines will help teenagers in aspects of health and wellbeing.

The term 'rigour' was not used in the instrument for the experts because it has almost a similar meaning as the term 'validity'. They both measure the quality of the data presented. Some authors argue that validity is a more appropriate term than rigour; however, in this study using 'validity' was considered suitable.

5.6 METHOD OF GUIDELINES DEVELOPMENT

5.6.1 Delphi technique as a design

The Delphi technique was used as an instrument to collect data during the process of guidelines development. Habibi, et al (2014:8) defines the Delphi technique as a "method of group knowledge acquisition which is also used for qualitative issue decision making". These authors further confirm the Delphi method is suitable for use in qualitative research, meaning that a researcher can utilise it to explore and describe a phenomenon in question and is also suitable to be used as an instrument to collect data from experts. The Delphi method was therefore used by the researcher in the current study to obtain different ideas from the experts (Habibi, et al 2014:8). The Delphi survey is further viewed as a technique for obtaining judgments from an expert panel about an issue of concern where experts are questioned individually in several rounds, with a summary for circulation between rounds to achieve some consensus (Polit and Beck 2012:725). According to De Villiers, et al (2015:639), the Delphi is a method for the collection of opinions on a particular topic, based on the premise that "pooled intelligence enhances individual judgement and captures the collective opinion of experts".

The current researcher described the Delphi technique as a method of structuring effective communication among a group of experts in the decision-making process, allowing the group as a whole to deal with themes under study. This technique was used to gather opinions on the draft guidelines from a group of experts within their domain of expertise without meeting. The technique was able to pool intelligence and convergence of opinions from the responses received thus building consensus on the guidelines for registered nurses (Ab Latif, et al 2016:89). In this study, the complex problem was associated with the challenges experienced by teenage mothers and their need to return to school. Therefore, teenage-

specific and youth-friendly guidelines needed to be developed to promote their health and wellbeing (Du Plessis and Human 2007:21).

5.6.2 Rationale for using the Delphi technique

The Delphi technique was used by the researcher in this study with the aim to present a comprehensive theoretical framework by applying this technique to provide more accurate data. The main reason for using this technique was to obtain rich information from the group of experts. The designed questionnaire was utilised to collect data from their intelligent opinions in a series of three rounds. Opinion feedback was given in each round for validation purpose (Habibi, et al 2014:8). The technique was used to improve understanding of the problem, provide possible solutions or develop forecasts. The researcher used this technique to identify and prioritise criteria for the development of guidelines as a framework of reference which was reliable, valid, clear, applicable and relevant to assess the rating of the overall quality of the guidelines and whether it would be recommended for use in practice to enhance the promotion of health and wellbeing of teenage mothers in Mopani District in the Limpopo province.

5.6.3 Objective of the design

The objective of Phase 2 was to develop guidelines based on Pender's revised health promotion model to promote the health and wellbeing of teenage mothers in rural areas and to support their return to school in the Mopani District in Limpopo.

5.6.4 Population/composition of the panel size

The population was a combination of individuals with multiple specialities and a heterogeneous group of experts in the nursing field. These individuals were working in health sectors or universities and colleges in different disciplines. They had experience in health promotion among teenage girls and teenage mothers in collaboration with social workers and other stakeholders who were directly involved with teenagers. The group of experts were geographically dispersed in various Provinces to prevent bias (Du Plessis and Human 2007:15). The researcher considered the expertise criteria to invite only experts who had knowledge, experience, and who demonstrated willingness to participate.

5.6.5 Sampling

To enhance credibility, selection of the participants was achieved through the Delphi technique. The researcher used purposive sampling to select experts from different disciplines with experience in health promotion among teenage girls and teenage mothers

without them actually meeting. The researcher chose this method as she deemed it vital for prestigious experts not to have an undue influence other members' opinion. All panel members were on equal footing. An email survey was chosen to be the mode of interaction and communication among experts. Fourteen experts agreed to participate in the formulation of these guidelines. However, one participant dropped out on the second round and never responded again. Descriptive information in table 5.2 is given below on the panel of experts.

Table 4: Descriptive information of the panel of experts

NO.	**PROFESSIONAL QUALIFICATION**	**OCCUPATION**	**INVOLVEMENT**	**EMPLOYER**	**PROFESSIONAL EXPERIENCE**
1	Doctor	Provincial Obstetrics and Gynaecological Specialist	Maternal, child and women's health	Mpumalanga Department of Health	44 years
2	Diploma in General Nursing, Midwifery, Community, Psychiatry, B Cur (Nursing Education and Management), Masters, PhD, Professor	Lecturer	Facilitates learning	University of Venda	15 years
3	Diploma in General Nursing, Midwifery, Community, Psychiatry, B Cur, M Cur and PhD	Lecturer	Manager in Nursing Education	Department of Health, Office of Nursing Education Directorate	40 years
4	Diploma in General Nursing, Midwifery, Community and Master's degree	Operational Manager	Operating theatre and women's health motivator	Tintswalo Hospital Mpumalanga	28 years
5	Diploma in General Nursing, Midwifery, Community and	Deputy Manager: Midwifery	Manages Midwifery Department	Limpopo College of Nursing (Giyani	36 years

	Advanced Midwifery, B Cur			Campus)	
6	Diploma in General Nursing, Midwifery, Community, PHC and PhD	National Manager: Ideal Clinic Realisation	Provides PHC-related issues	National Department of Health	33 years
7	Diploma in General Nursing, Midwifery, Community, PHC,B Cur and Masters	Director Public Health Programmes	Involved in Sport, Arts and Culture	Department of Health	34 years
8	Diploma in General Nursing, Midwifery, Community and Masters	Deputy Manager Community Health	Manager Community Department	Limpopo College of Nursing (Giyani Campus)	32 years
9	Diploma in General Nursing, Midwifery, Community and B Cur	Deputy Director of women, child and people with disabilities in SA	Office of Rights, Child and Status of Women	Department of Women	33 years
10	B Social Work	Social worker	Provides health and wellbeing to teenagers at SASA dealing with substance abuse teenagers	Life Recovery Centre	6 years
11	Diploma in General Nursing, Midwifery, Community and B Cur, PHC, Masters	Manager Primary Health Care	Supervises provision of health and wellbeing of individuals and mother and child health	Department of Health Vhembe District	6 years
12	Diploma in General Nursing, Community, Psychiatry and Midwifery, BA in	General nurse	Provides healthcare	Evuxakeni Mental Hospital	8 years

	Environmental Management				
13	Diploma in General Nursing, Community and Midwifery	Nursing lecturer	Facilitates learning	Department of Health Mpumalanga	33 years
14	General Nursing, Midwifery, Psychiatry, Doctorate	Psychiatric nursing	Lecturer Counselling	University of Pretoria	25 years

5.6.6 Data collection and data analysis

The researcher drafted a set of guidelines based on the findings of the empirical data collected in Phase 1 of the study. In this Phase 2, questionnaires with guiding criteria were used to collect data from the panel of experts who were involved in the rounds to generate their opinions until consensus was reached.

Data collection instrument

Delphi technique was used as an instrument to collect data. Data was collected by making use of a four-point Likert scale which was inked with the criteria used. circulated via emails to every individual expert. The purpose was to identify the nature and fundamental elements of a phenomenon as a basis for the study. The four-point Likert scale (1 “Strongly agree”; 2 “Agree”; 3 “Disagree”; and 4 “Strongly disagree”) was used to rate the quality of the guidelines by the experts using the criteria for validity, reliability, clarity, applicability and relevancy. The Likert scale was used to measure attitudes involving the summation of scores on a set of items that respondents rated for their degree of agreement or disagreement by the experts (Polit and Beck 2012:346). Each statement was rated by the level of agreement of the experts as indicated.

Pilot study

Before the main data collection, piloting was conducted in this study with the goals of testing and adjusting the Delphi questionnaire to improve comprehension and to work out any procedural problems (Skulmoski, Hartman and Krahn 2007:4). The additional purpose of the pilot study was to pre-test the questionnaires to assess whether the tool would be well understood by all participants. Furthermore, to test the reliability and validity of the questionnaire, improve where necessary before involving experts to obtain their

knowledgeable opinions. Hsu and Sandford (2007:2) point out three reiterations are often sufficient to collect the needed information. Consensus is usually reached within three rounds.

Data collection

The researcher invited experts from various health sectors and provinces via SMS indicating that those interested should provide their email addresses for further communication. The title was also provided so the participants could choose to participate properly and willingly. The questionnaires were e-mailed to the expert panel members for exploration by those who responded to the SMS. The outcome of the questionnaires seemed to be understood by the participants who gave inputs through their comments to the guidelines based on the criteria. The three experts who participated in the pilot study were not included in the actual study. Feedback was received from the pilot experts and the researcher commended on their participation. The researcher analysed and consolidated the comments and then refined the questionnaire for Round 1.

ROUND 1

During first round, the researcher e-mailed 20 invitations indicating the title, objectives of the study, summary of the findings, deadlines, conditions of participation and informed consent leaflets**.** The participants were requested to respond within seven days (one week). During the first round, the experts (participants) were given the structured questionnaire with preliminary guidelines using a 4-point Likert scale where 1 signified “Strongly disagree”; 2 signified “Disagree”; 3 signified “Agree”; and 4 signified “Strongly agree” (Habibi, et al 2014:11). The participants were expected to explore and rate the categorised responses, providing comments regarding the structured preliminary guidelines and the criteria used. This stage was very important to me as I had no idea what the outcome will be. The participants were clarified about their responsibilities and that the development of the guidelines would constitute a process of three rounds in order to gain their cooperation. During the first round, only fourteen out of 20 participants assessed, responded and critically reviewed the guidelines as well as the criterions and gave inputs regarding the guidelines. The participants then submitted their comments to the researcher.

Analysis

The preliminary guidelines from the experts were analysed, consolidated, rated and refined for the second round. The suggestions were sought out and modifications were made by the researcher by comparing statements and categorising them according to their similarities.

The modified structured questionnaires were used for the second round of Delphi technique (Hsu and Sandford 2007.)

ROUND 2

Data collection

The participants were acknowledged and the inputs and feedback were given to participants about their findings. The modified questionnaires were e-mailed for the second round for data collection and to be returned to the researcher for analysis. During this round, all participants received a refined Delphi questionnaire and were asked to review again the items summarised by the researcher based on the information provided in the first round. The participants were again requested to return the questionnaire within seven days. The participants rated and commented on the items of the questionnaires to refine preliminary priorities and returned them to the researcher. Some participants returned the questionnaire within seven days, but some delayed. During this round, out of 14 sent questionnaires only 13 participants returned the questionnaires. Thirteen comments were received by the researcher and one did not respond. The researcher waited longer with no response. Then proceeded with analysis.

Analysis

The researcher again organise the received questionnaires who rated, analysed, refined and consolidated the guideline as well as the criterions. The suggestions were sought out and modifications were made by the researcher. As a result of this round, areas of disagreement were becoming fewer and agreement were more. In some cases, the experts were starting the rationale concerning rating priorities among items in their responses. In this round, consensus began to be observable when most participants rated 3 and 4. During the second round, the questionnaire was exposed to further modification based on the inputs provided by experts as well as actual understanding of the researcher. The guidelines were refined and consolidated to prepare it for the third round.

ROUND 3

The participants were appropriately acknowledged for their participation. The feedback was distributed to the participants via e-mails. Thirteen questionnaires were again circulated to the 13 participants for the third round. During the third round, each Delphi panellist received a questionnaire that included the items and ratings summarised by the researcher in the previous rounds. The participants were further requested to return the questionnaires within

seven days. The third round gave Delphi panellists an opportunity to make further clarifications of both the information and their judgments of the relative importance of the items. All participants returned the questionnaires on time.

Analysis

The participants strongly agreed on the items according to set criteria that were on the Likert scale. The panel was made aware on the third round that, it was their last opportunity to provide their contributions. The researcher analysed the final round and consolidated the findings. The comments were found to be similar to the guidelines; meaning all participants had the same opinions regarding the guidelines and their individual ratings indicated either “Agree” or ”Strongly agree”. This became the final round since opinions were no longer needed. A final decision was made and consensus had been reached. Acknowledgement and feedback were provided to the expert panel members. They were also informed that all inputs were useful and those which did not appear in the guidelines were used in the application.

5.7 DEVELOPED GUIDELINES

Name of Guideline

Promoting the health and wellbeing of teenage mothers in Mopani District, Limpopo was the basis of the guidelines developed and formulated by the researcher. The participants (experts) also contributed to the final formulation of these guidelines. The guidelines were refined during the session of three rounds where inputs were given by the expert participants anonymously until a consensus was reached.

5.7.1 Aims of the guidelines

The guidelines were developed to:

- promote the health and wellbeing of teenage mothers by registered nurses
- act as a tool to provide services specifically for teenagers
- assist the Department of Health in the improvement of mother and child health to integrate the guidelines including services specifically for teenagers.

5.7.2 Scope of the guidelines

SIGN 50 (2011:1) states the target users of guidelines should be clearly stated and piloted among users. The guidelines of this study will be used by registered nurses and other stakeholders as providers of healthcare. The RNAO (2010:4) indicates guidelines are intended for nurses who are not necessarily experts in practice areas and who work in a variety of practice setting across a range of care in schools, communities, hospitals and clinics specifically with teenagers.

5.7.3 Description of the guidelines

Eight (8) guidelines were developed by the researcher and justified. In this section, the guidelines are discussed one by one indicating the guideline, rationale and application.

GUIDEINE 1 REGISTERED NURSES TO GIVE HEALTH EDUCATION TO TEENAGE MOTHERS ON INCREASING CONTROL OVER AND IMPROVE THEIR OWN HEALTH AND WELLBEING DURING ANTENATAL, LABOUR AND POST-NATAL CARE

Rationale

Health education in this study was based on health promotion assumptions of a range of activities to enable people to take greater control over their health (Wills and Jackson 2014:19). The assumptions sought renewal and transformation of educational practices in healthcare domains directed at individuals, families and communities. These changes may occur when health education is understood as a factor for promoting and protecting the health of individuals. Viero, et al (2015:485) observe heath education can be achieved by empowering teenagers to change their unhealthy behaviours. It was envisaged that the guidelines would yield a positive change of attitude when implemented to all teenage mothers. Girls end up with an unplanned pregnancy because teenagers have absolute insufficient and wrong knowledge regarding pregnancies and contraceptives.

Guidance from parents, families and the community at large regarding the use of contraceptives was non-existent because talking about, mentioning or referring to sexuality or any topic related to sexual and reproductive health (SRH) is a taboo in the area (Rangiah 2012:48). From about the onset of puberty – or even from a younger age – children and young teenagers receive either no information or misinformation from parents, church and community leaders, teachers and adults in general about SRH. An example is the warning that using any form of contraception is dangerous because it will make a female barren and

she will therefore never have children (Thobejane 2015:274). This is a powerful deterrent to contraception because in some African cultures, not to have children is an inconceivable idea. However, this guideline does not address this issue. Its purpose is for registered nurses to enhance the life skills of teenagers by providing them with truthful and accurate information to postpone motherhood until they are old enough (i.e. their physical development, emotional strength and financial wellbeing) to properly take care of babies.

By empowering them with knowledge and the know-how they can exercise control over themselves and their environment and make choices conducive to their health as well as the infant's health during the antenatal, labour and post-natal periods. By strengthening their resolve to take care of themselves as pregnant girls and as teenage mothers with babies will help them to cope with the emotional and physical personal stress as well as the strain and insults they have to endure in schools, homes, and community settings not only during an unplanned pregnancy but in all stages of their lives (McQueen and de Salazar 2011:195). The knowledge and information young teenage girls receive from registered nurses during the antenatal care, labour and post-natal care through health education may transform teenage mothers' perceptions on how they can change their lifestyle and make decisive decisions to ensure their health and wellbeing as well as that of their infant and possible future children.

Application

Nurses and other healthcare providers should apply Guideline 1 as set out below.

- Provide workshops to equip teenage mothers with knowledge and skills about pregnancy, labour, childbirth, and baby care to prevent complications during delivery and post-natal care for the improvement of their own health.

- Enhancing life skills which allow teenagers to exercise control over their environment and to make choices conducive to their health. It will teach them to cope with stress caused by victimisation, ostracism and angry behaviours and attitudes in schools, homes, and community settings.

- Counsel teenagers correctly and truthfully about abstinence, the use condoms and some other forms of contraceptives.

- Conduct peer group training together with youth development programmes to prevent unwanted pregnancies and sexual transmitted infections.

- Initiate and implement educating teenage boys and girls together on reproductive health, sexuality and the use of contraceptives so that they have the same understanding about SRH. At the same time, promote mutual respect for gender differences and a better understanding of how to accommodate each other's wants and needs in a 'friendship' way.

- Promote family planning (contraceptives) and focus specifically on providing age-related and youth-friendly SRH education at primary schools. Young girls may start experiencing their menstrual cycles at 10 years old. They may be shocked, scared or misinformed by peers about menarche and it is important for them that a kind and knowledgeable adult, namely a registered nurse, explain and educate them correctly.

GUIDELINE 2
REGISTERED NURSES TO GIVE HEALTH EDUCATION TO PARENTS, FAMILIES, CHURCHES, COMMUNITY LEADERS AND COMMUNITIES ABOUT PROVIDING SUPPORT REGARDING REPRODUCTIVE HEALTH INCLUDING SEXUALITY TO ALL TEENAGERS AT AN EARLY STAGE OF DEVELOPMENT AT PRIMARY LEVEL

Rationale

Promoting health entails giving attention to integral development, paying attention to the quality of interpersonal relationships and access to healthcare services, access to information through formal professional education and doing leisure activities to promote healthy lifestyles (Guedes, et al 2009:774). In this study, the community at large regarding sexuality and the use of contraceptives because speaking or sharing such information was not culturally allowed. Since teenagers (particularly girls) were instructed to abstain from sexual practices, they were labelled as 'prostitutes' when it was discovered they were pregnant. As a result, they lacked self-esteem, self-worth, and self-respect and wanted to hide from the world. They felt isolated, alone and had no motivation to continue with school, look after their health or appear in public places. But, the tragedy of maternal mortality, stillbirth and premature births cannot be ignored and neither can the fact that for many of these young pregnant girls this is what awaits them simply because they were not informed, told or warned by community and church groups as well as parents – particularly the mothers – that having sex is not a game. In other words, from the start of adolescence many young girls are left in the lurch about risky behaviours; peer pressure or sexual abusive practices in the home and/or community cause innocent girls to become innocent mothers.

Health education must be provided to parents, families, church and community leaders and groups, school-going children as well as teachers and communities regarding reproductive health, sex education and the use of contraceptives in order to minimise the risk of unwanted pregnancy and school drop-out. Although confirmed by Rangiah (2012:48) that most families admit they find it difficult to talk openly or to discuss anything sexually related with their children, “teenage pregnancy is a health issue that has an effect on all of us” (Akella and Jordan 2015:41).

Empowering parents to have insight into the dilemma their teenage children have with SRH, teaching them that SRH programmes do not promote promiscuous lifestyles and, importantly, involving them in health education on their teenage children’s health and wellbeing will make them be part of the country’s future development agenda to address “the triple challenge of poverty, unemployment and inequality” and improve the quality of life for all South Africans (MDG Country Report 2013:18, 22).

Application

Nurses and other healthcare providers have to apply this guideline in the following ways:

- Develop implementation plans in collaboration with chiefs, indunas, educators and families in making their children aware of the dangers of teenage pregnancies at a young age.
- Make them acutely aware of sexual abuse at an early stage in their life.
- Facilitate accessible youth-friendly services in order to teach teenagers about the choices and correct use of contraceptives including implants which takes three years being in situ.
- Encourage parents and relatives to support teenagers during pregnancy, labour and post-delivery.
- Reinforce knowledge and support to parents, schools, and communities through campaigns about prevention of pregnancies to improve the promotion of health and wellbeing of teenagers.
- Encourage parents and relatives to communicate and orientate teenagers about sex education and pregnancy at an earlier developmental stage of life, namely at primary school level.

- Enlighten the community about social change to understand the term ‘taboo’.
- Encourage parents and relatives to remain with the babies at home while teenage mothers attend school

GUIDELINE 3

REGISTERED NURSES TO PROVIDE 24-HOUR CONTRACEPTIVE SERVICES WHICH ARE EASILY ACCESSIBLE TO TEENAGERS IN A NON-JUDGMENTAL MANNER

Rationale

Teenagers remain one of the biggest challenges for family planning service while sexual activity can start early – sometimes as young as 10–12 years of age – and often unknown to the parents (Macdonald, et al 2012:336). The Department of Health (2010:5) confirms that poor access to health services for advice and support of teenagers occur as a result of teenagers’ fear of the staff’s attitudes. This situation is unfavourable and contributes to teenage pregnancies. James, Rall and Strümpher (2012:7) argue that in a non-judgmental and stress-free clinic environment the possibility that pregnant teenagers will willingly make use of the SRH services is much more viable. According to Mnyanda (2013:17), services rendered at clinics which are not youth-friendly and where staff members are accused of being judgmental and cruel will not succeed in delivering health education to teenagers. Long lines and clinic hours are not flexible enough to accommodate teenagers’ times and needs.

Attending school prevents teenagers from managing to arrive at the clinic in the times they are currently open and consequently they arrive late in which case nurses request them to return the next day or at some other time when the clinic is open. The teenagers’ needs are therefore not met. The National Contraception Policy Guidelines (2012:16) states clinics opening hours, waiting times at clinics and concerns regarding confidentiality make the environment unfavourable for teenagers resulting in failure to make use of the healthcare services. In this study, participants indicated that the times allocated for the provision of contraceptives to teenagers were unacceptable and not conducive to pregnancy prevention because by the time they had left school and arrived at the clinic, it had already closed for the day.

They also stated services are not youth-friendly and they feared the staff’s attitudes to access health services. Therefore, free, non-judgmental and accessible services for

teenagers should be provided by nurses and other health providers to prevent recurrent pregnancies. A significant improvement in the attitude of healthcare providers towards teenagers who want to practise safe sex and make use of the SRH is essential since being youth-friendly is the cornerstone to improve positive change in the attitude of teenagers in all villages in Limpopo towards the health promotion services offered.

Application

Nurses and other healthcare providers need to apply this guideline in the way described below.

- Initiate mobile clinic to remain at the visiting point until teenagers are out of school in the afternoon and they are able to access the health services.
- Create a clinic environment that is non-judgmental, where confidentiality is maintained and teenagers do not feel stressed or guilty.
- Initiate motivations to the government to be flexible regarding the times open for teenagers to obtain contraceptives.
- Advertise the service in local news letters.
- Motivate the employment of more staff to render teenage services.
- Change and improve the attitudes of staff towards pregnant teenagers and those coming for contraceptives.
- Motivate for the budget from the Department of Health for adequate resources, education, training and skill development for teenagers.
- Design sessions for education and continuous support to teenagers.

GUIDELINE 4
REGISTERED NURSES TO ASSIST, SUPPORT AND ENCOURAGE TEENAGE MOTHERS TO RETURN TO SCHOOL POST-DELIVERY.

Rationale

Pregnancy and motherhood do not necessarily need to end the teenager's school-going years. Shefer and Bhana (2012:139) cite when teenage mothers return to school, their

performance is often affected from doing well academically to becoming average because of having to balance motherhood and attending school. Willan (2013:39) indicates the teenage mothers who have support from their mothers are most likely to return to and remain in school. The National Framework Strategy (2015:33) highlights the exercise of personal choice to build a supportive network through active involvement of the family to promote contraceptive use and enhance return to school. Malahlela and Chireshe (2013:140) found gaps exist in teenage mothers' knowledge about the use of contraceptives. They subsequently become pregnant, thus hindering their educational progress. Participants in this study also indicated that forced marriage as well as discrimination at school by teachers and peers made them leave and not return to school.

They further voiced the problem of role demands; being a mother, doing chores in the home, looking after their infant and attending class and then completing their homework were too much to handle and they therefore decided not to return to school. Youth-friendly health professionals are the key role players to encourage teenage mothers to return to school. Because they see these young mothers and their babies on a regular basis for health provision (i.e. post-natal care, immunisations and SRH), they are in an ideal position to explain to the young mothers that their situation is not unique and would not last for ever. Health professionals should encourage return to school; they should inspire girls to look after their health to become strong emotionally and physically and to initiate plans that would help them to continue with their education. In other words, they should affirm the fact that motherhood does not erase a girl's future, it merely prolongs it a bit.

Application

Nurses and other healthcare providers have to apply this guideline in the following way.

- Involve family members of teenage mothers for continuity of care and support at home, e.g., by looking after their babies, as part of encouraging mothers to return to school in preparation for their future.
- Inform parents, families and communities about South Africa's education policy that allows pregnant teenagers to remain in school and to return to school post-delivery.
- Conduct an action plan together with the government and community to erect a communal centre, similar to a crèche, so that teenage mothers leave their children there when attending school. It should be a free service delivery initiative for the mothers since they already struggle financially.

- Provide assistance to teenage mothers to apply for the Child Support Grant in collaboration with social workers; assist and support local crèches for children while teenage mothers attend school; motivate for funds from the government for salaries of the child minders.

- Assist teenage mothers to make decisions about their education and future.

GUIDELINE 5
REGISTERED NURSES TO INITIATE COLLABORATION WITH PARENTS, EDUCATORS, CHURCHES AND COMMUNITY LEADERS AND GROUPS AND ALL RELEVANT STAKEHOLDERS IN RURAL VILLAGES TO PROVIDE COMPREHENSIVE SUPPORT IN THE PROMOTION OF THE HEALTH AND WELLBEING OF ALL TEENAGERS.

Rationale

The NASRHRFS (2015:34) recommends for the family and community to be considered as key stakeholders in the intervention programmes related to teenage health and education. In support, Engebretsen (2012:2) suggest that investments in teenagers could reduce early child bearing while increasing their productive capacity, thereby benefitting them, their families and communities, and the greater economy and society. Pricilah, et al. (2014:138) state a concerted effort to improve adult education is paramount.

Therefore, the community, families and parents should be encouraged to forgive and reconcile with their daughters, allow and encourage them to complete their schooling while the parents/families take care of their babies. Rangiah (2012:51) notes there is insufficient communication about sex in the home environment between parents and their teenage children and this needs to be improved. According to Taylor, et al (2014:856), the lack of youth-friendly services in South Africa reduces teenagers' access to contraceptives resulting in teenage pregnancy. Taylor, et al. (2014) also put emphasis on community initiatives. The authors state collaboration is required to involve all different stakeholders in encouraging teenagers to return to school. This can be done by making sure the available services for the promotion of contraception use is youth-orientated.

Application

Nurses and other healthcare providers need to apply this guideline in the way described below.

- Organise outreach at villages involving all stakeholders, social workers, educators and non-governmental organisations (NGOs).
- Motivate pastors and church leaders to have programmes in church informing teenagers about the importance of keeping one's virginity by abstaining or, alternatively, to practise safe sex.
- Empower parents, church and community leaders and groups, educators and communities with knowledge and skills in collaboration with stakeholders involved with teenagers to disseminate information and support the teenagers about their health and wellbeing.
- Conduct community awareness campaigns involving teenagers to inform other teenagers about contraceptives and reproductive health.
- Empower school teachers with knowledge and skills about reproductive health and sex education in order to disseminate information to the school children.
- Collaborate with pastors and church leaders, teachers, the school governing body and parents to work together in a youth-friendly manner by respecting the sexual and reproductive rights of young people in a non-judgmental and accessible manner.

GUIDELINE 6
THE REGISTERED NURSES TO DEVELOP AN ACTION PLAN IN COLLABORATION WITH OTHER DEPARTMENTS IN EXPANDING FRIENDLY HEALTH SERVICES FOR TEENAGERS.

Rationale

The participants suggested youth-friendly health services for both girls and boys which will be supervised by some young registered nurses who understand the teenagers' challenges and needs. Training teachers regarding sex education, reproductive health and contraceptives. Thobejane (2015:276) advises for workshops to be conducted for teenagers by the Department of Education to initiate teacher training programmes which will assist teachers in changing their prejudices against pregnant teenage girls. Life Orientation is not taken seriously as a subject in schools because if it was taught properly, it could prevent or even stop teenage pregnancy (Molapo 2012:106).

This author also supports the issue of eliminating being judgmental towards pregnant learners at school. Glanz (2011:8) views health behaviour to be acquired at an interpersonal

level where individuals exist within the environment. In that environment, people's thoughts, advice, examples, assistance and emotional support will affect their own feelings and behaviour resulting in improved health. Glanz (2011) thus supports the idea for the Department of Education to become involved in initiating teacher training programmes which will assist teachers to address and get rid of their prejudices against pregnant teenagers (Gyan 2013:59). Therefore, an action plan to initiate some programmes regarding youth-friendly services and campaigns is required in collaboration with other health and educational departments.

Application

Nurses and other healthcare providers have to apply this guideline in the following way.

- Adopt a multidisciplinary approach to achieve better outcome regarding the health and wellbeing of teenagers.
- Collaborate with the Department of Education to develop teacher training programmes which inform teachers about how to present sex education and contraceptives skills lessons in order to eliminate the occurrence of pregnancies. These training programmes need to also address teachers' prejudicial approaches towards pregnant teenagers. They should be trained on how to rise above such attitudes and feelings to concentrate on teaching and educating learners. Teachers cannot and should not apply victimisation, methods of belittling pregnant girls or mothers and judge them. They need to act as adults and support and educate all learners equally.
- Collaborate with clinic committees to create a user-friendly environment for teenagers alone where they feel safe and free to communicate about sex education and contraceptives assisted by young nurses who understand how teenagers think and behave.
- Motivate in collaboration with the non-governmental organisations and community committees to build crèches for children near the school to relieve teenager's role demand.
- Strengthen youth-friendly services in collaboration with other stakeholders in all healthcare facilities.
- Engage teenagers in collaboration with other departments to be actively involved and contribute to the decisions made that affect their life.

GUIDELINE 7
REGISTERED NURSES TO ENHANCE KNOWLEDGE AND SKILLS ON THE USE OF CONTRACEPTIVES FOR BOTH TEENAGE BOYS AND GIRLS THROUGH INFORMATION DISSEMINATION IN ALL VILLAGES.

Rationale

The National Department of Health (2010:19) states the majority of teenagers do have knowledge and skills about the use of contraceptives. Mothiba and Maputle (2012:2) found the reasons for teenagers pretending they are 'ignorant' about how to avoid pregnancy (in the sense that they ignore information they receive or are neglectful) are that teenagers actually want to be pregnant (or impregnate a girl) because their peers are doing it – and peer influence in adolescence is extremely powerful. Teenagers coerce their peers to participate in unwanted sex with the promise that they will get the approval of specific individuals or the group (Akintola, Ngubane and Makhaba 2011:144). Mnyanda (2013:17) found that most teenagers who knew about contraceptives perceived them as bad. Some believe it makes a person wet or gain weight. In this study, it was clear that some teenagers did know about contraceptives, but they were ignorant thinking it would make them 'barren' and they were also scared about the side effects they heard about from peers. Having correct knowledge and proper education about SRH and contraceptive use would assist in the reduction of recurring pregnancies among teenagers. Therefore, information dissemination regarding contraceptives is required through formal and informal education, e.g., during sports activities (Masemola-Yende and Mataboge 2015:8).

Application

Nurses and other healthcare providers need to apply this guideline in the way described below.

- Encourage parents to teach life skills at home regarding sexuality and use of contraceptives from childhood to both boys and girls to prevent unwanted pregnancies.
- Initiate the re-establishment of youth development programmes such as love life to keep teenagers off the streets. Involve both girls and boys in the same venue. If taught together about contraceptives, respecting each other's differences and understanding each other's problems would enhance teenagers' appreciation of gender-differences and possibly reduce risk-taking sexual behaviours.

- Initiate peer group training on contraceptives, HIV, and facts of life. The groups can meet on a particular day of the week. Talking about sexual and reproductive issues and hearing each other's stories, views and perceptions can help to prevent further unwanted pregnancies and promote the health of both genders.
- Conduct community awareness campaigns involving teenagers to enhance knowledge and skills regarding contraceptives to empower other teenagers.
- Encourage teenagers to have a voice in the programmes and activities affecting their own health and wellbeing and to contribute ideas for improvement.

GUIDELINE 8

REGISTERED NURSES IN COLLABORATION WITH EDUCATORS, SOCIAL WORKERS AND NURSING MANAGERS SHOULD INITIATE PROGRAMMES TO DISSEMINATE INFORMATION TO PARENTS, FAMILIES, COMMUNITIES AND RELEVANT STAKEHOLDERS REGARDING THE LEGAL RIGHTS OF TEENAGERS IN REPORTING SEXUAL ABUSE, CHILD ABUSE, NEGLECT AND EXPLOITATION.

Rationale

Teenage girls are vulnerable to sexual violence and abuse therefore there is a critical need for nurses and other healthcare workers to identify and counsel them (Jamieson, Mathews and Berry 2014:3). On Provincial Health Research Day (2012:44) it was indicated that poverty exposes teenagers to be abused; often by relatives such as stepfathers and uncles. Teenagers should be empowered to break the silence and voice their experiences of abuse. Thobejane (2015:273) further asserts poverty may increase opportunities for the perpetrators to sexually abuse teenagers and children due to unequal power relations, especially if the male is the breadwinner. Despite the existing of Adolescent and Youth Health and Rural School Policy that put emphasis on ensuring education for all leaners and quality one, abuse still takes place. The Children's Act (38 of 2005) makes provision for the mandatory of reporting all suspected forms of child abuse, neglect and exploitation (ISHP 2012:3)

However, teenagers are not conversant with their legal rights of reporting sexual exploitation abuse, child abuse and neglect. It is therefore essential to empower them with the relevant and available legal information and to make sure they can and do report such abuse to the authorities.

Application

Nurses and other healthcare providers have to apply this guideline in the following way.

- Collaborate with social workers to advocate for the prevention of sexual abuse and exploitation by elderly men who take advantage of abusing teenagers by enticing them with money and expensive gifts.
- Empower the community with knowledge of open communication with their children about sex at an early age for the prevention of sexual abuse.
- Disseminate information in collaboration with non-governmental organisations (NGOs) and community health workers regarding legal rights of teenagers and reporting abuse during home visits.
- Strengthen child support grant for the orphans and teenage households to prevent abuse and provide these households with an income.
- Initiate comprehensive programmes to facilitate implementation of the Children's Act (38 of 2005) which makes provision for the mandatory reporting of all suspected forms of child abuse, neglect and exploitation.

5.8 TRUSTWORTHINESS IN GUIDELINE DEVELOPMENT

Polit and Beck (2012:745) define trustworthiness as the degree of confidence qualitative researchers have in their data and is assessed by the criteria of credibility, transferability, dependability, confirmability and authenticity. In Phase 1, the researcher ensured honesty and reliability by the collection of rich data which was analysed, synthesised and supported by verbatim evidence and literature control. The process of preliminary guidelines was informed by empirical research findings. During Phase 2, trustworthiness was ensured through assuring the validity and reliability of the questionnaire. Credibility was enhanced by purposive sampling, using Delphi techniques and involving a group of experts who contributed to the development of the guidelines. The researcher chose the experts anonymously. She did not meet them personally and neither did they know each other or introduced to each other.

Anonymity and confidentiality were thus guaranteed. The combined expertise and knowledge of the diverse members of the panel and the painstaking process of refining the final guidelines assured validity (De Villiers, et al 2015:639). The researcher chose the experts

based on their knowledge, skills and their experience. The final guidelines will be reviewed externally to further augment validity.

5.9 DISSEMINATION AND IMPLEMENTATION OF THE GUIDELINES

"Dissemination involves making guidelines accessible, advertising their availability and distributing them widely" (WHO 2012:51). The researcher will share the developed guidelines with the nursing service manager in the Limpopo District office, the management of the college in order to fit the guidelines into the curriculum and also with colleagues in nursing education. The guidelines will be submitted to the South African National Department of Health for approval, review and implementation. Piloting of the guidelines will be done before they are implemented. Some information will be disseminated in the form of publication in various nursing and scientific journals. With the approval of the University of Pretoria, the guidelines will be disseminated at national and international conferences as and when approval has been confirmed

5.10 GUIDELINES REVIEWS AND UPDATES

Full guidelines provide a complete coverage of a health topic and are expected to include recommendations in relation to all aspects of the topic. Review every two to three years is recommended (WHO 2012:5). In this study, the review is a living publication, continually revised to reflect future developments intended to be published as it was reviewed externally. This review was done to ensure clarity, validity and applicability. The guidelines of this study were validated by the experts who had the experience of developing guidelines. The review will be done on regular basis to ensure that they reflect current decisions that affect the service in three to five years depending on what is required and funded by the South African Government.

5.11 CONCLUSION

In this study, guidelines were developed by the researcher. These guidelines were validated by the experts who participated in the study. It started as some preliminary guidelines. The participants were involved using the Delphi technique. Consensus was reached in the third round of the Delphi. The experts' inputs and criticism assisted in refining the guidelines. The information contributed by the participants was used in both the guidelines and its application. The time for guideline review was also stipulated.

CHAPTER 6

REVIEW OF THE FINDINGS, VALIDATION AND DESCRIPTION OF THE GUIDELINES WITH APPLICABLE RECOMMENDATIONS, LIMITATIONS, IMPLICATIONS AND CONCLUSIONS

6.1 INTRODUCTION

The goal of Chapter 1 was to provide an overview and rationale for the research methodology applied in the study. In Chapter 2, the research design and methodology were described in detailed. A qualitative, explorative and descriptive design was used. In Chapter 3, the empirical research findings were presented, discussed and justified with literature. The findings were presented as the description of challenges experienced by registered nurses regarding the promotion of the health and wellbeing of teenage mothers. Also included was a description of barriers experienced by teenage mothers to return to school after delivery of their babies at Mopani District in Limpopo Province.

In Chapter 4, the discussion focused on the findings of the empirical study, matched with Pender's health promotion model, and supported by relevant literature control. Seven (7) themes from the analysis of the empirical study were identified and described. These themes were harmonized with Pender's health promotion model which also formed the basis of the development of the guidelines. Chapter 5 concentrated on the process of developing guidelines for promoting the health and wellbeing of teenage mothers in Mopani District, Greater Giyani Municipality in Limpopo province. This chapter focuses on the review of the findings, validation of the guidelines together with recommendations and limitations. Implications of the guidelines are discussed and conclusions are described.

6.2 SUMMARY OF THE STUDY FINDINGS

PHASE 1

The first summary pertains to the findings of the empirical phase, Phase 1. The two research objectives of Phase 1 are given followed by a summary of the findings of Phase 1.

The aim of the study was to develop guidelines to promote the health and wellbeing of teenage mothers in rural villages of Mopani District in Limpopo.

6.2.1 Research objectives of Phase 1

- Explore and describe the challenges experienced by registered nurses regarding the promotion of the health and wellbeing of teenage mothers.
- Explore and describe the barriers experienced by teenage mothers to return to school after delivery of the baby.

6.2.2 Summary of the findings of Phase 1

The following themes emerged from the findings of the analysed data collected in Phase 1 which assisted the researcher in the development of the preliminary guidelines. The first themes presented are summaries of the findings from the registered nurses followed by summaries of the findings from the teenage mothers.

6.2.3 Themes from the registered nurses

6.2.3.1 Theme: 1 Challenges regarding healthcare service provision

Registered nurses are expected to provide health promotion according to the scope of practice of the South African Nursing Council. However, in this study they indicated that they experienced a range of challenges during the provision of healthcare. The participants in this study (registered nurses) stated that most of the teenage mothers were found not to be prepared for pregnancy either physically or psychologically. The participants indicated that they noticed that children as young as 11 years were falling pregnant even before starting menstruation. These pregnancies were not at will and they did not make decisions in that regard.

The main challenge reported was that, some teenagers were forced to have sex by their relatives (uncles) or unknown men, who raped or sexually abused and exploited them, which resulted in unwanted teenage pregnancy. Some were not even aware that they were

pregnant due to lack of knowledge and were waiting to see their first menstruation as advised by friends and peers. Their human rights are violated, even though they are protected by the Constitution of South Africa and various other statutes. The pathetic issue is that these cases are not reported as required by the relevant legislation, due to threats they receive. Some are promised to be killed or to have their family members killed. This resulted in silencing the teenager from sharing the problem or reporting the issues to their parents. Since the teenagers are rarely visiting the clinics, most of the cases went unnoticed by the nurses.

The participants also indicated that teenage mothers were under the age of 16, meaning that they are under age and do not qualify to possess identity documents. This implied that they were not able to receive a Child Support Grant to care for their babies. Due to this problem, some of them registered their babies for grants through their parents or care takers. Those who received Child Support Grant used the money for their own needs and not for their babies.

The participants further indicated that teenagers were poorly accessing the clinics for the services offered and reported only during their late pregnancy. The teenagers were confused not knowing whether they were adults or children, because of becoming mothers at an early stage of their development. They still needed to play with their peers and many ended up isolating themselves. The participants confirmed that pregnant teenagers lacked knowledge regarding preparation for birth, breastfeeding, bonding and taking care of their babies.

The participants stated that younger teenage mothers were afraid to handle their own babies after delivery and it was observed that, when their babies cried, they also cried. Some new mothers even refused to accept the babies as their own and thus rejected them while others developed puerperal psychosis and depression. Many young mothers ended up giving birth through a Caesarean section due to difficult labour because of their age.

The participants confirmed that the young mothers were unable to ensure follow-up visits to the healthcare centre. When health education was given to the clients who came to the clinic, it was found that most of the pregnant teenagers were not availing themselves for follow-up visits and for acquiring the health education they needed.

6.2.3.2 Theme 2: Challenges of teenage mothers to utilise healthcare services

Unsatisfactory service utilisation was indicated by the participants in that teenage mothers lacked support from family and the community when they became pregnant. Most of the

teenage mothers were found to be HIV positive during ANC and some showed denial and therefore refused to go for counselling and testing or to take ARV treatment as prescribed.

The participants indicated that the negative attitude of some of them as nurses resulted in teenagers not attending family planning services and some then ended up with an unwanted pregnancy. The lack of knowledge about family planning also resulted in teenagers not going for assistance at the clinic. The participants reflected that some teenagers were afraid of facing the healthcare providers who sometimes scolded them and said they were so young, yet they slept with boys. Consequently, many of these teenage girls eventually became pregnant.

Another contributing factor was incorrect information they received from peers about the side effects of contraceptives, like becoming obese or looking elderly. The participants further stated peer pressure was a real threat as girls and boys were ridiculed if they did not have a baby and not getting a Child Support Grant or when they were seen going for family planning. The registered nurse participants voiced that some teenagers became pregnant in order to keep their boyfriends and therefore did not report to the clinics for advice and contraceptives in their early stage of pregnancy. The participants confirmed that teenage mothers attended the clinic at a late stage in their pregnancy or did not attend antenatal services at clinics despite having booked appointments. The lack of access to transport was perceived as a major barrier to clinic visits.

6.2.3.3 Theme 3: Proposed interventions

The participants shared that healthcare providers should encourage teenage mothers to form their own support groups where they will have an opportunity to discuss their issues freely and to receive contraceptives. The community must encourage nurses to conduct health talks or organise health campaigns in order to teach teenagers about the importance of completing their education. The registered nurses also indicated that the teenagers should be provided with youth-friendly services and confirmed that they do not have that service at the village. They further stated community awareness campaigns should be conducted by the healthcare providers in which teenagers must be involved to empower other teenagers about contraceptives and reproductive health.

One of the participants confirmed that previously they had “Love Life” which was assisting teenagers, but now the NGO is closed. Follow-up sessions to verify whether teenagers were adhering to the advice and information provided during educational sessions or lectures given was another intervention mentioned. However, as a result of shortage of staff, this would not be possible. The participants further suggested campaigns to disseminate

information at schools to teachers and peers. This, however, would also not be possible as a result of insufficient employees and resources.

6.2.4 Themes from the teenage mothers

6.2.4.1 Theme 1: Challenges experienced by teenage mothers before pregnancy, during pregnancy and labour

One of the participants shared that before she became pregnant, she did not have any knowledge about contraceptives. She was also very scared of the nurses' attitudes towards teenage girls who explained to the registered nurses that their pregnancy was a shock because they were unaware that having a sexual relationship could lead to a pregnancy. Seemingly, the registered nurses did not believe young girls who did not know or suspect they were pregnant; the nurses therefore berated the girls and questioned their ignorance about contraceptive use.

Teenage mothers actually reflected that they did not know what they were doing when having sex; very young ones thought they "were playing". One participant confirmed that she was not even aware that she is pregnant, especially because she never started menstruating. When visiting the clinics for minor illnesses and being told by the healthcare providers that she is pregnant, it was an immense shock to the teenage girl. One participant confirmed that she was only 15 years old when she discovered she was carrying a baby. She admitted she was influenced by what she saw on the television about being in love and having intercourse. However, it never occurred to her that her sexual activities could result in a pregnancy. She said she was devastated on discovery of the pregnancy.

The teenage participants showed that friends and peers made them aware about menstruation that would occur in their future as women. Parents could not tell their teenage girls about contraceptives or menstruation. They were also informed by peers that contraceptive use is very bad as they have side effects. Unfortunately, all the advice and knowledge they received from girls of their same age or a little older were misinformation which made them decide not to even consider making use of contraceptives. The teenagers were obviously ignorant and misinformed about sexuality or reproductive health. They lived in an environment where talking about sex was a taboo. Neither parents nor the community leaders or family spoke about sexual health and wellbeing. Teenagers, specifically the females, were mostly left to fight and find their own way through the emotionally and physically complicated phase of life known as 'a teenager'.

Teenage participants confirmed they were not using health services effectively. Sometimes after school, if they need contraceptives, nurses would say the service is closed, come tomorrow and still the clinic will be closed while still at school. Apart from the nurses' negative attitudes, they also experienced victimisation and stigmatisation from learners, teachers and family members, not only during pregnancy, but also as young mothers. Having an unintended pregnancy meant by far the most had to drop out of school. Any dream some might have had for learning a skill or getting an education to better their future lives was crushed - not only by the pregnancy, but by the total lack of support, understanding, care and information sharing in their whole environment

During labour they experience more pain since they did not know what will happen next. Illness during pregnancy also contributed to dropout from school. Rejection occurred from learners, teachers, parents and community as a whole was also contributing factor.

Some experiences the participants shared were very traumatic. They existed in a world where poverty, hunger, gender-bias and cultural traditions such as forced marriages to older men were everyday occurrences. One shared she was sexually abused in exchange for money to keep the family alive, another was forced to have intercourse with her uncles, yet another was a victim of forced marriage at the age of 11. Some had unplanned pregnancies to obtain a Child Support Grant because the parents were not employed. In all of this, the teenage girls had no say; they had no choice but to follow in the footsteps of many others before them.

6.2.4.2 Theme 2: Challenges of teenage mothers to return to school post-delivery

The young mothers in the study, who had all reached the age of 18 at the time of the study, shared with the researcher their sadness, tragedy of their lives, their experiences of rejection, and in some cases their resignation to a life of perpetual poverty and abuse. The participant teenage mothers share how all met with anger from their parents, especially from their fathers, once their pregnancy became known. One indicated her father was so angry that he got her expelled from school against her wish. He had never talked to her since that day because he felt she had destroyed his trust in her. Although her mother was also devastated, she supported the participant throughout the pregnancy. In the first place, they were not told about reproductive health, sexuality and sex education. Instead, they acquire information from the peers. But when they become pregnant, they become victims of blame. They can hardly support their children in this stressful situation. Another participant shared although she time and again asked for forgiveness, her father refused to answer any letters from school and so she simply assumed it was his intent for her 'to learn a lesson'. That is how she dropped out of school and never returned.

One participant confirmed her father forced her to marry the young father and she was also forced to drop out of school. This participant voiced how much she wanted to be educated. She had thought of joining ABET but it was far from where she was staying. She wanted to complete her schooling, but had no time as she had to take care of the children, do the house chores and attend to her husband's needs. She also had nobody to take care of her children (at the time of study she had had two more babies) while attending school. Her role demand made her not to perform well at school. Another participant stayed at home for almost a year before being allowed to return to school.

Most of the teenage participants indicated they had the will and determination to return to school, but circumstances prevented them to do so. They stated post-natal barriers to return to school included financial challenges, their fear of negative reactions from learners and teachers, and the lack of support from parents or caregivers to care for the baby when they return to school. A further challenge was role demands. The challenge of fulfilling the roles of being a mother, a wife sometimes, and a learner, was extremely demanding and they found there was very little time to pay attention to their school work.

They said they would undoubtedly return to school if their parents could support them. Having a day care centre near school would help them as they could leave their children there safely and be close enough to breastfeed if the baby was still on breast milk. In their opinion, if they were the recipients of the Child Support Grant, it would be used to pay for their child to stay at the centre. Some opined they needed the support of the government to finance the day care centre. The teenage mothers also called for the biological fathers to assist with taking care of their children either financially or by means of organised care.

6.2.4.3 Theme 3: Challenges to access health service delivery

The participants revealed that they became pregnant because they were afraid to communicate with their parents about sexuality. One of the participants reflected that she was very young, inexperienced and not at all knowledgeable about sexuality, contraceptives or pregnancy. Her pregnancy came as a complete shock. In her opinion, she was afraid of talking about sexual matters to her mother because in their home this subject was not discussed or even mentioned. Hence, because of her ignorance and naivety, she became one of the many teenage mothers who did not know anything about contraception, sexually risk behaviours and pregnancy.

A participant reflected she feared her parents would not allow her to use contraceptives. The participant confirmed that her mother never said anything about sex or sex education or 'female growth' (reproductive health). Another participant added she used to visit the clinic

for an injection stealthily to hide from her parents. She was afraid to use the pill in case they discovered it at home and stop her from using it. She skipped one injection and was unable to go for a next one because she came late from school and access to the clinic services was denied because it was closing time. She became pregnant.

According to the participants, their male partners suffered no consequences from engaging in unprotected sexual behaviours and took no responsibility of their offspring if the teenage girl become pregnant or even after the birth of the infant. In these communities, girls are the ones responsible for the pregnancy, but they are unaware about the dangers of unprotected sex such as STIs, including HIV, because nobody explains it to them. One shared that the boy or the father of the baby was not held responsible for the pregnancy. She was taken by force by her aunt to the family to show the boy who made her pregnant. She indicated that she was so embarrassed since the boy rejected her and said he did not even know her. She also said that day she cried while another one who was accepted had to remain in that family and become a wife without even asking her if she is wiling. The participants stated they had many fears concerning making use of sexual and reproductive health services offered at the health centres. These included: fear of being scolded by the nurses, fear of being seen by somebody in the community who would tell their parents, fear of suffering terrible side effects, and also fear that they would lose their boyfriend if he should find his girlfriend accessing the services.

The participants had insufficient information (or no information at all); they had the wrong information; they did not know anything about contraception or what the purpose of using protection is; mostly, they were simply just ignored and left to grow up with no guidance or assistance. Even being victims of sexual abusive acts within families or by forced marriage appeared to be acceptable and admissible – the 10 or 11 year-old, or even a 15 year-old had no choices. The children remain victims of different types of abuses. Laws to protect children are not effectively implemented. Nurses and social workers are desperate because of shortages of staff. Police rarely arrests the perpetrators and if arrested, within a week they are out to continue with the threats, according to the participants.

6.2.4.4 Theme 4: Suggestions to overcome challenges

The registered nurses' role is to promote family planning to teenagers. The participants' suggestions included for the rendering of teenage- or youth-friendly services to be provided at their different levels of understanding. They desired for sexual and reproductive healthcare nurses to be non-judgmental but understanding, welcoming and listening to their problems. They desired for an accessible and a youth-friendly environment where information dissemination regarding contraceptives, practising safe sex and sexual health should include

males as well as females together in the same setting. Peer group, community- and nurse-driven information should be shared through campaigns. The participants suggested that nurses should promote family planning (contraceptives) at schools especially at the primary schools where 10-year-olds who had just started experiencing their menstrual cycles can learn the facts about menarche. Even at this age, the participants indicated girls should be allowed access to family planning in order to prevent unwanted pregnancies any time when there is a need. Healthcare providers need to teach teenagers about the correct use of contraceptives and also share information on the different methods available. The use of implants should be promoted. Door-to-door campaigns are needed to spread correct information about sexual health and rights, the school educational programmes on sexual wellbeing and the urgency for living a healthy lifestyle. Both male and female condom use must be promoted.

Participants also stated specifically registered nurses should go out to schools and the community to teach teenagers about the importance of family planning and that unprotected sex can lead to sexually transmitted infections including HIV. Teenage girls need to be encouraged to go for family planning when experiencing their first menstrual cycle without fear of nurses being biased or condescending. Contraceptives should be made accessible to teenagers. Life skills should be taught at home from early childhood at home and female parents should take their daughters for family planning in order to prevent unwanted pregnancies. Education of young girls about the dangers of unprotected sex at a young age is needed. Participants propose that both boys and girls should access the same venue to clarify issues of contraceptives as under normal circumstances, boys are not taught about the prevention of pregnancies, however they are the ones responsible for pregnancies. Boys and girls must share the same venue in order to have the same understanding regarding sex education, sexuality and reproductive health. The more boys and girls are close to each other and discuss issues of pregnancy, reduction of pregnancies can occur as well as attitude changes. Community involvement may also assist as a policing forum to prevent and respond to rape.

PHASE 2

The research objective of Phase 2 is given followed by the presentation of the developed guidelines.

6.2.5 Research objective of Phase 2

The objective of Phase 2 was to develop and validate guidelines for the promotion of the health and wellbeing of teenage mothers in Mopani District, Limpopo Province.

6.3 THE PROCESS OF THE DEVELOPMENT OF GUIDELINES

The development of guidelines started with the empirical findings and literature control. This led to the development of preliminary guidelines. Pender's health promotion model was used as a reference to structure the empirical findings. The findings were presented as the description of the challenges experienced by registered nurses regarding the promotion of the health and wellbeing of pregnant teenagers and teenage mothers as well as the barriers experienced by teenage mothers to access health services and to return to school after delivery of their babies in Mopani District in the Limpopo province. The process of the guidelines development is summarised below.

6.3.1 Methodology of guidelines development

The researcher used a qualitative research method. The Delphi technique with a 4-point Likert scale was used as an instrument to collect data. These individuals were working in health sectors or universities and colleges in different disciplines. They had experience in health promotion among teenage girls and teenage mothers in collaboration with social workers and other stakeholders who were directly involved with teenagers. The group of experts were geographically dispersed in various Provinces to prevent bias. The description of the panel is described in chapter 5 (5.2) Sampling was done by purposefully selecting participants from the population of experts who met specific criteria. The description of the methodology of the guidelines is detailed in Chapter 5.

6.3.2 Guiding attributes

The following attributes were used throughout the development of the guidelines, namely: validity, reliability, clarity, applicability and relevance. Attributes were also described fully in Chapter 4 and in section 5.2, Chapter 5.

6.3.3 The Guideline development group

The panel of experts were utilised in the validation of the guidelines as participants. The panel members were anonymous to each other to prevent bias. They were identified through SMS and also communicated with via emails. The purpose for choosing them was that they were experts in their working areas. They had knowledge, skills, experience regarding teenagers. Among them were Professors, Doctor specialists, Deputy director of Reproductive Health, women, child and people with disability in South Africa to name a few and some with over 30 years' experience.

6.3.4 Criteria used by the experts for validation of the guidelines

A set of criteria was used by the experts as an instrument to validate the guidelines. The purpose was to determine the validity, reliability, clarity, applicability and the relevance of the guidelines. Below is the illustration of how the panel of experts utilised the Delphi Technique as an instrument to measure the quality of the guidelines. Delphi technique was used as validation instrument and was applied in table 6.1 below.

Table 5: Criteria and rating scale for evaluation of guidelines

Rating scale	**Criteria**				
1=Strongly disagree 2=Disagree 3=Agree 4=Strongly agree	Validity: The guideline will assist in the promotion of health and wellbeing of teenage mothers	Reliability: The guideline will produce similar results if applied in similar circumstances	Clarity: The guideline is clear, simple and unambiguous	Applicability: The target population of the guideline is clearly stated	Relevance: The guideline is purposeful and focused in current society
Guidelines	**1 2 3 4**	**1 2 3 4**	**1 2 3 4**	**1 2 3 4**	**1 2 3 4**
Comments					

Sources (Agree II: 11; Sign 50:2).

6.3.5 Validation of guidelines

The guidelines were formulated by the researcher and developed by the panel of experts who provided valuable and insightful contributions. The final guidelines were developed. For validation of the guidelines, the Delphi technique was used as a tool to ensure a panel of experienced and highly acclaimed experts measured the quality of the guidelines. The checklist used to validate the guidelines with the ratings to confirm consensus is displayed below.

Table 6.2 The Delphi questionnaire

ROUNDS	CRITERIA																			
1=Strongly disagree 2=Disagree 3=Agree 4=Strongly agree	Validity				Reliability				Clarity				Applicability				Relevance			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Guideline 1			**1**	**12**			**1**	**12**				**13**				**13**				**13**
Guideline 2			**1**	**12**				**13**			**1**	**13**				**13**				**13**
Guideline 3			**3**	**10**				**13**				**13**				**13**				**13**
Guideline 4				**13**				**13**				**13**				**13**				**13**
Guideline 5				**13**				**13**				**13**				**13**				**13**
Guideline 6				**13**				**13**				**13**				**13**				**13**
Guideline 7				**13**				**13**				**13**				**13**				**13**
Guideline 8				**13**				**13**				**13**				**13**				**13**
TOTAL			**5**	**99**			**1**	**103**			**1**	**103**				**104**				**104**

6.4 DESCRIPTION OF THE DEVELOPED GUIDELINES

The guidelines were developed by the researcher with the assistance of the experts who contributed valuable opinions and ideas towards the refinement of the guidelines. The process of developing the guidelines is described in chapter 2, 4, 5 and 6. The guidelines were composed of the following:

- Name of the guidelines
- Purpose of the guidelines
- Scope of the guidelines
- Objectives of the guidelines
- Methodology followed
- Experts involved in the development of the guidelines
- Validation of the guidelines

- Validity of the guidelines
- Review and updating of the guidelines

6.4.1 Introduction of the developed guidelines

This part deals with the developed guidelines. It tells about the name of the guidelines, methodology that followed, experts involved and how the guidelines were validated and conclude with the review of the guidelines.

Name of the guidelines: Promoting the health and wellbeing of teenage mothers in Mopani District, Limpopo Province.

These guidelines emerged from the empirical phase 1 of this study which resulted into preliminary guidelines.

6.4.2 Scope of the guidelines

The scope of the guidelines includes registered nurses, other healthcare providers and stakeholders who will use the guidelines, the teenagers in general and teenage mothers will also benefit as the recipients of care. The guidelines will assist in the reduction of teenage pregnancies, increase utilization of service by teenagers without fear. Nurses may observe experiences of abuse if teenagers visit the clinics frequently and cases are reported. Women during ANC, labour and delivery will benefit as recipients.

6.4.3 Purpose of the guidelines

The overall objectives of the guidelines are to promote the health and wellbeing of teenage mothers and their return to school.

6.4.4 Methodology followed

The method followed was the Delphi technique using a 4-point Likert scale to measure the quality and reliability of the guidelines. The guidelines were developed with reference to empirical data collected to determine promoting the health and wellbeing of teenage mothers in Mopani District, Limpopo province (Habibi, et al 2014:10).

6.4.5 Experts involved in the development of the guidelines

Experts completed questionnaires in several rounds of preliminary developed guidelines. They critically assessed and gave opinions which contributed to refining the final guidelines. Using the summary of the panel's views were circulated between rounds until on the third

consensus was fostered. Consensus was reached in the third round (Hsu and Sandford 2007:3).

6.4.6 Validation of the guidelines

Validation of the guidelines was ensured through the use of the Delphi technique and panel of experts who measured the guidelines until they reached consensus. The Delphi technique is best for obtaining judgement from a panel of experts about any issue of concern (Heale and Twycross 2015:66). The experts never met during the process. Each expert contributed original ideas and thereby ensured the trustworthy of the guidelines.

6.4.7 Validity of the guidelines

Validity is the domain related to the extent to which the instrument adequately covers the entire domain related to the construct it was designed to measure. Guidelines are clearly described and validated by experts after a consensus was reached and agreed on the guidelines (Heale and Twycross 2015:66).

6.4.8 Review and updating of the guidelines

The review of the guidelines will be done to ensure that they reflect current decisions that affect the service in three to five years after implementation by the Department of Health, Limpopo Province.

6.5 RECOMMENDATIONS FOR REGISTERED NURSES

- In South Africa, improved access to and utilisation of comprehensive sexual and reproductive healthcare for teenagers would significantly improve a range of health outcomes.

- Nurses should take initiatives of the implementation of National Adolescent and Youth Health Policy regarding ideal clinics.

- Teenage fathers should also be held accountable for their pregnancies and be involved throughout the process of pregnancy, delivery and childcare.

- Health education should be provided regarding reproductive health and sexuality at primary level for better understanding of pregnancies.

- All child-headed families be reported to the social workers for proper handling of their cases.

- Registered nurses initiate programmes in which families, communities, managers, and other stakeholders to respect human rights and to collaborate with social workers and community workers to disseminate information through health education among teenagers regarding their legal right to identify and report any form of sexual abuse to prevent and protect young teenagers becoming victims of child abuse, neglect and exploitation.

- Registered nurses to counsel families, discourage early marriages among teenagers and to support their return to school.

6.6 RECOMMENDATIONS FOR FURTHER RESEACH

In further research, the researcher will use the panel of experts with knowledge and experience of being involved with teenagers before pregnancy, during pregnancy and post-delivery. Sampling will be extracted from the population of experts with specific criteria which are specified below:

- A survey on teenage pregnancy should include teenagers from 12 to 22 years as stipulated in Adolescent and Youth Policy.

- Conduct further research on school drop-outs post-delivery

- The topic of promoting the health and wellbeing of teenage mothers can generate further important research studies.

6.7 IMPLICATIONS

The result of the study has the following implications for nursing practice, nursing education, Department of Health and policy makers.

For policy makers:

- Nurses be involved in policy formulation for better understanding and easy implementation as a matter of urgency

- The National Department of Health should enforce the implementation of Adolescent and Youth Health Policy and fast track the finalisation of Rural School Health Policy to reduce teenage pregnancy and encourage teenage mothers to return to school.

For nursing practice:

Nurses should work according to the scope of practice as determined by the South African Nursing Council by:

- implementing the guidelines which will direct and guide nurses to improve health and wellbeing of teenagers.
- involving teenagers actively to build their knowledge and skills through projects and change their current attitudes towards teenagers.
- collaborating with stakeholders and the community to offer accessible services using available resources by supporting teenage mothers to abstain, use condoms and other methods of contraceptives.
- building good relationship and open communication with teenagers, allowing free time to visit the service for advice and contraceptives.
- having non-judgemental attitudes towards teenagers as they visit the clinics and counsel them.

Nursing education:

- The guidelines developed may be incorporated into the relevant curricula for learning purposes.
- Nursing education should participate in comprehensive school health approaches while working in partnership with educators, families, community agencies and other stakeholders.
- Further study should be done regarding the return of teenage mothers to schools after delivery.

6.8 LIMITATIONS

Grove, et al (2013:699) describe limitations as “theoretical and methodological restrictions in a study that may decrease the generalizability of the findings”.

- The results of this study were limited to the population of the rural villages in Mopani District of Limpopo. Registered nurses from limited settings (two clinics, a health centre and one hospital in two villages) were participants in Phase 1 of the study. Teenage mothers between the age of 18 and 21 participated and excluded those between 11 to 17 years. Therefore, it cannot be assumed that the results of the study would be the same in another context.

- The guidelines have not yet been implemented in a clinical setting therefore it cannot be assumed that the goal has been reached.

- All focus groups of teachers, school governing body was not recommended by Ethics Committee of the University of Pretoria and resulted doing individual study only.

- Teenage fathers were not included in the study to their point of view

- Not all villages in the Districts were involved in the study

- The guidelines will be controlled by the Department of health and therefore the researcher will depend on them.

6.9 CONTRIBUTION TO THE BODY OF KNOWLEDGE

- The guidelines developed will be included in the relevant nursing education curriculum with the purpose of teaching students in training to apply this knowledge in nursing practice.

- The guidelines will empower health professionals, especially nurses with knowledge and skills to collaborate with other stakeholders in the dissemination of information regarding contraceptives.

- The concepts and the modified framework will be used by other researchers to expand their knowledge.

- The guidelines will close the existing gaps that are described by the researcher during implementation such as reporting sexual abusers if observed.

6.10 CONCLUSION

The purpose of the study was to develop guidelines for the promotion of the health and wellbeing of teenage mothers in Mopani District, Limpopo Province. The researcher utilised a qualitative, descriptive and explorative design to explore and describe the challenges

experienced by registered nurses regarding the promotion of the health and wellbeing of teenage mothers and to describe the barriers experienced by teenage mothers to return to school after delivery. Based on the results of the study, the research question, purpose of study and the objectives were achieved. The results of the findings in phase 1 on both registered nurses and teenage mothers reflected that, while nurses attempt to provide health and wellbeing to teenagers as well as all clients coming to the clinic for services according to the scope of practice, shortage of staff hindered their performance. The registered nurses indicated that teenage mothers are also reluctant to utilise the service and receive the health education they needed. Social grants remain important to alleviate poverty. Early marriages, sexual abuse, rape in which some are caused by relatives are the greatest problems and cases remain unreported fearing threats which pose a great concern for teenagers.

Rejection in schools by teachers and leaners was a problem for teenage mothers. On the other hand, motherhood role demands also made it difficult for them to return to school and further their education.

The issue of taboo still exists within the villages which result in teenagers not using the health services sufficiently. Participant nurses also confirmed that their attitudes towards teenagers when they report to the service, perceiving that they are still young to use contraceptives and if mothers brought their children to the clinics, further victimize teenagers.

However, teenagers themselves need to be informed of matters related to their sexuality, reproductive health and rights, including both girls and boys, in order to have the same understanding and prevent unwanted pregnancies. Teenage fathers need to assume co-responsibility for pregnancies.

Pender's Health Promotion model was used in the development of guidelines after analysis of data and literature control. The model and empirical phase 1 were integrated to serve as a guide for the formulation of preliminary guidelines. The Delphi technique was used as an instrument to collect data using experts as participants. The preliminary guidelines were given to the panel of experts for critical analysis and adjustment. Three rounds were conducted where expert participants contributed to the development of guidelines with their inputs and refinement of the guidelines until consensus was reached. The experts then accepted the preliminary guidelines which were confirmed as final after validation according to the criteria used.

Implementation of guidelines may improve the health and wellbeing of teenagers and also ensure that sexual abuse is reported.

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ANNEXURE A

PERMISSION LETTER FROM THE UNIVERSITY OF PRETORIA ETHICS COMMITTEE

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 22/04/2017

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

30/10/2014

Approval Certificate
New Application

Ethics Reference No.: 338/2014

Title: Promoting the health and wellbeing of teenage mothers in Mopani District, Limpopo Province

Dear Beauty Hlongwane

The **New Application** as supported by documents specified in your cover letter for your research received on the 27/07/2014, was provisionally approved by the Faculty of Health Sciences Research Ethics Committee on the 29/10/2014

Please note the following about your ethics approval:
- Ethics Approval is valid for 2 years.
- Please remember to use your protocol number (**338/2014**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:
- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

Additional Conditions:
- Provisionally approved, pending permissions from the Provisional Department of Health and Department of Education.

We wish you the best with your research.

Yours sincerely

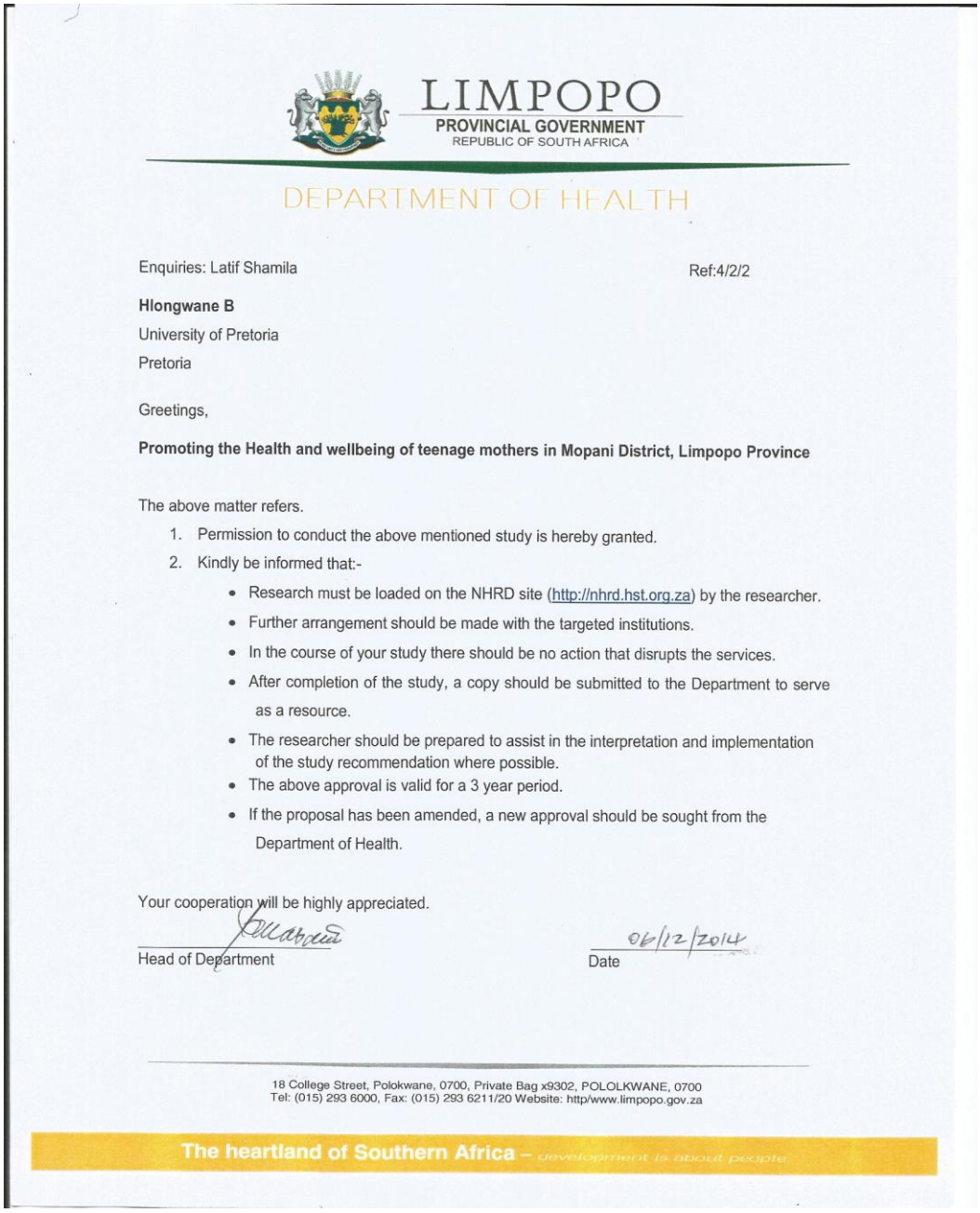
Dr R Sommers; MBChB; MMed (Int); MPharMed.
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

012 354 1677 | 0866516047 | deopeka.behari@up.ac.za | http://www.healthethics.up.ac.za
Private Bag X323, Arcadia, 0007 - 31 Bophelo Road, HW Snyman South Building, Level 2, Room 2.33, Gezina, Pretoria

ANNEXURE B

PERMISSION LETTER FROM LIMPOPO DEPARTMENT OF HEALTH



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila

Ref:4/2/2

Hlongwane B
University of Pretoria
Pretoria

Greetings,

Promoting the Health and wellbeing of teenage mothers in Mopani District, Limpopo Province

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
   - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
   - Further arrangement should be made with the targeted institutions.
   - In the course of your study there should be no action that disrupts the services.
   - After completion of the study, a copy should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - The above approval is valid for a 3 year period.
   - If the proposal has been amended, a new approval should be sought from the Department of Health.

Your cooperation will be highly appreciated.

Head of Department

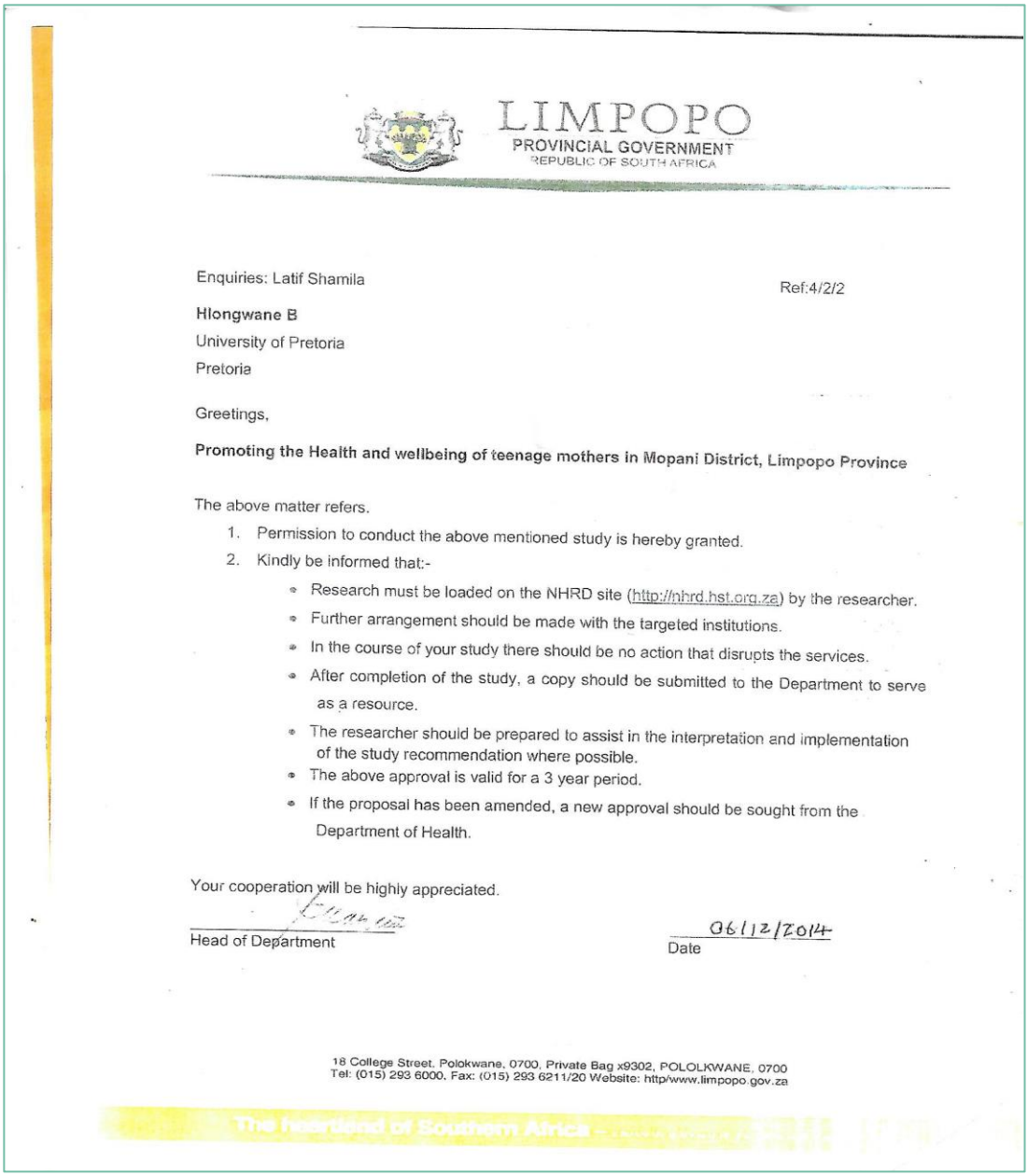
06/12/2014
Date

18 College Street, Polokwane, 0700, Private Bag x9302, POLOLKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: http/www.limpopo.gov.za

The heartland of Southern Africa – development is about people

ANNEXURE C

PERMISSION LETTER FROM GIYANI DISTRICT OFFICE, LIMPOPO



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Enquiries: Latif Shamila

Ref:4/2/2

Hlongwane B
University of Pretoria
Pretoria

Greetings,

Promoting the Health and wellbeing of teenage mothers in Mopani District, Limpopo Province

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
   - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
   - Further arrangement should be made with the targeted institutions.
   - In the course of your study there should be no action that disrupts the services.
   - After completion of the study, a copy should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - The above approval is valid for a 3 year period.
   - If the proposal has been amended, a new approval should be sought from the Department of Health.

Your cooperation will be highly appreciated.

Head of Department

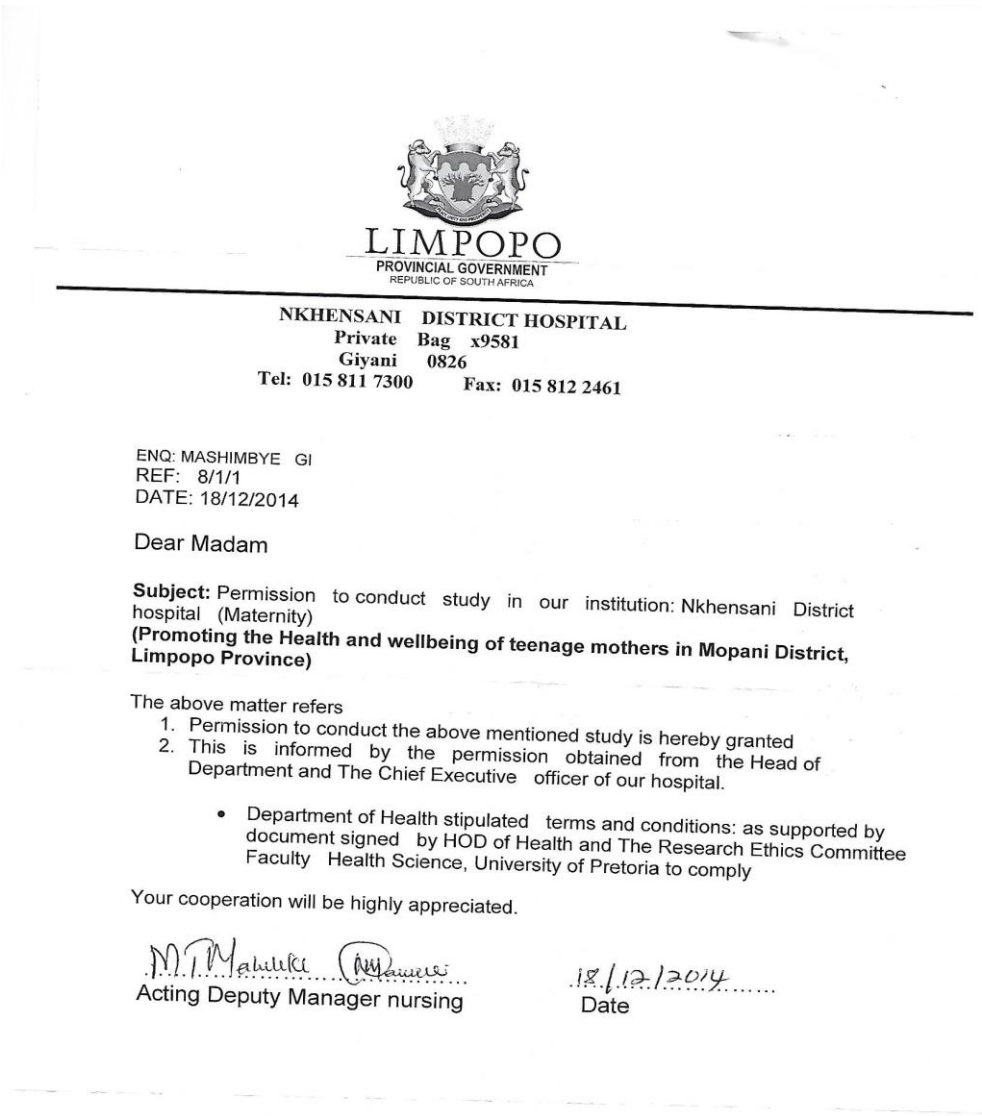
06/12/2014
Date

18 College Street, Polokwane, 0700, Private Bag x9302, POLOKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: http/www.limpopo.gov.za

The heartland of Southern Africa

ANNEXURE D

CONSENT FORM TO PARTICIPATE IN THE STUDY



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

NKHENSANI DISTRICT HOSPITAL
Private Bag x9581
Giyani 0826
Tel: 015 811 7300 Fax: 015 812 2461

ENQ: MASHIMBYE GI
REF: 8/1/1
DATE: 18/12/2014

Dear Madam

Subject: Permission to conduct study in our institution: Nkhensani District hospital (Maternity)
(Promoting the Health and wellbeing of teenage mothers in Mopani District, Limpopo Province)

The above matter refers

1. Permission to conduct the above mentioned study is hereby granted
2. This is informed by the permission obtained from the Head of Department and The Chief Executive officer of our hospital.

- Department of Health stipulated terms and conditions: as supported by document signed by HOD of Health and The Research Ethics Committee Faculty Health Science, University of Pretoria to comply

Your cooperation will be highly appreciated.

M T Mahlaku
Acting Deputy Manager nursing

18/12/2014
Date

ANNEXURE E

CONSENT FORM TO PARTICIPATE IN THE STUDY

I confirm that I read and understood the information about the study. I agree to participate in the research project “Promoting the health and wellbeing of teenage mothers in Mopani District, Limpopo Province.” All the information that is entailed in the research project has been explained to me fully and clearly. I understand that the information provided by me shall remain confidential. My participation is voluntary. I can participate in part or whole research project and I can withdraw at any stage or time by the reason known by me, without being restricted anyhow or penalized.

I understand that I will not be paid for the participation and that to agree participation means that I am willing to respond to the questions posed by the researcher.

Participant's Name			(Please print)
Person seeking consent			(Please print)
Signature		Date	
Witness's name			(Please print)
Signature		Date	

VERBAL INFORMED CONSENT

I the undersigned, have read the confirmation and have fully explained the information leaflet to the participant about the nature, process, risks, discomforts and benefits of the study. The participant displayed understanding that the results of the study as well as personal matters detailed in the interview will be anonymously processed into research report. The participant has no objection to participate in the study. She understands that, participation is voluntary and can participate in part or whole research project. She can withdraw at any stage or time by the reason known by her without being restricted anyhow or penalized. She further understands that she will not be paid for the participation and that agreeing with participation means that she is willing to respond to the questions posed by the researcher.

Participant's Name			(Please print)
Person seeking consent			(Please print)
Signature		Date	
Witness's name			(Please print)
Signature		Date	

ANNEXURE F

INTERVIEW GUIDE

MAIN QUESTION

What are the current practices in promoting health wellbeing of teenage mothers in Mopani District, Limpopo Province?

For the registered nurses

- What are the current healthcare services that you provide to pregnant teenagers, during and after pregnancy?
    - What are the challenges you experience as a nurse when rendering antenatal services?
    - Are there challenges teenage mothers experience that are observed after giving birth?
    - What are the barriers for teenage mothers to use family planning services?
    - What are the barriers for teenage mothers to return to school?
    - How do you support teenage mothers to improve their situation?
    - What do you think should be done to encourage teenage girls, pregnant teenagers and teenage mothers to return to school?
- What can be done by healthcare practitioners, families, schools, and the community to encourage teenagers' use of healthcare services?
    - Is there anything you would like to tell me regarding rendering services to teenage mothers that we did not talk about?
    - Are there any questions that you think I should have asked you?
- In case I need to clarify something about the study will you allow me to contact you?

For teenage mothers

- Please tell me about the birth of your baby. When was your baby born?
    - Probe: when is/ was your due date)?
    - Probe: was this a normal full-term pregnancy?
- Have you stayed in school while you were pregnant?
    - Probe: What did you experience during your stay with pregnancy at school?
- Have you returned to school after the birth of your baby or will you return to school after delivery? Please explain to me why/why not?
    - Probe: What barriers did you experience when returning to school (if applicable)?
    - Probe: How were you supported in returning to school by your family and teachers (if applicable)?
- What do you think should be done in future in this community, to promote the health and wellbeing of teenage mothers in order to support your return to school?
    - Probe: by nurses, school/educators/ families?
- Are there any questions that you think I should have asked or information that you need to share with me regarding teenage pregnancy?

ANNEXURE F(a)
INVITATION TO PARTICIPATE IN RESEARCH
PHASE 1

(REGISTERED NURSES)

Address

Date

Dear Sir/Madam,

Invitation to participate in the study for the purpose of PhD. REF. Student number: 22275020

My name is Beauty Ruth Hlongwane, inviting you to participate in a research study, titled as "Promoting the health and wellbeing of teenage mothers in Mopani District, Limpopo Province. This project is the requirement for my doctoral studies in the University of Pretoria.This study is approved by the Univerity of Pretoria Ethics committee and the ethics committee of the Department of Health, Limpopo province. The study will be conducted in two phases.

Phase 1

Specific objectives of phase 1 is to:

- Explore and describe the challenges experienced by *registered nurses regard*ing the promotion of health and wellbeing of teenage mothers.
- Describe the barriers experienced by teenage mothers to return to school after delivery of the baby.

Specific objective of phase two is to:

- Develop guidelines to promote the health and wellbeing of teenage mothers in rural villages in Mopani District, Limpopo Province.

This information leaflet will help you to decide if you want to participate. Before you agree to take part, you should fully understand what this is all about. If you have any questions that

this leaflet does not fully explain, please feel free to ask the investigator, Beauty Hlongwane. Cell. 076 147 0093.

The aim of this study is to develop guidelines for registered nurses to promote the health and well-being of teenage mothers in Greater Giyani at Mopani District, Limpopo Province. This study involves asking you questions as registered nurses regarding teenage mothers aged 18 – 21 on how their health and wellbeing are promoted and their continued schooling can be promoted. You have been selected to participate in the study based on your experience in working with teenage mothers. Your permission to take field notes and to record the interviews on a tape is requested.

Risk and discomfort involved

There are no risks for you if you choose to take part in the study. Some of the questions may make you feel uncomfortable, but you need not answer them if you don't want to. The interview will take about 45 minutes to an hour of your time.

Possible benefits of this study

The result of the study will help to promote the health and wellbeing of teenage mothers by encouraging teenagers to return to school to complete their studies post-delivery.

Your rights as a participant

The participation in this study is voluntary. It is completely your own choice. You have the right to withdraw or withhold information at any stage of the interview. You can refuse to participate or stop at any time during the interview without giving any reason. This will not affect the care you receive at the clinic or school in anyway. You will be given a consent form to sign if you are willing to proceed with the interview.

Compensation

Taking part in the study is voluntary. You will not be paid for being part of the study. The participants will incur no costs

Confidentiality

Privacy will be maintained. All information that you give will be kept secret. No one will be able to access the information that you gave us. Your name will not be written in any report.

ANNEXURE F(b)
INVITATION TO PARTICIPATE IN RESEARCH
PHASE 1

(TEENAGE MOTHERS)

Address

Date

Dear Madam,

Invitation to participate in the study for the purpose of PhD. REF. Student number: 22275020

My name is Beauty Ruth Hlongwane, inviting you to participate in a research study, titled as "Promoting the health and wellbeing of teenage mothers in Mopani District, Limpopo Province. This project is the requirement for my doctoral studies in the University of Pretoria. This study is approved by the University of Pretoria Ethics committee and the ethics committee of the Department of Health, Limpopo province. The study will be conducted in two phases.

Phase 1

Specific objectives of phase 1 are to:

- Explore and describe the challenges experienced by *registered nurses regard*ing the promotion of health and wellbeing of teenage mothers.
- Describe the barriers experienced by teenage mothers to return to school after delivery of the baby.

Specific objective of phase two is to:

- Develop guidelines to promote the health and wellbeing of teenage mothers in rural villages in Mopani District, Limpopo Province.

This information leaflet will help you to decide if you want to participate. Before you agree to take part, you should fully understand what this is all about. If you have any questions that this leaflet does not fully explain, please feel free to ask the investigator, Beauty Hlongwane. Cell. 076 147 0093

The aim of this study is to develop guidelines for registered nurses to promote the health and well-being of teenage mothers in schools in Greater Giyani at Mopani District, Limpopo Province. This study involves asking you questions as a teenage mother aged 18 – 21 about your experience during access to health service for the promotion of health and wellbeing and barriers to return to school after delivery. You have been selected to participate in the study based on your experience as a pregnant teenager or teenage mother who are using the service and who returned to school after delivery. Your permission to take field notes and to record the interviews on a tape is requested.

Risk and discomfort involved

There are no risks for you if you choose to take part in the study. Some of the questions may make you feel uncomfortable, but you need not answer them if you don't want to. The interview will take about 45 minutes to an hour of your time.

Possible benefits of this study

The result of the study will help to promote the health and wellbeing of teenage mothers by encouraging teenagers to return to school to complete their studies post-delivery.

Your rights as a participant

The participation in this study is voluntary. It is completely your own choice. You have the right to withdraw or withhold information at any stage of the interview. You can refuse to participate or stop at any time during the interview without giving any reason. This will not affect the care you receive at the clinic or school in anyway. You will be given a consent form to sign if you are willing to proceed with the interview.

Compensation

Taking part in the study is voluntary. You will not be paid for being part of the study. The participants will incur no costs

Confidentiality

Privacy will be maintained. All information that you give will be kept secret. No one will be able to access the information that you gave us. Your name will not be written in any report.

ANNEXURE G

TRANSCRIPT OF INTERVIEWS FOR REGISTERED NURSES AND TEENAGE MOTHERS

(a) Registered nurses

R = Researcher

RN = Registered nurses

R Good afternoon and welcome.

RN Good afternoon

R How are you?

RN I am fine mam.

R My name is Beauty Hlongwane I am a nurse by profession and a PhD scholar at University of Pretoria. I am here to interview you about healthcare for pregnant teenagers and teenage mothers. My aim is to get rich information on "What can be done to improve the health and well-being of teenage mothers during and after pregnancy to support their return to school and completion of their education". The information will help me to develop guidelines. As I explained in the informed consent guide, the interview will be audio taped, and my assistant will write down field notes during the interview. There are no right or wrong answers to my questions. The interview will last for about 45 minutes to an hour.

Before I proceed, do you have any questions for clarification?

RN No

R Thank you. Let us start.

R Please explain the current services that you provide to pregnant teenagers during and after delivery.

RN As registered nurses, we encourage doing exercises. They are taught the importance of breast feeding and to return for antenatal visit. We teach about birth procedures e. g. what will happen

in labour and in postnatal ward. We encourage bonding between mother and the baby from birth. Immediately after birth, the baby is placed in the mother's abdomen for an hour to facilitate bonding and then transferred to post-natal ward. Cot bed is no longer encouraged. Therefore, mothers should sleep with their babies to enable them feed their babies when they cry. Breast feeding is done on demand; hence we teach them not to wake the babies up for feeding, but that the baby should cry for feeding. The baby should be placed on the breast only when he or she is being fed. We also encourage the teenagers to go back to school after delivery of their babies. We teach them only to breast feed and nothing else. During school attendance, we encourage them to express milk from breast before going to school. The may be refrigerated but not be placed in a freezer, so that the baby can be during her absence. The care giver must first warm the milk before feeding the baby. The government discourages the use of formula milk as a way of promoting breast feeding.

R As you are explaining the Health care services, that you are rendering, can you also elaborate about specific services that are related to teenagers?

RN Teenagers are taught about family planning and more so, the Government has introduced the "Indolite" which can be implanted for three (3) years without falling pregnant and teenagers can proceed with their studies. After three years, it is replaced by another one for the period of three years again if she wishes to proceed with her studies.

R According to my understanding, unless I missed some of the points, you only teach family planning during antenatal services?

RN Yes, during antenatal clinic (ANC) we teach them different types of family planning such as oral contraceptives, injections and also collect blood for Human Immuno-Deficiency Virus (HIV).

R Are there other specific services that you provide after giving birth?

RN Yes, after delivery we encourage them to come back for postnatal checking after five (5) days both the mother and the baby. After six (6) weeks we start with 'under' five clinics as well as family planning if the mother agrees to do so.

R What are the challenges you experience as a nurse when rendering antenatal care to teenage mothers?

RN One notices that children as young as eleven (11) years old are falling pregnant and some do so without having experienced the menstrual cycle. Mostly are between 14 and 16 years and they fall pregnant because of peer group influence. We render service also from HOMU 14C and the "TWO ROOMED" squatter camps in Giyani, Mopani District who fall pregnant in order to receive child support grant.

R Are there other challenges you can think of regarding teenage mothers?

RN Some of them do not return to school after delivery of their babies. When they come for ante natal clinic (ANC), most of them are found to be Human Immunodeficiency Virus (HIV) positive after

conducting a test. It is a big challenge indeed and they will never come to the clinic until delivery or term.

R Are there challenges teenage mothers experience that you observe/ are occurring after giving birth?

RN Some of them reject their babies indicating that they are not theirs, but for their mothers and some are even afraid to handle their own babies. They do not want to breastfeed their babies.

R In your opinion, what hinders the teenage mothers or barriers to come for family planning?

RN They are afraid of facing the health care providers, who will sometimes scold them and say they are so young and yet they sleep with boys and that they cannot be provided with anything for family planning because they do not have families. Then they go home without receiving any contraceptives and they fall pregnant as a result of attitude of some health care providers.

R So, in your opinion what should be done to encourage these teenage mothers to promote their health and wellbeing?

RN I would suggest a clinic session for teenagers, where they can form a support group and that they should not share with adults. The health care providers for that clinic should not be an elderly person who will discriminate them. She should be young and friendly for free communication. Parents must talk about sex with their children and also encourage about to abstain.

R As a family member, since you are also a mother, what can you say about helping teenage mothers to return to school?

RN One should sit down with them and discuss about advantages of going back to school and what they are going to benefit by doing so. Also, that having a baby is not the end of the road for them, but they must just be courageous and go back to school. Warn them about the disadvantages of not going back to school because education is a key to life.

R Which disadvantages are you referring to?

RN Such as lack of employment leading to poverty which will also affect the baby.

R Thank you. We have come to the end of the interview. Is there any question you think I should have asked you but did not ask and you feel that it is necessary that will contribute to their wellbeing?

RN No there is nothing to add.

Researcher: Thanks for the participation.

(b)Teenage mothers

R = Researcher **TM** = Teenage mother

R Good morning and welcome

TM Good morning mam

R How are you?

TM I am fine.

R My name is Beauty Hlongwane I am a nurse by profession and a PhD scholar at University of Pretoria. I am here to interview you about the healthcare you received during pregnancy and now that you are a mother. My aim is to get rich information on "What can be done to improve the health and well-being of teenage mothers during and after pregnancy to support their return to school and completion of their education". The information will help me to develop guidelines. As I explained in the informed consent guide, the interview will be audio taped, and my assistant will write down field notes during the interview. There are no right or wrong answers to my questions. The interview will last for about 45 minutes to an hour.

Before I proceed, do you have any questions for clarification?

RN No

R Thank you. Please tell me everything that you remember about your pregnancy, the birth of your baby, when and how was your baby born?

TM It was a normal birth with episiotomy to premature twin babies in August 2014. No caesarean section was done to me. The babies weighed 2, 5 kg each, but it went up to 2,9kg after three days. Nurses were good to me, telling me what to do such as positioning. But it was so painful. I stayed for two weeks in hospital.

R Have you stayed at school when you became pregnant?

TM Yes, I was at school doing grade 11.

R What did you experience during your pregnancy at school?

TM They treated me nicely and my pregnancy was not visible. Most of them did not know that I was pregnant even teachers. That is why most of the students and the teachers were surprised when I did not return to school. I used to go and write common tests before exams. Our school allow us to stay at home after five months of pregnancy and only to write tests and examination where possible.

R What did you experience physically during your pregnancy?

TM The problem at school was that of sleeping in class and I was also vomiting or fainting. Other children will sometimes say, is there any one pregnant here? Why are we sleeping like this? I felt as if they are aware that I am pregnant. When teachers discovered that I was pregnant, I was told that my parents should come to school to see the Principal. From there, I never returned to school with the fear that students and some teachers will make fun of me.

R So, you did not write your final exams in Grade 11 due to your pregnancy?

TM Yes mom.

R Did you go back to school after delivery?

TM I did not go back to school after delivery that year. There was no one to remain with the kids if I go back to school. My parents were still angry with me and could not give me money as it was a problem. The following year I went back to school. I wanted to complete Grade 12 and go to Tertiary. I needed to complete education which can enable me to take care of the kids (twins.) My parents allowed me to go back to school and I managed. My kids were staying with parents from both families.

R What was the reaction of other students when you go back to school?

TM No problems identified from fellow students. Some were surprised to hear that I am having a baby

R Tell me more about you becoming pregnant?

TM Mam, I was not preventing (using contraceptives). I did not want to use either condoms or contraceptives. I believe that I had an attitude towards nurses, fearing that they will scold me. Some of our peer group told us that, nurses need us to have permission from our parents. I was afraid that my parents will not allow me to do that because even my mother never said anything about sex or sex education. I was afraid.

R How are you going to prevent yourself from falling pregnant again in order to pursue your education?

TM I have already started using contraceptives. I have learned a lot with my pregnancy. Sometimes you do not have money to buy napkins.

R How were you supported in returning to school by your family and teachers?

TM Most family members accepted the pregnancy except for my brother who complained about the extra mouth to be fed, but he also accepted it in the end. They all supported me in going back to school. I had a challenge of pocket money because my parents were taking care of the children.

R Now that you have this experience, what do you think should be done to promote health and wellbeing of teenage mothers and their return to school after delivery?

TM I can request my parents to allow me to return to school as I am still young. Another reason is that I want to prepare my own future because without education I will be nothing.

R What do you think should be done in future in this community to promote health and wellbeing of teenage mothers in order to support their return to school?

TM We should have Police Forums who will assist in curbing crime within the villages and prevent rapes. The crèches should be built near schools so that our babies can be there and be collected after school.

R What barriers are experienced by teenage mothers to go back to school?

TM Sometimes it is because some parents are after money and then allow elderly people to abuse their children. Lack of money also contributes for teenagers not returning to school. Some are getting married as soon as she becomes pregnant and have dual role, to be a wife, mother and student. It is difficult to continue with education, and therefore terminate. Sometimes when a parent takes her 10-year-old girl to the Health Care Facility, like a Clinic, Nurses will judge and scold at her and tell her that she is the one who encourages young children to enjoy sexual intercourse, whereas the poor parent was trying to protect the child from falling pregnant and thus destroy her future and disturb the progress of her education.

R What do you think in future should be done to promote health and wellbeing of teenage mothers in order to support their return to school?

TM You as nurses should promote family planning at schools especially at the Primary Schools where you will find a 10-year old child, who had just started experiencing their menstrual cycles. They should be advised to go for family planning in order to prevent unwanted pregnancies. I can also tell my siblings about the dangers of having sexual intercourse with boys after they have started experiencing their menstrual cycles.

R What do you think nurses should do to promote their health and wellbeing?

TM Nurses should teach the community about the importance of Family Planning because some members of the community will spread falls information about the dangers of contraceptives when taken at a tender age (early age). In the community they will say that a child will become a barren because this medication she takes is in her bloodstream or body and she will never fall pregnant.

R I see. In other words, you infer that nurses should teach parents to teach their children about the dangers of having sexual intercourse, instead of taking them to the clinic?

TM Yes, nurses should tell them that, they must teach us to take time to have sex in life and try to get education first and thereafter we can go for marriage.

R Is there anything else you feel should be done at school or in the community to prevent teenage pregnancies?

TM Yes, a ten-year-old girl should be warned about the dangers of giving birth at such a tender age. They should be encouraged to go for family planning, since prevention is better than cure. In most of the time, the young teenagers have to undergo operations in order to deliver their babies.

R Do you have any information you would like to impart to me except what we have already discussed?

TM Members of the community should take a parental role to those children who are orphaned by encouraging them to go back to school especially that now education is free. You just pass matric but no money to proceed to tertiary.

R Thank you for the information, we have come to the end of our interview and God bless.

ANNEXURE H

INVITATION TO PARTICIPATE IN RESEARCH PHASE 2

Address

Date

Dear Sir/ Madam,

Re-Invitation to participate in the study for the purpose of PhD. REF. Student number: 22275020

My name is Beauty Ruth Hlongwane, inviting you to participate in a research study, titled as "Promoting the health and wellbeing of teenage mothers in Mopani District, Limpopo Province. This project is the requirement for my doctoral studies in the University of Pretoria.This study is approved by the Univerity of Pretoria Ethics committee and the ethics committee of the Department of Health, Limpopo province. The study will be conducted in two phases.

Phase 1

Specific objectives of phase one was to:

- Explore and describe the challenges experienced by *registered nurses regard*ing the promotion of health and wellbeing of teenage mothers.
- Describe the barriers experienced by teenage mothers to return to school after delivery of the baby.

Specific objective of phase two is to:

- Develop guidelines to promote the health and wellbeing of teenage mothers in rural villages in Mopani District, Limpopo Province.

You are invited to participate in the second phase of this research study during July and September 2017. You are identified as an expert in reproductive health, mother and child health care, midwifery and obstatric care. This information leaflet will help you to decide if you want to participate. Before you agree to take part, you should fully understand what this is all about. If you have any questions that this leaflet does not fully explain, please feel free to ask the investigator, Beauty Hlongwane at 076 147 0093.

This study has received written approval from research ethics committees at the University of Pretoria and the Limpopo Province Department of Health. Copies of the approval letters are available if you wish to have one.

The procedure

Kindly be informed that you will form part of the panel of experts. Delphi technique will be used to gather opinions from the panel of experts without having to meet physically. It provides for a consensus-based structured communication process to gather opinions and make decisions. As a member of the panel of experts, you will be expected to respond to a set of open-ended questions over a series of 3 rounds to generate expert opinions on the drafted guidelines until consensus is reached.

Risk and discomfort involved

There are no risks for you if you choose to take part in the study.

Possible benefits of this study

The result of the study will help to promote the health and wellbeing of teenage mothers in their local communities by encouraging them to return to school to complete their studies.

Your rights as a participant

Taking part in the study is voluntary. Your participation in this study is completely your own choice. You have the right to withdraw or withhold information at any stage of the rounds. You can refuse to participate or stop at any time during the rounds without giving any reason.

Compensation

You will not be paid any incentives or incur any costs as being part of the study.

Confidentiality

Privacy will be maintained. All information that you give will be kept secret. No one will be able to access the information that you gave us. Your name will not be written in any report.

The contact person for the study is Dr. Peu D if you have any questions about the study please contact her at tel: 012 354 2133. Alternatively, you may contact my co-supervisor at 012 354 2133 Dr. De Waal.

Yours faithfully,

Mrs. B R Hlongwane

ANNEXURE I

INFORMED CONSENT FOR EXPERTS

I agree to participate in the research project “Developing guidelines to promote the health and wellbeing of teenage mothers in Mopani District, Limpopo Province.” All the information that is entailed in the research project has been explained to me fully and clearly. I understand that the information provided by me shall remain confidential. My participation is voluntary. I can participate in part or whole research project and I can withdraw at any stage or time by the reason known by me, without being restricted anyhow or penalized.

I understand that I will not be paid for the participation and that to agree participation means that I am willing to respond to the questions posed by the researcher.

Signature of participant		Date	
Signature of witness		Date	

ANNEXURE J

FINAL SUMMARY SHEET OF THE RATED GUIDELINES

ROUNDS	**CRITERIA**																			
1=Strongly disagree 2=Disagree 3=Agree 4=Strongly agree	Validity				Reliability				Clarity				Applicability				Relevance			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Guideline 1			1	12			1	12				13				13				13
Guideline 2			1	12				13			1	13				13				13
Guideline 3			3	10				13				13				13				13
Guideline 4				13				13				13				13				13
Guideline 5				13				13				13				13				13
Guideline 6				13				13				13				13				13
Guideline 7				13				13				13				13				13
Guideline 8				13				13				13				13				13
TOTAL			**5**	**99**			**1**	**103**			**1**	**103**				**104**				**104**

ANNEXURE K

LETTER FROM LANGUAGE EDITOR

Suzette M. Botes

FULL MEMBER: Professional Editors' Guild

18 February 2018

TO WHOM IT MAY CONCERN

I, Suzette Marié Botes (ID 5211190101087), confirm that I have edited the noted PHILOSOPHIAE DOCTOR in NURSING SCIENCE. However, the accuracy of the final work remains the responsibility of the student.

Student: Ms Beauty Ruth Hlongwane

Student number: 2227520

Title:

PROMOTING THE HEALTH AND WELLBEING OF TEENAGE MOTHERS IN MOPANI DISTRICT, LIMPOPO PROVINCE

The edit included the following:

- Spelling
- Vocabulary
- Punctuation
- Grammar (tenses; pronoun matches; word choice etc.)
- Consistency in terminology, italisation etc.
- Sentence construction
- Suggestions for text with unclear meaning
- Logic, relevance, clarity, consistency
- Checking reference list against in-text sources
- Basic formatting

Thank you

Suzette M Botes (not signed – sent electronically)

060 619 3137
suzette.botes.21@gmail.com