THE EXPERIENCES OF PREGNANT TEENAGERS ABOUT THEIR PREGNANCY

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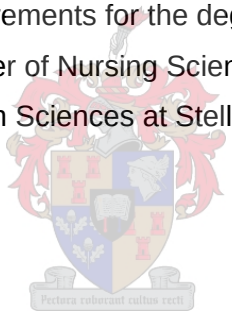
the requirements for the degree of
Master of Nursing Science
in the faculty of Health Sciences at Stellenbosch University



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DECLARATION

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ABSTRACT

The alarming rate of teenage pregnancies among South Africans became a driving force for the researcher to investigate this particular phenomenon. The goal of this study was to explore and describe the experiences of pregnant teenagers about their pregnancy. Guided by the research question " What are the experiences of pregnant teenagers about their pregnancy?" a scientific investigation was undertaken. The objectives set for the study were to determine their experience of their current pregnancy; to determine their knowledge of contraceptives; and to explore their experience regarding the services delivered by the health care workers.

A phenomenological descriptive design with a qualitative approach was the most suitable scientific method to describe the experiences of pregnant teenagers who attend an antenatal clinic in Chatsworth, Kwazulu Natal. An interview guide or protocol that includes a list of open-ended questions based on the objectives, the literature review, and the professional experience of the researcher was designed and used to explore during each interview. The final sample consisted of ten participants.

Experts in the field of nursing and research methodology were consulted to determine the feasibility and content of the study, to evaluate the research process and outcome. The researcher collected the data personally. Data was collected by means of individual interviews. The researcher did the transcription of the interviews. Ethical approval was obtained from Stellenbosch University and the relevant health authorities. Informed written consent was obtained from the participants. Parental permission was obtained for participants under the age of 18 years. Participants younger than 18 years of age also completed an assent form.

Data that emerged from the data analysis was coded and categorised into sub-themes and themes. The researcher compiled a written account of the interpretations that emerged from the data analysis. In addition, member checking was done with each participant after individual interviews, to validate the transcribed data.

The conceptual framework for this study was adapted from Maslow (1968). The findings suggest that there is a need for parental intervention as far as teenage pregnancy is concerned, financial difficulties associated with poverty was identified as one of the major contributing factor to teenage pregnancy, and attitudes of providers of contraceptives led to teenagers, not using contraceptives in some cases. It is recommended that services at the

clinic be improved; health care workers undergo extensive training and education regarding teenage health and sexuality needs. Furthermore review and revitalisation of education programs at schools, to meet the needs of teenagers, which are constantly changing according to the times, are recommended. The involvement of parents and the community in combating issues surrounding teenage pregnancy is vital. Further research is recommended to find solutions to alleviate this problem of teenage pregnancy. All stakeholders need to work together to remedy this social problem as it is not an issue that can be dealt with in isolation.

OPSOMMING

Die veronrustende voorkoms van tienerswangerskappe onder Suid-Afrikaners was die motiverende faktor vir die navorser om die studie te onderneem. Die doel van die studie was om die ervaringe van swanger tieners ten opsigte van hul swangerskap te identifiseer en te beskryf. Die wetenskaplike ondersoek is gelei deur die navorsingsvraag, “wat is die ervaringe van swanger tieners betreffende swangerskap?” Die doelwitte vir die studie was om te bepaal: die ervaringe van die huidige swangerskap; kennis betreffende voorbehoedmiddels sowel as die ervaring ten opsigte van die dienste soos gelewer deur die gesondheidswerkers.

'n Fenomenologiese, beskrywende ontwerp met 'n kwalitatiewe benadering is as die mees geskikte wetenskaplike metode beskou om die ervaringe van swanger tieners wie 'n voorgeboorte-kliniek in Chatsworth, KwaZulu-Natal bywoon, te beskryf. Die navorser het gebruik gemaak van 'n vooraf opgestelde onderhoud gids, protokol bestaande uit 'n lys van oop vrae gebaseer op die doelwitte, die literatuuroorsig en die professionele ervaring van die navorser. Die finale steekproef was tien deelnemers.

Kundiges op die gebied van verpleging en navorsingsmetodologie is geraadpleeg ten opsigte van die haalbaarheid, inhoud van die studie sowel, as om die proses en uitkoms van die navorsing te evalueer. Die data is persoonlik deur die navorser versamel. Data is ingesamel deur middel van individuele onderhoude. Transkripsie van die onderhoude is deur die navorser self-gedoen. Etiese goedkeuring is vooraf verkry vanaf die Universiteit van Stellenbosch sowel as die betrokke gesondheidsowerhede. Ingeligte skriftelike toestemming is verkry van die deelnemers sowel as van die ouers in geval van minderjaige tieners.

Tydens die data-analise is data gekodeer en in temas en sub- temas kategoriseer. 'n Skriftelike verslag is saamgestel ooreenkomstig die interpretasie uit die data-analise. Die navorser het na transkripsie met elke onderskeie deelnemer gekontroleer ten einde geldigheid van die data te verseker. Maslow (1968) se teorie is gebruik as konseptuele raamwerk vir die studie. Die bevindinge dui daarop dat daar 'n behoefte is aan ouerlike tussentrede betreffende tienerswangerskappe. Finansiële probleme in verband met armoede is ïdentifiseer as een van die groot bydraende faktore tot tienerswangerskappe, sowel as dat houdings van diegene wat kontrasepsie verskaf daartoe kan lei dat tieners nie wil gebruik maak van voorbehoedmiddels nie. Dit word aanbeveel dat die dienste by die kliniek moet verbeter; gesondheidswerkers uitgebreide opleiding en onderrig moet kry ten opsigte van tienergesondheid en seksualiteit behoeftes. Hersiening en vernuwing van opvoedkundige

programme by skole om in die voortdurende veranderende behoeftes van tieners, te voldoen. Die betrokkenheid van ouers en die gemeenskap in die bestryding van kwessies rondom tienerswangerskappe is noodsaaklik. Verdere navorsing word aanbeveel om oplossings te vind om hierdie probleem van tienerswangerskappe aan te spreek. Alle belanghebbendes moet saamwerk om hierdie sosiale probleem op te los.

DEDICATION

I dedicate this study to my lovely daughter Michaela Rangiah. Thank you for being an independent, mature girl when I was unable to give you my full attention. For succeeding in your own studies and I hope this study will inspire you to remain a responsible young woman.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
DOE	Department of Education
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
SA	South African
STI	Sexually Transmitted Infection

CHAPTER 1

SCIENTIFIC FOUNDATION OF THE STUDY

1.1 Introduction

Teenage pregnancy is a global public health problem and has been a concern to all health workers, community developers, industrialists, educationists, and parents since the early 1990's (Smith-Battle, 2000:85). Teenage birth rates in the United States rose in 2007 for the second year in a row. These increases follow a continuous decline between 1991 and 2005. Teenage birth rates in the United States are high, exceeding those in most developed countries (American Preliminary Data for 2007, 2009:2). Arai (2007:87-88) reported that in 2000 in the United Kingdom, the conception rate of teenagers younger than 18 years ranged from 19.4/1000 in Richmond upon Thames, to 89.8/1000 in Hackney. Recent British statistics show those more than 42 000 girls under the age of 18 fall pregnant each year (Arai, 2007:88).

Despite Government strategies to reduce the number of unintended and unplanned pregnancies, by making contraception a human right basic to human dignity, teenage pregnancies in South Africa are still a common prevalence although statistics have shown that it is declining. Moultrie and McGrath (2007:442-443) demonstrated a 10% decrease in teenage fertility between 1996 (78 per 1000) and 2001 (65 per 1000).

More than 17 000 KwaZulu-Natal schoolgirls fell pregnant last year - and for many it was a deliberate choice, flying in the face of poverty and the risk of disease (Sunday Tribune, 2011:4). SundayTribune (2011:4) has learnt that on average about 240 HIV-positive mothers give birth every month at Durban's Addington Hospital alone. Most are teenagers.

Teenage pregnancy in the residential area of Chatsworth, KwaZulu- Natal is still a common occurrence although family planning methods are free. Modern society is characterised by children who mature physically and sexually much earlier than previously. A younger age at menarche would seem to be an outcome of social changes in lifestyle, sexual attitudes, and practices (Netshikweta & Ehlers, 2002:79).

1.2 Rationale

The Children's Act (No.38 of 2005), lowers the age of majority to 18 and allows those above the age of 12 years access to HIV testing (Childrens's Act 38 of 2005:92) and contraceptives (Children's Act 38 of 2005:94) with immediate effect. There are many policies in place to

assist teenagers in preventing pregnancy, yet there are still so many unplanned pregnancies amongst teenagers.

Literature provides various figures to indicate the incidence of teenage pregnancy:

- The annual number of babies born to girls younger than 16 years is estimated to be 17 000. Of those, 4 000 babies were born to mothers younger than 14 years (Mwaba, 2000:30).

- According to Ruwaydah (2006:14), thousands of South African girls leave school and do not return after falling pregnant and having their babies.

- Statistics South Africa (2006) writes that teenage pregnancy is an important indicator of the well-being of teenage girls, specifically in terms of their education; in 2002, there were 66 000 teenage girls that reported pregnancy as the main reason for not attending an educational institution. This figure rose to 86 000 in 2004, but dropped to 71 000 in 2006. In 2002, 11.8% of teenage girls who were not in an educational institution cited pregnancy as the main reason. In 2004, the figure rose to 17.4% and declined to 13.9% in 2006.

The teenage pregnancy rate in South African schools, especially KwaZulu- Natal is of concern as indicated in many media reports (SundayTribune, 2011:4). As a result, most schools have urgently requested teenage pregnancy health talks even though subjects like life orientation are included in the curriculum. The researcher, a registered professional nurse who worked in the labour, maternity, and antenatal units of a government hospital in the Chatsworth area for a period of 6 years, also saw evidence of the problem. There are no published studies to suggest that research on teenage pregnancies in Chatsworth was done. A detailed review of relevant literature will follow in chapter 2.

1.3 Significance of the study

All data obtained from this study will assist in the exploration of the experiences of pregnant teenagers in Chatsworth, KwaZulu Natal. It will also, be used to educate teenagers about unplanned/unwanted pregnancies with the aim of preventing it. The findings from the study will be published, and will assist policy makers in education and health during the policy formulation process.

1.4 Problem statement

As explained in the rationale, the incidence of teenage pregnancies is influenced by various factors ranging from educational, social, health, biological and institutional factors. Despite having various structures in place to reduce the incidence of unwanted pregnancies among teenagers in the residential area of Chatsworth, KwaZulu- Natal, the prevalence of unwanted babies remains a problem. Consequently, it was endeavoured to explore the experiences of pregnant teenagers about their pregnancy in the Chatsworth area.

1.5 Research Question

The following research question was posed as a guide for this study: “What are the experiences of pregnant teenagers about their pregnancy?”

1.6 Research Aim

The aim of this study was to explore and describe the experiences of pregnant teenagers about their pregnancy.

1.7 Research Objectives

The objectives set for this study were to determine the pregnant teenagers:

Experience of the current pregnancy;

Knowledge of contraceptives;

Experience regarding the services delivered by the health care workers.

1.8 Research methodology

In this chapter a brief discussion on the research methodology applied is provided, a more in-depth approach is described in chapter 3.

1.8.1 Research design

In this study, a phenomenological, descriptive, exploratory study with a qualitative approach was used to explore the experiences of pregnant teenagers who attended an antenatal clinic in Chatsworth, KwaZulu- Natal about their pregnancy.

1.8.2 Population and Sampling

The target population was pregnant teenagers between the ages of 15 and 19 years who attended the antenatal clinic in Chatsworth. Subject selection through the technique of purposive sampling – sometimes referred to as judgemental or selective sampling was used. The use of this selection method facilitates the conscious selection of those participants who

can teach one about the central focus of the study (Burns & Grove, 2009:355). The participants were selected by searching through patient files and identifying those who meet the study inclusion criteria.

This area to conduct the study was chosen because it is easily accessible. Owing to the in-depth nature of this research project the sample size was limited to a small selective sample of ten (10) participants as saturation was reached by the repetition of themes and a lack of emerging new themes. According to De Vos, Strydom, Fouche, and Delport (2005:192-204) a total number of ten in depth interviews would usually lead to saturation.

1.8.2.1 Inclusion criteria

The participants were between the ages of 15-19 years, they were pregnant and willing to participate in the study.

1.8.2.2 Exclusion criteria

Women below and above the required age groups were not included. Those that did not wish to participate in the study were exempt.

1.8.3 Instrumentation

In order to explore each interview an interview guide (Annexure D) or protocol that includes a list of open-ended questions based on the objectives, the literature review, and the professional clinical experience was used. The interview guide consisted of Section A (Demographic data) and Section B (Experiences related to the pregnancy). There were no predetermined responses, and being a semi-structured interview the interviewer was free to probe and explore within these predetermined inquiry areas. The use of the interview guide ensured that the limited interview time was used beneficially. The guide also made the process of interviewing multiple subjects more systematic and comprehensive; and helped to keep the interactions focused.

1.8.4 Pilot study

According to Polit and Beck (2008:761), a pilot study is a small scale, or trial run, done in preparation for a major study.

The purpose of the pilot study was to pre-test the methodology and the feasibility of the study. One participant was purposively selected by going through the files of patients who were present at the clinic on that particular day. The inclusion criteria were taken into consideration during selection. This was done in order to evaluate whether the open-ended

semi-structured interview schedule did indeed explore and stimulate in-depth discussion about the participants' pregnancy. The interview schedule was sufficient to guide the researcher to explore the experiences of the pregnant teenager regarding her pregnancy. The pilot study was successful and was included in the findings of the main study.

1.8.5 Trustworthiness

The following principles, as described by Lincoln and Guba (1985:290), were applied to ensure trustworthiness of this study.

1.8.5.1 Credibility

Credibility- refers to confidence in the truth (Polit & Beck, 2008:538). This was ensured by accurately describing and interpreting the information provided by the participants in this study – data collection method of semi-structured interviews, validated the truth and confirmed the results as described in chapter 4.

1.8.5.2 Confirmability

Confirmability referring to objectivity or neutrality of the data and interpretations is the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning (Polit & Beck, 2008:539). Confirmability was attained through the involvement of an experienced supervisor who reviewed all data, documents, and results independently. These ensure that the findings are the product of the focus of the study and not the biases of the researcher (Babbie & Mouton, 2006:278). Member checking was done with each participant after individual interviews, to validate the transcribed data.

1.8.5.3 Transferability

According to De Vos et al. (2005:346), generalizing findings in qualitative research may be problematic but is possible if researchers could show that the study was guided by concepts, models and the use of multiple data collection methods. The conceptual framework used for this study was Maslow (1968:260-261).

1.8.5.4 Dependability

According to Babbie and Mouton (2006:278), dependability refers to the stability of data. If this study were to be repeated with the same or similar respondents in the same or similar context, its findings would be similar. In this study, all interviews were conducted in the same manner using an interview guide. The data was transcribed and analysed after each interview and verified by a fellow researcher and an expert in qualitative research.

1.8.6 Data collection

The semi-structured interviews were personally conducted. All logistical arrangements, for example, the place of interviewing, appointment, and the general atmosphere were aimed at enhancing the scientific rigour of the study. All open-ended questions of the interview guide were in English. Each participant was interviewed individually. Each interview was conducted in a single session with each participant. It was confirmed that the participants understood the questions. The participants had an opportunity to verify the contents of the document to fulfil the requirements of member checking to enhance the credibility of the data. The data was collected over a period of one month in April 2011. Notes were taken and transcribed after each interview.

1.8.7 Data analysis

The data reduction process was done in alignment with Tesch's 8-step model (1985) open coding method of data analysis as described in Creswell (2004: 256). The data was analysed by transcribing the responses obtained from the interviews. Data was explored in detail for common themes and these were then established into codes. The transcribed interviews were captured onto a master file on Microsoft Word document immediately after each interview. A colour-coded index via "highlighting" of the phrases was used to identify the different themes that evolved. Themes were added until saturation was met. The results are discussed in chapter four.

1.8.8 Ethical considerations

Permission to conduct the study was requested from the Human Research Ethics Committee, Faculty of Health Sciences, at Stellenbosch University (Annexure F); and the KwaZulu- Natal Health Department, Chatsworth Antenatal clinic (Annexure E). A clear statement of the purpose, procedures, risks, and benefits of the research project, as well as the obligations and commitments of both the participants and the researcher were discussed and contained in the consent form as described by Sales and Folkman (2000:35). Voluntarily informed written consent was obtained from individual participants, ensuring confidentiality (Annexure A). Parental permission was obtained for participants under the age of 18 years (Annexure B). Participants younger than 18 years of age (Annexure C) also completed an assent form. The supervisor and co-supervisor validated the interview guide, and it was presented at the master's tutorial scholarly committee for constructive critique as well as the ethics committee. None of the participants wanted to have the interview recorded, as they were afraid of their voices being identified, although confidentiality was assured.

All data obtained was managed with the help of supervisors. The name of the participants did not relate to the transcribed data. Data was stored in a locked cupboard accessible to the researcher and supervisor as it is intellectual property of Stellenbosch University, and can be destroyed after a period of five years after the completion of the study.

1.8.9 Limitations

One of the limitations was that none of the participants was willing to have the interview tape- recorded due to fear of their voices being identified, although confidentiality was ensured. Limitations will be discussed in detail in chapter 5.

1.9 Operational definitions

The following terminology utilised in the study is defined or clarified to ensure consistent interpretations.

Teenage pregnancy: According to Statistics Canada (2007:1), teenage pregnancy is a pregnancy of a woman who was aged 15 to 19 when her pregnancy ended.

Adolescent: Nodin (2001:16) defines an adolescent as an individual living through a period of major change at various levels: physical, family, social, emotional, and personal. It is during this phase that, in a way, the adolescent becomes a person, tries to become autonomous, and tries to determine her position in the world, something necessary to give some significance to her own existence. According to Statistics Canada (2007:1), an adolescent (teenager) is any person between the ages of 12 and 17.

Teenage fertility rate: According to Statistics Canada (2007:1), the teenage pregnancy rate is the number of pregnancies per 1,000 women aged 15 to 19.

Contraceptives: are agents that are used to temporarily prevent the occurrence of conception, including oral pills, condoms, intra-uterine devices, and injections (Kirby 2001:56).

1.10 Chapter outline

The chapter outlay of the dissertation is as follows:

Chapter 1: Scientific foundation of the study

This chapter describes the background, the focus, and rationale of the study. A brief outline of the goals, objectives, and methodology are also described.

Chapter 2: Literature Review

A literature review related to the experience of pregnant teenagers about their pregnancies and conceptual theoretical framework is described in this chapter.

Chapter 3: Research Methodology

In this chapter the research, methodology applied in the study, which include the research design, population, sampling, and data analysis is described.

Chapter 4: Data Analysis, Interpretation, and Discussion

The findings are discussed, interpreted, and analysed based on the data collected.

Chapter 5: Conclusion and Recommendations

In this chapter, the findings according to the study objectives are concluded and recommendations are made based on scientific evidence obtained in the study.

1.11 Summary

The local newspapers, like the Rising Sun and Chatsworth Tabloid are constantly reporting that, teenager's turn to prostitution to earn an income, as the child support grant that they receive, amounting to R250-00 per month is barely enough to sustain their children. In the process, they become pregnant, as some clients refuse to use condoms. In a recent report published by the Rising Sun (2010:1), the article entitled "Prostitution uncovered," a seven-month-old baby was found in the den where these girls operate. According to the Rising Sun (2010;1) it is difficult for the South African police services to make arrests for soliciting for the purpose of prostitution, as they require visual evidence to convict the perpetrators in a court of law. They however, admit that the prostitution rate in Chatsworth is increasing due to teenage drug abuse. They turn to prostitution as a means to support their drug habit.

The research focus for the study was therefore to gain an in-depth understanding of the experiences of pregnant teenagers in Chatsworth about their pregnancies, with the aim of reducing or preventing teenage pregnancies in this community.

1.12 Conclusion

This chapter has provided the scientific foundation of the study. The background, rationale, and focus were explained. An outline of the methodology has been included. The literature review and conceptual framework, which serves to support the rationale, will be discussed in chapter two.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter discusses the literature review conducted on teenage pregnancies. In order to efficiently meet the demands of a scientific study, national and international literature was consulted. This chapter thus deals with the search for, and review of literature relevant to the research topic.

2.2 Reviewing and Presenting the Literature

According to Burns and Grove (2003:110), the purpose of a literature review is "… to guide the development of a study to increase the evidence needed to guide practice…" The review of the literature provides a deepening of the researcher's knowledge on the topic and provides information about existing studies on the topic.

Keyword searches were conducted on PubMed and Cinahl research databases using the words: **teenage pregnancy**, **teenage contraception, and teenage fertility**, for local and international articles in English. Studies dated between 2000 and 2011 were eligible for inclusion. However, seminal works prior to 2000 were also considered. The search focused on teenagers between the ages of 15-19 years. The searches included published peer-reviewed journal articles, conference presentations, reports, book chapters, abstracts, as well as evaluations of interventions targeting youth and adolescents.

The aims of the literature study may be described as follows:

- Reviewing the existing available body of knowledge to see how researchers have investigated "experiences of pregnant teenagers"
- To identify what actions or programmes can be implemented to deal with the problem of unplanned, unwanted pregnancies amongst teenagers
- To ensure that one does not duplicate a previous study and waste time and money as indicated by Mouton (2006:87).

2.3 The Prevalence of Teenage Pregnancy

The prevalence of unplanned pregnancies among South African teenage girls warrants urgent attention (Lesch & Kruger, 2005:1072). Internationally, the situation is also extensive. According to the World Health Organisation (2001), each year 75 million teenagers have unwanted pregnancies worldwide. Arai (2007:87-88) reported that in 2000 in the United Kingdom, the conception rate of teenagers younger than 18 years ranged from 19.4/1000 in Richmond upon Thames, to 89.8/1000 in Hackney. Recent British statistics show that more than 42 000 girls under the age of 18 fall pregnant each year (Arai, 2007:88).

In the United States, about 11% of all births in 2002 were from teenagers aged 15-19 years. The majority of teenage births (67%) are girls aged 18 and 19. An estimated number of 860 000 teenagers become pregnant each year and about 425 000 give birth (Moss, 2004: 1-2).

In South Africa, literature provides various figures to indicate the incidence of teenage pregnancies. The number of babies born to girls younger than 16 years annually is estimated to be 17 000. Of those 4 000 babies were born to mothers younger than 14 years (Mwaba, 2000:30). According to Ruwaydah (2006:14), thousands of South African girls leave school and do not return after falling pregnant and having their babies.

Statistics South Africa (2006) reports that teenage pregnancy is an important indicator of the well-being of teenage girls, specifically in terms of their education. In 2002, there were 66 000 teenage girls that reported pregnancy as the main reason for not attending an educational institution. This figure increased to 86 000 in 2004, but dropped to 71 000 in 2006. In 2002, 11.8% of teenage girls who were not in an educational institution cited pregnancy as the main reason for not attending school and in 2004; the figure rose to 17.4% and declined to 13.9% in 2006.

2.4 Factors Contributing to Teenage Pregnancy

2.4.1 Lack of knowledge about sexuality and reproductive functions

In their study on “socio-cultural deterrents to family planning practices among Swazi women” Ziyane and Ehlers (2006:31) reported that 60% of participants were not informed about contraceptives, no information was available in their communities and that education programmes were unavailable to their schools. Substantiated further Mbambo, Ehlers and Monareng (2006:9) also reported that the lack of knowledge about contraceptives and negative attitudes towards the use of contraceptives were some of the reasons for failure to use contraceptives by adolescents in the Mkhondo area.

Several aspects influence teenagers' unawareness regarding sexuality and reproductive functions. Most important of these are the processes influencing communication between parent and child. Seekoe (2005:23) states that elders do not provide useful information on sexual issues to youth at all due to the limitations in communication between parent and child. According to Hughes (2003: 32-34), teenage pregnancy can be reduced if they are given early, detailed information and advice about contraception and pregnancy. Providing factual information about pregnancy prevention helps reduce the incidence of unwanted pregnancies (Hockenberry & Wilson, 2007: 864).

2.4.2 Poverty and social conditions

For the past two decades, the influence of poverty on teenage pregnancy has regularly been written about. Mfono (2003: 8) who conducted a study on teenage pregnancy concluded that teenage pregnancy is high among child headed households. The teenagers in those households often engage in several activities in exchange for money to assist them to survive. Mfono also revealed that there is high rate of teenage pregnancy among black poor teenagers who get involved in unprotected sexual activities as a means to survive their circumstances. This study further confirmed that economically poor countries have more teenage mothers as compared with economically rich countries as poverty has a role in perpetuating teenage pregnancy.

According to MacPhail and Campbell, (2001:1620) poverty could be an important factor influencing decisions on whether or not to use contraceptives. Lack of finance and support may also result from teenage pregnancy. According to Kaufman, De Wet and Stadler (2001: 148) boyfriends of adolescent mothers failed to take responsibility for their babies because of negative influence on their education and employment opportunities.

The Human Sciences Research Council (HSRC) (2009:58) survey on teenage pregnancy in South Africa, points out that teenage fertility is in fact the result of a complex set of factors largely related to the social conditions under which children grow up. They are at a significantly higher risk of early pregnancy if:

- They drop out of school early often because of economic barriers and poor school performance;
- They grow up in residential areas where poverty is entrenched (informal areas and rural areas);

- Both parents are deceased and in particular if there is no mother in the home;
- They have little knowledge about contraception, and limited access to friendly, judgement-free, health services;
- There is a general stigma about adolescent sexuality in their community and there are few opportunities for open communication about sexual matters with parents and partners;
- Young women are often involved in relationships where power is imbalanced; men decide the conditions under which sex occurs. All too often, this involves coerced or forced sex;
- Young women struggle to meet immediate material needs, and they make trade-offs between health and economic security. Sex in exchange for material goods leads to young women remaining in dysfunctional relationships, engaging in multiple sexual partnerships and involvement with older men. Under such conditions, there are few opportunities to negotiate safe sex and the risk for pregnancy is increased.

2.4.3 Non- contraceptive usage and misconceptions

Several perceptions and misconceptions regarding the use of contraceptives are reported in literature. Wood and Jewkes (2006:112) indicated that poor access to medical information about the reproductive system provided space for medically inaccurate notions about the conditions necessary for conception. Some girls feel they are not at risk as the blood of her sexual partner had to "get used" to hers through a series of sexual contacts before conception could occur. There is a belief that pregnancy cannot occur if one woman alternates multi-partners regularly, because the blood is different each time (Wood &Jewkes 2006:112).

The healthcare practitioner should give information regarding advantages and disadvantages of the different contraceptive methods. In addition, information should also be given about the effectiveness rate of the different contraception methods, its hassle-free availability, and the 'morning after pill'. This protects against HIV (Human Immunodeficiency Virus) and STI'S (Sexually Transmitted Infections), since STI and HIV rates are high among teenagers (Hockenberry & Wilson, 2007:864). Amenorrhoea should be explained as a side effect of Depo-Provera (medroxyprogesterone acetate) is an injectable medicine (a "shot") that prevents pregnancy for up to 3 months with each injection), especially after the first year

of use. Silberschmidt and Rasch (2001:1819) also reported that some girls who had tried oral contraceptives had stopped using it because of side effects such as irregular bleeding.

Substantiated further when experiencing side effects, many teenagers discontinue the use of contraceptives without seeking advice from nurses or care providers. Discontinuing all protection during sexual interaction may lead to an unplanned pregnancy (Maja & Ehlers, 2004:49-50).

Mwaba (2000:33) found that 50% of the adolescents in this study were ashamed to use contraceptives, whilst 49% feared parental reaction should their contraceptive use be discovered. In addition, 43% did not trust contraceptives. Teenage mothers often indicate that teenage pregnancy is infinitely preferable to the possibility of infertility caused by contraceptives (Jewkes, Vundule, Maforah & Jordaan, 2001:733).

2.4.4 Attitudes of contraceptive providers

The study conducted by the Medical Research Council (2007) showed that the attitudes of nurses at the hospitals and other health centres are a barrier to adolescent contraceptive use in South Africa. These attitudes hinder teenagers from seeking protection and it therefore contributes to teenage pregnancy. The findings of the study showed that most nurses feel uncomfortable to provide teenagers with contraception because of their belief systems; they feel that adolescents should not be having sex at an early age. This study also found that the nurses' attitude to requests for contraception was highly judgmental and they were perceived as unhelpful to teenage mothers. According to Woo and Twinn (2004: 595-602) the healthcare worker must be aware of their own attitudes, beliefs and values so that effectiveness in discussing sexuality as a professional is not limited.

Contraceptive providers are often reluctant to give contraceptives to young people especially to those who are unmarried. In some instances, teenagers were compelled to change their school uniforms for ordinary clothes when accessing contraceptives as they could be denied to schoolgirls (Ziyane & Ehlers, 2006:40). In a study conducted by Forrest (2009:1-7) participants spoke of a need to revise adolescent sexual and reproductive health services to make it more youth-friendly in order to avoid it being seen as stigma- generated by community healthcare workers.

2.4.5 Media Influence

Adolescents who were more exposed to sexuality in the media were also more likely to engage in sexual activity themselves. The mass media with its sexualised content is another

contributing factor that perpetuates teenage pregnancies as it gives teenagers easy access to pornographic, adult television programmes and multimedia text messages. It seems that many societies are going through high moral degeneration, as pornographic information is accessible free of charge via devices such as computers and cell phones. Free access to pornographic material on the internet is also likely to influence teenagers' minds (L'Engle, Ladin, Brown,& Kenneay, 2006:6).

Bezuidenhout (2004: 31) adds that " sexually arousing material, whether it is on film, in print or set to music, is freely available to the teenager and such information is often presented out of the context of the prescribed sexual norms of that society". However, according to Schultz (2004: 11), sex educators, social workers, other helping professionals, and parents should work together to educate teenagers about the truths around sex and the consequences of indulging in unprotected or early sexual intercourse.

2.4.6 Culture

In some societies, early marriage and traditional gender roles are important factors in the rate of teenage pregnancy. In some sub-Saharan African countries, early pregnancy is often seen as a blessing because it is proof of the young woman's fertility (Locoh, 2000:1).

Cultural barriers and respect for elders in discussing sexuality issues contributed to problems as neither parents nor children could initiate a conversation (Seekoe, 2005:27). Yako (2007:16) reports that in the Basotho culture, it is unacceptable for parents to discuss sexuality with children. Discussing these issues is perceived as encouraging children to engage in sexual activity prematurely. The result is that the daughters are not free to talk to their mothers about sexuality issues. Mother-daughter interaction is important in this regard and mothers especially are highly influential figures in the lives of their daughters.

In a study in South Africa, Mwaba (2000:32) found that 23% of the adolescents confirmed their pregnancy was because of trying to prove fertility.

2.4.7 Peer Pressure

Peer pressure has a strong influence on teenager's sexual behaviour. Jewkes, Levin, and Penn-Kekana (2003:131) reported that one out of five sexually active girls indicated that they have sex with their boyfriends to please their friends. The assumption should not be made that it is only boys influencing young teenage girls to become sexually active. However,Tripp and Viner (2005:590-593) believes that using peers of similar age as educators has reduced the prevalence of sexual activity at age 16. News 24 (2011:1) reported that two boys

allegedly had sex with a 15-year-old girl while the third filmed them and the Western Cape education authorities are considering expelling the three boys. A month later,the pupils were arrested after a cell phone video clip was shown around the school.

Mwaba's study (2000:31) sought to determine the attitudes, perceptions and beliefs of a group of South African adolescents regarding teenage pregnancy. The results showed that both males and females held a negative attitude toward teenage pregnancy due to peer pressure. Pressure from males to engage in sex and reluctance to use contraceptives was perceived as the main cause of teenage pregnancy.

2.5 Consequences of Teenage Pregnancy

2.5.1 School dropout or interrupted education

Under the Education Act (27 of 1996), pregnant schoolgirls may not be excluded from school except for health reasons, and must be readmitted if they apply after giving birth. However, many young mothers do drop out of school, especially if they do not come back to class within a year of giving birth (HSRC, 2009:58).

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 financial provision becomes a major challenge or threat (Yako, 2007:16).

2.5.2 Health risks to teenager and baby

According to the Centers for Disease Control and Prevention in the USA (2004:1-4) of 12 million cases of pregnant girls, 9.1 million teenagers were affected by sexually transmitted infections annually (STI). These include *chlamydia, trichomoniasis, genital herpes, gonorrhoea, syphilis, hepatitis B* and HIV. These can be fatal to the mother and baby. In 2001, one in five pregnant teenagers was infected in South Africa (Jewkes *et al.,* 2001:733).

There is an increased risk for assisted deliveries, such as caesarean section or forceps, as the pelvis may be inadequate and may not be mature for the delivery of a baby. Even when deliveries are normal, because of the lack of elasticity, these may be slow and difficult and can cause lesions (Costa 2000:111). Adolescents 16 years of age and younger are at an increased risk of cephalo- pelvic disproportion, which results in obstructed labour (Cronje & Grobler 2003:665).

2.5.3 Child neglect and abandonment

Teen mothers usually do not have good parenting skills nor do they have the social support system to help them deal with the challenges of raising an infant. A child born to a teenage mother is 50% more likely to repeat a grade in school and is more likely to perform poorly on standardised tests to become a school dropout. They are often isolated as a result. In an episode of Third Degree which was broadcast on television entitled ‘Killer moms’ (8 February 2011) Government was urged to take harsh steps against claims of increasing teenage pregnancies and cases of ‘baby dumping’.

2.6 Legislation and Policies to Prevent Teenage Pregnancy

2.6.1 The Child Act

The overarching legal document governing children's rights to access contraceptives is the Children’s Act (38 of 2005:17). The sections of the Children's Act regarding the responsibilities of the national government, such as reproductive health rights and children's courts were approved by the President in 2006. Provisions regarding the responsibilities of provincial governments, such as foster care and child-care centres are contained in the Children's Amendment Act (41 of 2007:36-52) approved by the President in 2008.

The Children's Act delineates rights not present in the Child Care Act of 1983, many of which are relevant to youth health programs. For instance, every child, regardless of age, has the right to “have access to information on . . . the prevention and treatment of ill-health and disease, sexuality and reproduction.” A 12-year-old child can consent to HIV testing, and children under 12 years can consent if they are of sufficient maturity to understand the benefits, risks, and social implications of a test.

2.6.1.1 International perspectives on the protection of the child

Internationally the laws differ in respect of Children’s Rights. For instance, eighteen is the age of majority in China. The civil law of China provides that people above eighteen years of age and those from sixteen to eighteen who make a living on their own have full civil conduct capacity according the general principle of the People’s Republic of China (2007:1).

According to an overview of the minors’ consent law, United States of America, Guttmacher Institute (2011:1), two states and the District of Columbia explicitly allow all minors to consent (12 years and older) to abortion services. Twenty-two states require that at least one parent has to give consent to a minor’s abortion, while ten states require prior notification of at least one parent. Four states require both notification of and consent from a

parent prior to a minor's abortion. Six additional states have parental involvement laws that are temporarily or permanently enjoined. Six states have no relevant policy or case law.

2.6.2 South African Basic Education Policy

2.6.2.1 Pregnant learners

HIV and sex education exists in schools as part of the wider Life Orientation curriculum, which was implemented in 2002 (Integrated Regional Information Networks PlusNews, 2008:1). The quality of the education, however, is hindered due to a lack of training of teachers, and unwillingness on the part of teachers and schools to provide this education. Training in life orientation often takes place outside of school hours, which acts as a disincentive to training. The shortage of trained teachers may result in just one teacher in a school being able to teach such classes, and school management could be resistant to what is being taught. This has led teaching unions to call for a life orientation module to be included in all teachers training (Integrated Regional Information Networks PlusNews, 2008:1).

In one survey, some teachers reported feeling uncomfortable about teaching a curriculum that contradicted with their own values and beliefs (Ahmed, 2009:52). Another problem was the disadvantaged home life of the learners, with some teachers believing poor role models at home did not help to reinforce HIV prevention messages received in the classroom (Ahmed, 2009:51). In the USA, Santelli, Lowry, Brener and Robin, (2000:1586), found that young people who receive interventions from infancy through elementary school have a greater likelihood of delaying childbirth in their teenage years.

In a rights-based society, young girls who fall pregnant should not be denied access to education and this is entrenched in law in South Africa through the Constitution (1996:s.27(1)) and Schools Act (84 of 1996). In 2007, The Department of Education released *Measures for the Prevention and Management of Learner Pregnancy*. Not without controversy, the guidelines continue to advocate for the right of pregnant girls to remain in school, but suggests up to a two-year waiting period before girls can return to school in the interest of the rights of the child. Any proposed shift in policy and practice needs to be informed by a well-rounded understanding of the context of teenage pregnancy (National Department of Education, 2009:5).

2.6.2.2 Provision of condoms to learners at school

In addition to the Children's Act, the South African Department of Education (South African Schools Act 84 of 1996:1-11) (DOE) policies also govern the distribution of condoms in schools. The current DOE policy is a politically pragmatic solution to the national debate: let local schools decide for themselves. In a 1999 policy document (still in force) on HIV and AIDS in public schools, the DOE stated that each school can decide "whether condoms need to be made accessible within a school . . . and if so under what circumstances."

The Children's Act (38 of 2005) thus preserves the schools' right to choose to distribute condoms, with one modification. If schools do distribute condoms, they must provide them to all learners 12 years and over. The Act does not impose an obligation on the government to distribute condoms. The condom access clause is a "negative right," which obligates the government to refrain from certain actions. It is not a "positive right," such as the Constitutional right that obligates the government to provide access to health care services. The Children's Act (38 of 2005) of South Africa states that no person may refuse to sell condoms to a child 12 years or older, or refuse to provide such a child with condoms on request where such condoms are distributed free of charge. No further regulations are needed to affect these rights.

However, whether these rights are appropriate remains the focus of intense debate (Sookha & Cole, 2007:1; Joseph, 2007:1). In the case of condom distribution in schools, the policy of decentralization has been poorly communicated. Most school staff is unaware of any policies on condom distribution in schools. Perhaps more worrisome, many funding agencies, advocacy groups, and government officials believe that condom distribution in schools is impermissible as a matter of stated policy. This view seems based on statements by senior government officials, including the Minister of Education, suggesting that condom distribution in schools is inappropriate (Fredericks, 2001:1; De Capua, 2006:1; Cullinan, 2004:1).

2.6.3 Access to contraceptive services

According to Woo and Twinn (2004:595-602) if teenagers know about contraceptive availability, methods and usage, it also helps them to overcome the feeling of ambivalence about managing their sexuality and sexual behaviour. In South Africa, by law a female at the age of 12 may now access contraceptives without parental consent according to the Children's Act (38 of 2005:17).

Ehlers (2003: 229-241) conducted a study in South Africa to explore the knowledge of young mothers regarding contraception. Data gained proved that adolescent mothers lacked

knowledge about contraceptives, emergency contraceptives, and termination of pregnancy services. Merely legalising the termination of pregnancies, and providing free contraceptive and emergency contraceptive services, did not affect utilization of these services by the adolescent mothers investigated. It was concluded that young mothers require more knowledge to enable them to make better-informed decisions, and the services need to become more readily accessible and user friendly to adolescents. Reproductive health services provided specifically to adolescents could enhance the utilisation of such services.

2.6.4 Abortion legislation in South Africa

Abortion in South Africa was legalised in 2005 due to the high death rate of women especially of poor black women who used back street abortion services. The Choice on Termination of Pregnancy Act (92 of 1996:1-5) was passed, providing abortion on demand. According to The Choice on Termination of Pregnancy Act (92 of 1996:1-5), abortion is provided free of charge in a variety of governmental institutions such as hospitals and clinics. In South Africa, a woman of any age can get an abortion by simply requesting it with no reasons given if she is:

- less than 12 weeks pregnant
- if she is between 13 and 20 weeks pregnant and her own physical or mental health is at stake
- if the baby will have severe mental or physical abnormalities
- if she is pregnant because of incest or rape
- or if she is of opinion that her economic or social situation is sufficient reason for the termination of pregnancy
- If she is more than 20 weeks pregnant, she can get the abortion only if the foetus' life is in danger.

Previously, a woman under the age of 18 was forced to consult with her parents prior to undergoing abortion, however now a woman as young as 12 can undergo an abortion without parental consent. According to an article published by Life News, (2007:1) abortions on adult women are increasing but the figures for teenagers have doubled in the last five years alone. In 2006, 9,895 teenagers 18 and young got abortions compared with 4,423 in 2001(Life news, 2007:1).

2.6.5 The child support grant

In a study done in the United States of America by Luker and Kristin (2006:251),they concluded that, whilst teenage pregnancy is problematic in nature, it is a subject of debate in South Africa and worldwide.

The above may not be true and one may argue that the current amount of R250-00 per month per child is hardly enough to alleviate poverty. According to a study conducted by Makiwane and Udjo (2006:2), they found that there is no relationship between teenage fertility and the Child Support Grant. While teenage pregnancy rose rapidly during the 1980's, it had stabilized and even started to decline by the time the Child Support Grant was introduced in 1998 in South Africa. Furthermore, only 20 percent of teens who bear children are beneficiaries of the Child Support Grant. This is disproportionately low compared to their contribution to fertility (Makiwane & Udjo, 2006:2).

2.7 Theoretical Basis for the Prevention of Teenage Pregnancy

The conceptual framework for this study was adapted from Maslow (1968:260-261). Maslow places love before esteem in his hierarchy of needs. Maslow (1968:260-261) stated that individuals mature and achieve a level of self-actualisation only if environmental conditions enable certain basic needs to be met first. Maslow (1968:260-261) stressed that individuals strive to first meet their physiological survival needs, then their need for love and belonging, self-esteem needs, and finally their desire to obtain knowledge to know and understand.

Self-actualisation is the quest to become the best you can be. It involves deciding what you want from life and then doing what is necessary to get what you want. Self-actualisation is a term coined by psychologist Abraham Maslow to describe the on-going process of fully developing your personal potential. The first thing to note about self-actualisation is that it is a process not a goal. In other words, self-actualisation is not something that you aim for: it is something that you do. Secondly, self-actualisation is not restricted to high profile, high-achieving individuals; you do not have to be famous to self-actualise (Maslow, 1970:150).

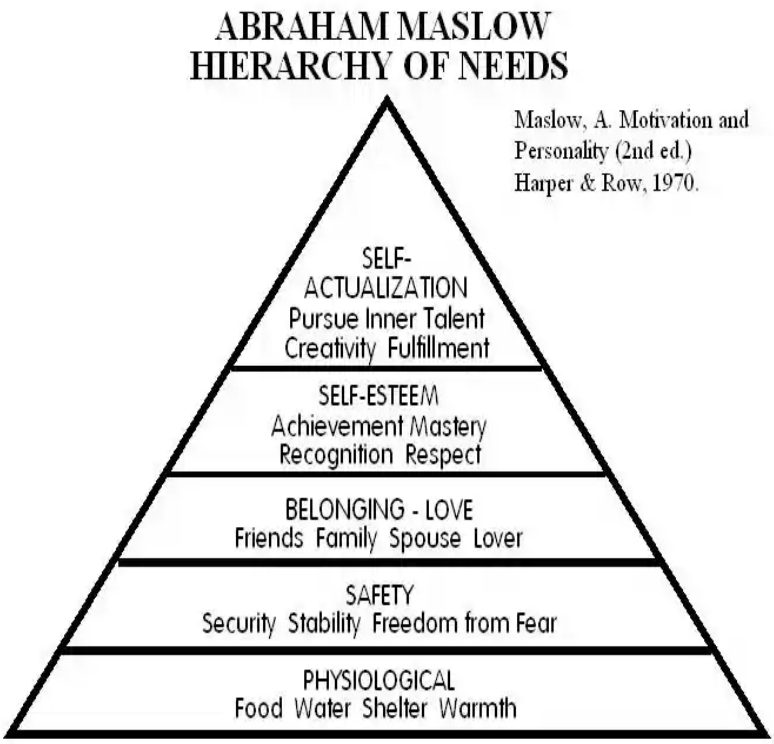

Figure 1. Maslow's hierarchy of human needs. (Maslow, 1970).

Maslow's theory of motivation will be discussed in relation to the prevention of teenage pregnancy.

2.7.1 Physiological Needs

Survival needs such as food, water, sleep, and shelter from the elements are among the needs at the bottom of the pyramid. Teenagers who are denied these basic needs may become physically weak and develop illnesses. Many people in society take for granted that basic physical needs are easily met. However, food, clean water, and shelter are not easily obtainable for many people. For example, social issues such as homelessness and poverty can be related to, and affect the health and physical needs of teenagers. According to the American National Campaign to prevent, teen pregnancy (2010:1) poverty is a cause as well as a consequence of early childbearing, and some impoverished young mothers may end up faring poorly no matter when their children are born.

2.7.2 Need for Safety

Satisfying the need for safety includes more than just safeguarding themselves against physical harm. In fact, the safety needs that are essential to teenager's personality can also be psychological in nature. Teenagers need the safety of familiar places and people that

make them feel secure, such as their homes, their family, and trusted friends. According to Costa (2000:54-55) if the problems of the teenager are not always addressed in the home, they search for the answers to many of their doubts outside the home, by chatting to their friends, receiving possibly misleading information.

2.7.3 Need to be loved and to belong

Humans are social beings who need to interact with other people and to know that they are valued members of the group that enhances their physical, mental, and social health. Teenagers generally want to belong to a community, such as a family, a circle of friends, or a social group such as a school club or a sports team. Feeling a sense of belonging can increase their confidence and strengthen their emotional health. Yako (2007:77) noted a great deal of mystery surrounding sexual contact and contraceptive use. According to Yako, (2002: 77) their friends apparently told adolescent mothers that contraceptives make people sick and that if they used them they would be sick. Although these adolescent mothers had not seen anybody who had become sick from using contraceptives, they believed what their friends told them.

2.7.4 Need to be valued and recognized

Teenagers feel a need to be appreciated, to be personally valued by family, friends, and peers. One way for them to meet this need is by participating in productive activities, such as studying, playing an instrument or sport, or writing short stories. By being able to do something well, they gain respect and a feeling of self-worth. According to Maluleke (2007:12), young people who discuss sexuality with their parents are more likely to delay sexual intercourse, and use protection, than those who have no guidance from their parents. Parents should be urged to be fully informed about sexuality issues to be able to share appropriate information with their children as part of their socialisation process. Getting information about sex from the adults they trust will enable them to be more responsible as grown-ups that know their rights and respect those of others Maluleke (2007:12).

2.7.5 Need to reach full potential

At the top of the pyramid is the need to reach their full potential as a person. This quest for self- actualisation includes having goals that motivate and inspire them. Self- actualisation means having courage to make changes in their lives in order to reach their goals and grow as individuals. During their teen years, they begin to recognise their potential and set goals for their future. They see more clearly what their talents are, what their dreams are, and who they want to become. Self- actualisation is a lifelong process. Part of the process is learning

self-discipline in order to reach their goals. However, Marule (2008:1) points out that teenage pregnancy is likely to force the younger girl to be more dependent on the adults around her, possibly frustrating her desires to become more independent and self-sufficient.

Healthcare workers have a responsibility to assist teenagers to set goals for their future and to reach self-actualisation, which in turn will assist them to reach their true potential, thus preventing teenage pregnancies. According to Hockenberry and Wilson (2007:862), the attitude, skills and knowledge of the healthcare worker regarding the subject is imperative in order to achieve positive outcomes in preventing teenage pregnancy. Communication and creating a trusting relationship is the basic factor in implementing a program of care (Hockenberry & Wilson, 2007:862). Having a baby, as a teenager does not mean that the mother has to give up her life and goals when it comes to her schooling; it simply means she has to learn to be a woman, learner, and most importantly a mother**.** The way that teenagers choose to meet these needs as outlined by Maslow may affect their emotional/mental health. For example, meeting the need for affection by building and maintaining respectful, loving relationships with people that they care about will strengthen their emotional/mental health. However, sometimes teenagers choose risky ways to fulfil their needs.

Some teens may decide to join a gang to feel a sense of belonging or engage in sexual activity in an attempt to feel loved. Such decisions carry dangerous consequences. Gang membership can lead to physical harm and trouble with the law. Sexual activity can result in unplanned pregnancy, sexually transmitted infections, and the loss of self-respect and respect for others. Practicing abstinence and finding healthy ways to meet emotional needs are strategies to avoid these risk behaviours.

Maslow's conceptual framework was chosen for this study because Maslow advocated an environment that would permit individuals to sequentially meet these needs and actualise their own potential.

2.8 Summary

A variety of research studies and programmes have been developed and implemented to investigate and address the issues of teenage pregnancies in South Africa. Some studies have contributed to a better understanding of the phenomenon of teenage pregnancy and its challenges, whilst others have identified areas where more research is required. Much effort has also been put into increasing the sex education and promotion of safer sex programmes to prevent teenage pregnancies. However, it seems that despite these efforts, teenage pregnancy continues to be a social problem in South Africa and global.

2.9 Conclusion

This chapter thus identified the factors that contribute to and the consequences of teenage pregnancy and looked at the literature that highlighted the legislation put in place by the South African Government to deal with teenage pregnancy. In the following chapter, the research methodology applied to conduct the study will be discussed.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

In chapter 2, the literature review undertaken for the study was described. The goal of this chapter is to provide an overview and rationale for the research methodology applied in the study to explore the experiences of pregnant teenagers about their pregnancy in the Chatsworth area of Kwa Zulu- Natal. The research methodology that was applied in this study will be described.

3.2 Goal of the Study

The goal of this study was to explore the experiences of pregnant teenagers about their pregnancy.

3.3 Objectives

The objectives set for this study were to explore the pregnant teenagers:

Experience of the current pregnancy;

Knowledge of contraceptives;

Experience regarding the services delivered by the health care workers.

3.4 Research Methodology

According to Burns and Grove (2003:488), methodology includes the design, setting, sample, methodological limitations and the data collection and analysis techniques in a study. In this study, methodology refers to the research process and its logical sequence.

The focus of the study was to explore the experiences of pregnant teenagers about their pregnancy; therefore, the research approach was qualitative.

3.4.1 Research design

Burns and Grove (2009:696) refer to research design as the “blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings. Burns and Grove (2007:551) refer to qualitative research design as a systematic, subjective approach used to describe life experiences and to give them meaning. In this study, a

phenomenological, descriptive, exploratory study with a qualitative approach was used to explore the experiences of pregnant teenagers who attended an antenatal clinic in Chatsworth in KwaZulu- Natal about their pregnancy.

A phenomenological study refers to the general description of the phenomenon as seen through the eyes of people who have experienced it at first hand (De Vos, Strydom, Fouche & Delport, 2005:264).

A descriptive strategy is defined, as a collection of accurate data on the problem to be studied. According to Burns and Grove (2003:26), descriptive research is defined as a way of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorising information. Polit supports this together with Beck (2008:237) who writes that a researcher who conducts a descriptive investigation observes, counts, describes and classifies.

According to Polit and Beck (2008:20), exploratory research is aimed at investigating the full nature of the phenomenon, the manner in which it is manifested and the other factors with which it is related. Burns and Grove (2003:357) indicate that exploratory studies are designed to increase the knowledge of the field of study.

3.4.2 Population and sampling

According to Burns and Grove (2003:491), population includes all the individuals that meet the sample criteria for inclusion in a study; also referred to as the target population. Participants were selected through the technique of purposive sampling – sometimes referred to as judgemental or selective sampling where the researcher consciously selects those participants that can provide information about the central focus of the study (Burns & Grove, 2009:355).

The target population for this study was pregnant teenagers who attended the antenatal clinic in Chatsworth. Due to the qualitative nature of the study, inclusion and exclusion criteria were developed to guide the inclusion or exclusion of participants.

3.4.2.1 Inclusion criteria

Inclusion sampling criteria are the characteristics that the subject or element must possess to be part of the target population (Burns & Grove, 2007:325). For this study, the participants were between the ages of 15-19 years. They were pregnant and willing to participate in the study.

3.4.2.2 Exclusion criteria

Exclusion sampling criteria are those characteristics that can cause a person or element to be excluded from the target population (Burns & Grove, 2007:325). Pregnant women below and above the required age groups were excluded. Those who did not wish to participate in the study were also excluded.

3.4.3 Interview guide

Welman and Kruger (2001:167) describe a semi-structured interview as a method where an attempt is made to understand how participants experience their life-world. Face to face, semi-structured interviews took place in a designated room at the Chatsworth antenatal clinic, KwaZulu Natal, in order to maintain privacy and to ensure confidentiality during the data collection process. The interview guide consisted of Section A (Demographic data) and Section B (Experiences related to the pregnancy).

The purpose of an interview is to allow the researcher to explore the experiences of other people as well as their meaning (Terre Blanche & Durrheim, 2002:128). It gives the researcher an opportunity to get to know the participants quite intimately and understand how they think and feel. The participants are able to give a more than detailed picture of their perceptions or beliefs (Welman & Kruger, 2001:167). Written notes were taken during the interview, as the participants were not comfortable with having the interviews recorded.

The advantages of using an interview in the data gathering process are undeniable. These advantages are:

- Flexibility that can allow the researcher to explore in-depth meaning that cannot be obtained with other methods;
- Using interpersonal skills to facilitate co-operation and elicit more information;
- Rephrasing questions to increase understanding; and
- Gathering of data from participants who may be illiterate or have low literacy and may have trouble in completing a questionnaire, is easier, (Burns & Grove 2005:397).

Burns and Grove (2005:397) describe the disadvantages of conducting interviews as follows:

- Limitations on interpersonal and interviewing skills of the researcher and interpreter can affect the outcome of the interview.

- The assumption that the information provided is correct.
- Time requirements, cost, and a limited sample size, can impose on the outcome.

The first measure taken to prevent these disadvantages from affecting the data quality was using the researcher to conduct the interviews. The researcher is a health care worker and has a Diploma in Nursing Education. Through many interactions and consultations with her clients, she has developed excellent communication skills. The limited sample size was countered by using the principle of saturation to determine the sample size for the study. The study was of a contextual nature and generalisability was never an aim of the study. The interview guide was developed to guide the semi-structured interview and to ensure that all interviews were conducted in the same manner.

An interview guide which included a list of questions based on the objectives, the literature review and professional experience of the researcher (Annexure: D) was used to explore the experiences of the teenage participants about their pregnancy. The use of the interview guide ensured good use of limited interview time; and made interviewing multiple subjects more systematic and comprehensive; and helped to keep interactions focused. There were no predetermined responses, and being a semi-structured interview the interviewer was free to probe and explore within these predetermined inquiry areas. The supervisor and co-supervisor validated the interview guide, which was presented at the master's tutorial scholarly committee for constructive critique as well as the ethics committee.

3.4.4 Pilot study

It is important to conduct a pre-test to identify problems early in the study (Welman & Kruger, 2000:146). The pilot study is the smaller version of the proposed study conducted to develop and refine the methodology, such as the instruments or data collection process to be used in the larger study (Burns & Grove, 2003:491).

The purpose of the pilot study was to pre-test the methodology and the feasibility of the study. One participant was purposively selected by going through the files of patients who were present at the clinic on that particular day. The inclusion criteria were taken into consideration during selection. This was done in order to evaluate whether the open-ended semi-structured interview schedule did indeed explore and stimulate in-depth discussion about the participants' pregnancy. The interview schedule was sufficient to guide the researcher to obtain a thorough understanding of the experiences of the pregnant teenager regarding her pregnancy. The interviewing skills and comprehension were adequate.,. No

changes were made to the interview schedule or methodology after the pre-test. The participant was requested to give feedback and make comments. It was decided to include the data of the pilot study into that of the main study. Ten (10) participants were interviewed for this study.

3.4.5 Trustworthiness

According to Creswell, (2009:192) it is necessary to clarify the bias brought to the study. This self-reflection creates an open and honest narrative that will resonate well with readers. Good qualitative research contains comments by the researchers about how their interpretations of the findings are shaped by their background, such as their gender, culture, history, and socioeconomic origin.

The following principles, as described by Lincoln and Guba (1985:290), to ensure trustworthiness of this study were, applied: credibility, confirmability, transferability, and dependability. The aim of trustworthiness in a qualitative inquiry is to support the argument that the enquiry of the findings are “worth paying attention to” (Lincoln & Guba, 1985:290).

3.4.5.1 Credibility

Credibility- refers to confidence in the truth (Polit & Beck, 2008:538). To ensure data credibility, Triangulation through the following data collection methods: Unstructured interview – until saturation occurred; field notes and member checks to confirm the results. “Member checking” with participants as, described by Lincoln and Guba, (1985:301-318) was done. Threats to the credibility of the study were minimised by means of peer examination of the research proposal by members of the Human Research Ethics Committee, Faculty of Health Sciences, at Stellenbosch University.

Prolonged exposure to the field of study as the researcher is a midwife who has knowledge and clinical experience in this area of expertise. The literature control was an enabler to satisfy the criterion of being knowledgeable about the phenomenon under investigation; the existing knowledge and preconceived ideas including specifically personal views about the existing problems in the clinical area were included. In particular, this study was assessed for adherence to the principles of good science and human ethics. The research techniques and sampling methods were examined for rigour and procedure.

3.4.5.2 Confirmability

Confirmability- refers to objectivity or neutrality of the data and interpretations, which has the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning (Polit & Beck, 2008:539).

To reduce bias in the research design and method these were described in detail. The research findings were confirmed by doing a literature control on all the identified themes and sub themes, which were also described in detail. During the data analysis process there was continuous reference to the interview scripts, field notes, and records to align findings with data at all times. Auditing of the entire research process, that is reflexive analysis, and triangulation was carried out. Data that allowed an independent auditor to reach a conclusion about the data (that is an audit trail) was systematically collected. Data collection was consistent with each interview. Confirmability was attained through the involvement of an experienced supervisor who reviewed the data, documents and results independently. This ensured that the findings are the product of the focus of the study and not the biases of the researcher (Babbie & Mouton, 2006:278).

3.4.5.3 Transferability

Transferability is the degree to which the findings of this inquiry can apply or transfer beyond the bounds of the project (Lincoln & Guba, 1985:296). According to De Vos et al. (2005:346), generalising findings in qualitative research may be problematic but is possible if researchers could show that the study was, guided by concepts, models and the use of multiple data collection methods.

Transferability was, assured through the conceptual framework for this study, which was drawn from Maslow (1968:260-261). It was chosen because Maslow advocated an environment that would permit individuals to sequentially meet these needs and actualise their own potential. Purposive sampling was used to select participants maximised the range of information collected.

The documented research methods provided an audit trail for application in other situations. Lincoln and Guba (1985:317) do propose one measure that might enhance the dependability of qualitative research and that is the use of an "inquiry audit," in which reviewers examine both the process and the product of the research for consistency.Clear descriptions of the demographics of the participants and a dense description of the results, with supporting direct quotations of the participants

3.4.5.4 Dependability

According to Babbie and Mouton (2006:278), dependability refers to the stability of data, that is, if this study were repeated with the same or similar respondents in the same or similar context, its findings would be similar. Data collection was, monitored and recorded correctly to yield similar results at all times during this study. All interviews were conducted in the same manner using an interview guide. The data was transcribed and analysed after each interview and verified by an expert in qualitative research. Dependability was achieved by thick description of methodology (data collection, analysis, and interpretation).

3.4.6 Data collection

Data collection is the precise, systematic gathering of information relevant to the research purpose, specific objectives, and questions of a study (Burns & Grove, 2009:695).The research interviews were conducted in April 2011. Individual interviews were conducted in a private room in the Chatsworth antenatal clinic.

The purpose of the study was clearly explained to build rapport and gain co-operation (Creswell, 2003:181). The participants understood the process and the questions asked. The questions were open-ended to elicit information (Creswell, 2003:181), for example: "*Please describe your experience of being pregnant*." Prior to data gathering, the participants signed informed consent documents. According to Creswell (2003:356), qualitative research must allow the teenagers to speak for themselves thereby emphasising their human capacity. During the interview, most teenagers first responded with "*I don't know*" but, because of the rapport and trust that developed, they continued to relate their experience and feelings. The participants were given enough opportunity to tell their story and to express themselves unreservedly.

The sample size realised was ten (10) participants. Burns and Grove, (2009:721), defines sample size as, the number of subjects or participants recruited and consenting to take part in a study. In qualitative research, data saturation occurs when additional sampling provides no new information, only redundancy of previous collected data, Burns and Grove, (2009:721).

Terre Blanche and Durrheim (2002:128) state that the interview should be taped using a tape recorder. Permission was, requested of each participant to use an audiotape recorder. None of the participants agreed to its use. The tape recorder was a sensitive issue and there were concerns regarding anonymity and confidentiality with its use, therefore it was, not used. The interviews were, conducted in English. The responses were, written during the interview. The participants had an opportunity to verify the contents of the document to fulfil

the requirements of member checking to enhance the credibility of the data. The interviews lasted approximately 45 minutes per participant.

3.4.7 Data analysis

According to Burns and Grove (2009:695), data analysis is conducted to reduce, organize and give meaning to data. Qualitative data analysis involves an examination of words and is done concurrently with data collection (Brink, 2001:192). The data analysis process included the compilation of all relevant notes, demographic information, and participants' information. The data reduction process, in alignment with Tesch's open coding method of data analysis as described in Creswell (2004: 256) was used. Burns and Grove, (2009:695) describe data reduction as a technique for analysing qualitative data that focuses on decreasing the volume of data to facilitate examination. Tesch's steps are described as follows:

- The researcher reads all of the transcriptions to get a sense of the whole and then jots down ideas as they come to mind.
- One interview is selected – it could be the most interesting – to establish the underlying meaning in the information. The meaning/interpretation is documented along the margin.
- Having completed the above task for a number of transcripts, the identified topics and groups similar topics into major topics, unique topics and leftovers are listed.
- The topics are abbreviated as codes and written next to the appropriate segments of the text while checking if new categories emerge.
- The most descriptive wording for the topics is checked and turned into categories. Related topics are grouped together to reduce the total list of categories and then lines are drawn between categories to show interrelationships.
- Final decisions on the codes of categories are made and codes are alphabetised.
- A preliminary analysis of data belonging to each category is done.
- If necessary, recoding of the existing data is done.

The data was analysed by transcribing the information obtained from the interviews. Data was explored in detail for common themes. The verbal responses of the researcher's notes

were captured onto a master file on Microsoft Word document immediately after each interview. Colour code indexes via “highlighting” of the phrases to identify the different themes that evolved, were used. Themes were added until saturation occurred. The results are described in chapter four.

3.4.8 Ethical considerations

According to Pera and Tonder, (2005:6), ethics is a very specialised field of study, which deals with dynamics of deciding what is right, and what is wrong. Ethical principles are important elements that provide direction for thoughts and performing in order to conclude what should or should not be done in particular situations, (Pera & van Tonder, 2005:32).

To protect the rights of human participants and the standards of any scientific enquiry the research proposal was, presented at the Mcur tutorial of the University of Stellenbosch, Faculty of Health Sciences for peer review and feedback on the feasibility of the study. Ethical clearance from the Human Research Ethics Committee, Faculty of Health Sciences, Stellenbosch University (Annexure: F) was obtained and the study was conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, and South African Guidelines for Good Clinical Practice. Permission to conduct the study at the KwaZulu Natal Health Department (Chatsworth Ante- Natal Clinic) (Annexure: E), was obtained from their Nursing Service Manager. According to Brink (2001:52) if patient and client records are,used at the very least the permission of the institution holding these records must be obtained.

The right to self- determination is, based on the ethical principle of respect for persons, and it indicates that humans are autonomous agents who are capable of controlling their own destiny (Burns & Grove, 2007:204). The autonomy was ensured by inviting the participants to participate in the study, details of which are outlined in (Annexure A). Participation remained voluntary, as the principle of self- determination was respected. This meant that each participant had the right to decide whether she will participate in the study.

Parental permission obtained for participants under the age of 18 years, as the chosen participants were accompanied by their mothers (Annexure B). According to, Brink (2001:52), it is the researcher’s responsibility to respect the autonomy of vulnerable individuals and to locate the legal guardians from whom consent to include these individuals in research could be obtained. An assent form was, completed by participants less than 18 years of age (Annexure A).

Data was stored in a locked cupboard and was accessible to the researcher and supervisor as it is intellectual property of Stellenbosch University, and can be destroyed after a period 5 years after the completion of the study.

The principle of justice states that human subjects should be treated fairly (Burns & Grove, 2009:706). The right to fair treatment included treating the participants tactfully, respecting their beliefs, culture and lifestyle and giving them the freedom to voice any feeling or to ask any questions were ensured by treating the participants equally irrespective of their age, race, employment status or any other factor. The participants' names or addresses were, not mentioned or written in any of the interview material to ensure anonymity. Assurance of anonymity and confidentiality, the right to participate or withdraw without penalty has to be, assured, offer to answer all questions; means of obtaining study results is, presented or published (Nieswiadomy, 2011:21-28). The participants were informed that they had the right to withdraw from the study at any stage without incurring any negative consequences. The interviews were, conducted in a private consulting room without interruptions to ensure privacy.

Polit and Beck, (2008:170 – 174) describes the Belmont Report regarding beneficence: the right to freedom from harm and discomfort as well as the right to protection from exploitation. According to Burns and Grove, (2009:689) the principle of beneficence encourages the researcher to do good and above all to do no harm; this was ensured through informing the participants that there would be no financial benefits from the study. Follow-ups with the social worker at the clinic were made. When dealing with sensitive topics according to Polit and Beck (2008:182) it is sometimes advisable to offer debriefing sessions after data collection is completed. By obtaining parental consent and an assent for teenagers below the age of 18 to participate in this study, freedom from exploitation was, respected. Results of the study would be available to participants on request.

3.5 Summary

According to Burns and Grove (2009:8), the philosophical orientation of qualitative research is holistic, and the purpose of this research was to examine the whole rather than the parts. They stated further that qualitative researchers are more interested in understanding complex phenomena than in determining cause-and-effect relationships among specific variables (Burns & Grove, 2009:8).

The goal of this study was to explore and describe the experiences of pregnant teenagers about their pregnancy. In depth, qualitative interviews were conducted with pregnant

teenagers. Rich data was obtained using the methodology and qualitative process as outlined in this chapter.

Due to the sensitive nature of this topic, where teenagers had to speak about their experiences of being pregnant, information regarding the ethical principles maintained, data collections, and analysis were discussed in detail. Due, to the fact that access to tape recording, was not possible, extra effort was put into completing the detailed documentation.

3.6 Conclusion

In chapter three, the research design and research method was described in detail namely; the research design, setting, population, sampling, data collection, pre-testing, trustworthiness, data analysis procedure, and ethical considerations. The results of the study will follow in Chapter 4.

CHAPTER 4

DATA ANALYSIS, INTERPRETATION, AND DISCUSSION

4.1 Introduction

In this chapter the findings of the research are presented and discussed. The discussion is structured according to the themes and categories that were identified through the analysis of the data that were collected to explore the experiences of pregnant teenagers about their pregnancies.The collected data was read and then transcribed word for word to confirm trustworthiness of the data. Inductive reasoning was applied to form themes. According to Burns and Grove (2007:542), inductive reasoning is an analysis from the specific to the general, in which particular instances are observed and then combined into a larger whole or general statement. Ten (10) individual interviews were conducted as mentioned in Chapter 3. Section 3.4.2.

The data was collected from the 1st of April until the 30th of April 2011.The analysis was done using Tesch's 8 step model (Creswell, 2004:256) see paragraph 3.4.7. The data was transcribed and keywords were identified representing the codes, as listed in table 4.5.

4.2 Demographic Profile of the Participants

Demographic information was considered essential as it provides a socio-cultural descriptive profile of the factors that contribute to the experiences of pregnant teenagers. The sample of ten participants was realised (Paragraph 3.4.6). The aspects, age, level of education, and race group were investigated.

Results show that out of the ten participants, six were in the 18-20 year age group. The mean educational level for the group was grade 10-12. One of the participants obtained grade 6 or less. The majority of the participants were Indian (six), as Chatsworth is largely an Indian dominant residential area. All the participants were able to communicate in English, all were single and all were unemployed. The current living arrangements showed that, three of the participants were living with both parents; four of them were living with their single parent; and the other three were staying with relatives. Only seven of the participants had access to financial support.

4.3 Codes that Emerged from the Interviews

There were a few concepts in the interviews that emerged in codes which will be described in table 4.1. Direct quotes were used to support the results and are printed in italics.

Table 4.1: Codes that emerged from the data

Code	Evidence: Example of quotation (source/number of interview in brackets)	Interpretation
Regret	*I regret my actions. (*Participant 1, line 2)	Some regret not using protection which led to them getting pregnant.
Extra mouth	*My mother says that I added one extra mouth*. (Participant 4, line 1)	Extra mouth to feed when they have no food for their existing family members.
Embarrassed	*I am embarrassed*. (Participant 8, line 21)	They feel embarrassed to ask for condoms at the clinics.
Life changes	*Your whole life changes.* (Participant 10, line 3)	Many participants expressed that their whole life changed once they got pregnant.
Friends	*I miss my friends*. (Participant 5, line 3)	Many participants verbalised that they miss spending time with friends.
Attitude	*I did not like their attitude*. (Participant 8, line 22)	Health care workers at the clinic are seen as unfriendly and many participants did not like their attitude.
Money	*My boyfriend gave me money to buy things for me.* (Participant 6, line 2-3)	A few participants performed sexual acts in order to get money.
Stress	*There is too much going on at home and the stress was killing me. (*Participant 3, line 5-6)	Some participants engaged in drug use due to family stress.

Know	*I didn't know that I would get pregnant the first time*. (Participant 10, line 4)	A few of the participants did not know that if they had unprotected sex for the first time, that they could get pregnant.
Afraid	*I am afraid if someone I know sees me at the clinic.* (Participant 8, line 24)	Many participants were afraid that their parents would find out that they are sexually active.
Old fashioned	*My parents don't even mention sex as they are old fashioned*. (Participant 9, line 7)	Participants verbalised that there was lack of communication regarding sex in the home as their parents are old fashioned.
Responsibility	*Having a baby is a big responsibility*. (Participant 4, line 4)	Participants acknowledged that they have a big responsibility, that is, to take care of their babies and themselves.
Love	*At least he made me feel loved*. (Participant 6, line 3)	Participants saw sex as a means to feeling loved and gaining attention.
Grant	*I will use the child support grant and will need to find a job too*. (Participant 3, line 10-11)	Participants were intent on applying for the child support grant.
School	*I cannot return to school and complete my education.* (Participant 1, line 4)	Participants who lacked family support said that they must stay home to take care of their babies and that school was over for them.

4.4 Sub-themes that Emerged from the Interviews

Table 4.2 outlines the sub-themes that emerged from the interviews. Direct quotes are used to support the results and are printed in italics.

Table 4.2: Sub-themes that emerged

Sub-themes	Evidence: Example of quotation (source/number of interview in brackets)	Interpretation
Need for family/partner support	*I realize how important it is to have support.* (Participant 4, line 4)	Having support, assured some participants that they are not alone.
Shame and disgrace	*I disgraced my parents and brought shame to them and myself.* (Participant 1, line 6-7)	Participants realised the impact of their actions on their family.
Importance of education	*If I finish school, at least I can find a job and try to further my studies*. (Participant 5, line 3-4)	Participants realised the value of continuing with their schooling.
Impact of family situations/poverty	*The stress in my family home made me try something to make me feel relaxed. One thing lead to another*. (Participant 3, line 6-7)	Participants mentioned the cycle of poverty, which lead to stress, and stress, which in turn lead them to finding comfort in drugs and alcohol, which created a dependency and ultimately lead to seeking money, which had to be earned through sex.
Need for contraceptive education at schools	*Maybe they should include family planning in our timetable at school.* (Participant 8, line 23-24)	Participants expressed that they did not know much about different contraceptives.

4.5 Themes that Emerged from the Interviews

Six (6) themes emerged from the interviews namely rejection by family, school drop out**,** alcohol and drug abuse, financial difficulties, ignorance, and attitude of nurses at the family planning clinics. Table 4.3 shows the six themes that emerged from the collected data.

Direct quotes are used to support the results and are printed in italics, relevant literature is also provided to support the findings.

Table 4.3: Six (6) themes

Themes	Evidence: Example of quotation (source/number of interview in brackets)	No
1.Rejection by family	"*My father is a strict man and he is very involved in the Church. When he heard that I am pregnant, he refused to listen to anything. He asked me to pack my bags and go. Thanks to my aunt, she felt sorry for me and let me stay at their house."* (Participant 1, line 8-10)	3
2.School drop out	"*When you get pregnant while you are in school, you are forced to drop out of school because it's too embarrassing and stressful to continue."* (Participant 4, line 5-6)	9
3.Alcohol and drug abuse	"*I got hooked on drugs and I would do anything to get my next fix. I even had unprotected sex because my body craved the drugs and I needed money desperately to buy some."* (Participant 3, line 8-10)	2
4.Financial difficulties	"*My mother is the breadwinner at home, since my father left us. She has to provide for my 2 younger sisters and myself. I used to help her to take care of them when she went to work. Now she has an extra mouth to feed. I feel sad that I ended up in this situation. We are struggling to make ends meet. "*(Participant 4, line 7-10)	8
5.Ignorance	"*I never knew that I can get pregnant the first time I had sex. My boyfriend told me that I am safe because he knows what he is doing. I trusted him because he is 5 years older than me and he had other girlfriends before me."* (Participant 10, line 4-6)	3

6.Attitude of nurse's at the family planning clinic	"*They look at you funny, like you are going to commit a serious crime. I went to the clinic a few times for the injection and condoms, but I dreaded going there. Once I saw my neighbor there and pretended like I was collecting some pamphlets for a school assignment. My mother will have a fit if she knows that I am having sex. I decided to use condoms. That did not much good, look at my stomach."* (Participant 8, line 25-28)	4

4.5.1 Rejection by family

For three of the participants the fear of rejection by parents and the community was a big consequence of teenage pregnancy. Swartz (2004:1) found that teenage pregnancy has a negative impact on the family of the teenage mother, her child as well as on her academic prospects or future career. Becoming a mother very early in one's life puts you at a disadvantage, as you cannot enjoy your teenage years and you tend to mature faster because of the responsibility you have.

> Participant 5, line1-3: *"When you become a mother in your teenage years, you can forget about going to the movies with your friends and you miss out on all the fun because you have to take care of your own child."*

> Participant 2, line 1-2: *"You become the black sheep of the family, especially if your family is well-known in the community/church."*

4.5.2 School drop out

When asked about their experience of being pregnant nine of the participants indicated that it could destroy the academic progress of the teen mother. The study conducted by Swartz (2004:1) also revealed that the mother loses out her on own development because her main responsibility and focus is now on the child. As a result, her career dreams and goals are shattered.

> Participant 7, line 1-4: *"My mother, was hurt when she found out I was pregnant. She asked me how I could get pregnant when I don't even work. She said that I know how expensive babies are. How could I burden our family with another head? Despite this, she said she would support me and encouraged me to go back to school."*

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 financial provision becomes a major challenge or threat (Yako, 2007:16).

> Participant 8, line 2-4: *"I know many girls in my district that never returned to school. I guess you cannot go back and face that shame and disgrace which you brought upon yourself and your family. You know how people talk."*

> Participant 2, line 4-7: *"How can I return to school? I must find a job to earn money to support my baby. I don't want my child to suffer like I did, being poor and even starving at times. I know the Government is allowing us to return to school, but this is not an option for me."*

> Participant 9, line 1-6: *"Being pregnant I don't think is a good idea especially if you are a teenager still at school. You start becoming very tired, even at school I get tired and can't concentrate. Pupils at school can be mean, it's like you have a disease. Sometimes you feel bad because some kids look at you and you know that they are talking about you. Even at home they tell you stories that you are young, you disappointed them, things like that, so I don't advise anyone to become pregnant."*

Ruwaydah (2006:14) confirms the above; thousands of South African girls leave school and do not return after falling pregnant and having their babies.

4.5.3 Alcohol and drug abuse

Two participants spoke about the role of alcohol and drugs in contributing them becoming pregnant. Alcohol and drugs may encourage unintended sexual activities (Shisana, 2005:1).

> Participant 7, line 4-8: *"They were selling drugs at the school I attended. Everyone was trying it, it was cool. I got involved so deep that I could not stop. I started sleeping around with the older boys from school, in order for them to share their drugs with me. This is how I got pregnant, some of them refused to use condoms as they wanted to experience sex without the condom."*

> Participant 3, line 1-5: *"My boyfriend is 5 years older than me and he is working, I went to parties with him and we had fun drinking alcohol and sometimes using drugs. It felt nice, you even forget about your problems for that time. He became crazy when he was in that mood, he wanted to have sex without a condom, and I tried to convince him, but never succeeded. I have no regrets because I love him; at least I proved that I can give him children."*

4.5.4 Financial difficulties

One of the consequences of teenage pregnancy is that the teenager tends to become financially dependent on the family or the Government. Eight of the participants confirmed this. According to Kaufman, De Wet and Stadler (2001:148), boyfriends of adolescent mothers failed to take responsibility for their babies because of negative influence on the boy's education and employment opportunities.

> Participant 3, line 11-12: *"I was denied a grant for the baby because I did not have an ID. But my mother, a domestic helper, receives a child grant."*

A research professor, Evan Mantzaris at the Mangosuthu University of Technology (KZN) reported that teens kept their babies for a number of reasons, that is, some need the social grant money, so the family will pressurise them to keep the baby. He said that although some girls used the social grant money for selfish reasons, many used it to support their families. *"Remember, some of these girls are born into situations where the social grant is already the only income…"* he said (Sunday Tribune, 2011:4). There is a definite link between teenage pregnancy and poverty. Mfono (2003: 8), also revealed that there is high rate of teenage pregnancy among black poor teenagers who get involved in unprotected sexual activities as a means to survive their circumstances.

> Participant 4, line 1-3: *"We are already having money problems, and I have added an extra mouth to feed. I wish I could reverse my actions. I guess, I cannot but I must work hard now to help my family."*

According to a study conducted by Makiwane and Udjo (2006:2), there is no relationship between teenage fertility and the Child Support Grant. While teenage pregnancy rose rapidly during the 1980's, it had stabilized and even started to decline by the time the Child Support Grant was introduced in 1998. Furthermore only 20 percent of teens who bear children are beneficiaries of the Child Support Grant. This is disproportionately low compared to their contribution to fertility. The study also shows that increases in youthful fertility have occurred across all social sectors, including amongst young people who would not qualify for the Child Support Grant on the means test.

> Participant 5, line 4-6: *"I will apply for the Child support grant. All my friends did, although they say it is so little. I will send my baby to my granny in the farm."*

4.5.5 Ignorance

A professional nurse of an Umlazi clinic (KZN) who deals with teenage mothers daily reported that, the new generation, society's immorality, rape, a lack of knowledge, ignorance, the lack of attention from teachers and parents and the social grants are all reasons girls are opting to keep their babies instead of aborting them." *They are just kids having kids*", she said. She also said the problem was increasing and called on parents, teachers and the government to take responsibility and stop pointing fingers (Sunday Tribune, 2011:4). Marston and King (2006: 1581) report that condoms are stigmatising and indicate a lack of trust. Three of the participants believed that ignorance is what led to them getting pregnant.

> Participant 6, line 4: *"We did not use a condom because he did not want to."*

Seekoe (2005:20), investigated youths' needs regarding communication and information about birth control and AIDS prevention. The majority of the young girls (92%-96%) requested a youth friendly clinic or special programmes during the school holidays and/or a knowledgeable accessible person to advise them concerning the realities of relationships with the opposite sex.

> Participant 8, line 5-7: *"I did not know that abortions were free. I only found out when it was too late. I would have had an abortion as I had big dreams for my future and career. Now all that has to be put on hold or it may never become a reality."*

Maputle (2006:87) reported that teenagers lacking information about signs of pregnancy were not likely to inform any family member and thus only attend ante-natal care when the pregnancy was advanced. This is confirmed by:

> Participant 9, line 7-8: *"I did not know that I was pregnant until I told my teacher that I was not getting my periods and went for a test."*

4.5.6 Attitude of nurse's at the family planning clinic

When asked about their knowledge of contraceptives and their experience regarding the services delivered by the health care workers, four of the participants expressed their disgust and disappointment with regards to nurse's attitudes towards them. Wood and Jewkes (2006:112) indicated that poor access to medical information about the reproductive system provided space for medically inaccurate notions about the conditions necessary for conception. According to a study done by Hughes (2003: 32-34), teenage pregnancy can be reduced if they are given early, detailed information and advice about contraception and pregnancy.

> One participant's response was (Participant 9, line 9-13): *"I could not go the clinic to get family planning, because most of the nurse's that work there are from my area. I was afraid that they will know about me being sexually active. I could not let my parents find out, as we never talked openly in my house about sex and other things that teenagers should know about. My parents are very old fashioned and expected me learn all about that in school. What if they told my parents?"*
>
> Participant 2, line 10-12: *"When the nurse's see us youngsters, they take their time in seeing us, either busy or on tea break. They ask you so many personal questions and tell you that you must not have sex because you are too young. They want to judge you. It puts me off."*

In a study conducted by Forrest (2009:1-7) participants spoke of a need to revise adolescent sexual and reproductive health services to make it more youth-friendly in order to avoid the stigma generated by community healthcare workers. Contraceptive providers are often reluctant to give contraceptives to young people especially to those who are unmarried. In some instances, teenagers were compelled to change their school uniforms for ordinary clothes when accessing contraceptives as they could be denied to school girls (Ziyane & Ehlers, 2006:40). To substantiate the above:

> Participant 6, line 5-7: *"They think that they are doing you a favour. They get paid to do their job and to educate the public. The sometimes make you feel so low and unwelcome. You are made to feel like you are doing something wrong."*

4.6 Discussion

The aim of the study was to explore the experiences of pregnant teenagers about their pregnancy. The following objectives were set for the study to determine:

- Teenagers experience of current pregnancy
- Teenagers knowledge of contraceptives
- Experience regarding the services delivered by the health care workers

The results obtained reflected the participants' knowledge, personal experiences as well as beliefs in accordance with the research questions and objectives of the study. In some instances there were similarities as well as differences in the information provided by the participants. It can be concluded that some of the participants were informed; knowledgeable and aware of the issues pertaining to teenage pregnancy. They were also aware of the

reasons or factors that led to their pregnancies. Some also demonstrated awareness of services for teenage mothers, such as contraceptive availability.

4.7 Summary

The findings show that the level of knowledge and awareness the participants showed during the study challenged the perception that the youth are ignorant about their wellbeing as far as teenage pregnancy is concerned. An optimistic attitude was also demonstrated by the youth in combating teenage pregnancy. All of them viewed teenage pregnancy as a problematic issue that needs to be addressed with immediate intervention.

4.8 Conclusion

In this chapter the results were presented and discussed. The data was transcribed and coded according to Tesch's model. Thereafter several sub-themes developed which later emerged into six themes. The research question was adequately answered regarding the experiences of pregnant teenagers about their pregnancy.

Chapter 5 will describe certain limitations of the study and draw together the final conclusions and suggest recommendations.

CHAPTER 5

CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

5.1 Introduction

Prior to this chapter, the objectives for this study were stipulated, an in-depth literature review was presented and the appropriate research methodology and data analysis for the purpose of this study was described and discussed. This chapter includes the conclusions and recommendations based on the findings of the study, as well as the limitations identified from the study.

5.2 Discussion of the findings

The aim of the study was to determine the experiences of pregnant teenagers about their pregnancy. The discussion of the findings of the study in relation to each study objective follows:

5.2.1 Objective 1: Experience of the current pregnancy

According to Mturi and Moerane (2001:259) as well as Whitehead (2001:437), stigma is a reality associated with teenage pregnancy. The study revealed that most of the participants were aware of the consequences of being pregnant as a teenager. Their experiences ranged from being rejected by family and partners to having to drop out of school due to their unplanned pregnancy.

In relation to their experience of being pregnant, financial difficulties associated with poverty was identified as one of the major contributing factors to teenage pregnancy and the participants indicated that the consequence of being pregnant was affecting their lives. Others expressed the need for communication between themselves and their parents regarding issues of sex and contraceptives, as most of their parents were orthodox. Cultural barriers and respect for elders in discussing sexuality issues compounded the problem as neither parents nor youth could initiate the conversation (Seekoe, 2005:27). This was also relevant in this study. Wood and Jewkes (2000:5) noted that most mothers would not discuss menstruation or had simply informed their children that it was a process of growing up without giving full details about what to expect and how to prevent pregnancies.

In conclusion, the participants view teenage pregnancy as a real problem in South Africa. It seems that the teenagers are well informed and knowledgeable about teenage pregnancy but it seems that they pay little or no attention to curbing teenage pregnancy.

5.2.2 Objective 2: Knowledge of contraceptives

According to the participants of this study it was clear that the main sources of information that teenagers utilise to obtain information about teenage pregnancy were the media and their friends (peer pressure). According to Brown (2008:1), adolescents rank parents, peers and the media as important sources of sexual health information. This is because most families find it difficult to talk openly about sex with their children. As a result, the majority of the teenagers were ignorant about contraceptives and the consequences of indulging in premarital, unprotected sex. Eisenberg (2004:51) confirms that, even when parents provide information, their knowledge about contraception, or other sexual health topics may often be inaccurate or incomplete.

In their study on "Socio-cultural deterrents to family planning practices among Swazi women" Ziyani, Ehlers and King (2003:46) reported that 60% of participants were not informed about contraceptives, no information was available in their communities and that education programmes were unavailable to their schools. A study on “Emergency contraception: knowledge and practices of tertiary students in Durban, South Africa”, conducted by Roberts, Moodley and Esterhuizen (2004:441-445) few students knew the specific methods of emergency contraception and only 11.8% knew the correct time limit in which it must be used. Only 60 students (7.8%) knew how effective emergency contraception was in preventing pregnancy. Ninety-one students (11.8%) had used emergency contraception and 50% responded that if they had to, they would use it or recommend it to a friend. They concluded that overall knowledge and use of emergency contraception by tertiary students is limited.

In conclusion, the findings showed that the participants need to be educated on contraceptive availability and the benefits of contraceptive use in preventing unwanted pregnancies, as the teenagers knowledge about contraceptives was poor.

5.2.3 Objective 3: Experience regarding the services delivered by the health care workers

It has become apparent from this study that youth still experience barriers in obtaining and utilising contraceptives effectively. One of the greatest needs of youth was information, as they reported not receiving it adequately at school or home. Their communication with

parents regarding sexuality issues was limited, owing to cultural barriers, respect, and fear of elders. The duty of confidentiality to a sixteen year old is the same as it is to an adult. Yet Donovan, Mellanby and Jacobson (1997:716), noted in their study on "Teenager's views on the general practice consultation and provision of contraception," that 25--50% of teenagers were worried that a request for contraception would be disclosed to their parents.

Attitudes of contraceptive providers led to teenagers not using contraceptives in some cases. This resulted in youth engaging in unprotected sex, as they did not feel comfortable to attend health care services. Nurses are often perceived to be judgmental about adolescents having sex and therefore reluctant to provide contraceptives to them (Wood and Jewkes, 2006:109).

In conclusion, the findings showed that the negative attitudes of the health care workers prevented most teenagers from obtaining contraceptives. Some felt that confidentiality could not be maintained and were afraid that their contraceptive use will be disclosed to their parents.

5.3 Recommendations

The following recommendations are based on the findings of the study.

5.3.1 Services at the clinics

Health care providers providing services to youth should be motivated, youth friendly and non-judgemental. They should be more constructive in their professional relationships with youth, and regard them as autonomous individuals who should prevent unintended pregnancy. Youth should be more respectful to nursing staff and appreciate the service they get. The introduction of adolescent clinics where trained peer-councellors provide information to their peers may be useful. Youngsters may feel more comfortable to speak to someone who is experiencing the same issues as they are.

5.3.2 Education and training of healthcare workers

The Department of Health needs to empower nurses through organised workshops and short courses. The topics to be addressed should include interpersonal skills, principles of customer care, patients' rights, and the value of community participation in family planning. The purpose of these short courses will be to change the nurses' attitudes towards teenagers seeking contraceptives, so that they will be more caring, supportive, patient, kind, and understanding. A training manual outlining the health education content to be given to

teenagers regarding contraceptives needs to be compiled to ensure that nurses provide adequate, up-to-date information.

Nurses need to be encouraged to update themselves with current evidence-based information regarding teenage pregnancy. This will enhance confidence in themselves, assertiveness, and sympathy in caring for their clients.

5.3.3 Education and programs at schools

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. The introduction of family planning education in schools is a good start to educate young people on the availability of contraceptives and the consequences of being sexually active at a young age. Lessons on sexual activities should start before children become sexually active. This can be done in the form of role-play.

School trips should include visits to safety houses, shelters for teenage mothers and homes for abandoned children/ children living with or orphaned by HIV. This will help them to see the realities around them, instead of only listening to what may become of them if they get pregnant at an early age. School campaigns, where they have a thermometer and display to the children the statistics of the learners that got pregnant may be helpful. The children would not want to be part of that statistic. It will lead to embarrassment. On the other hand, achievements could also be displayed to motivate the learners to want to achieve.

Reality games during life orientation lessons, where learners are given a doll to take care of as if it is real baby can be introduced. Doll cries periodically, the learner must feed the doll and take care of it as if it were a real baby. Learners then get the feeling of what it is like to have responsibility of having a baby. Community service for all scholars at Hospices where people with terminal HIV disease are nursed must be made compulsory. Helping to take care of orphaned babies will also highlight the responsibilities of taking care of a baby. This will serve as a revelation. Videos on the birthing process should be shown to them at school; the pain one has to endure to give birth will make them face reality.

The youth, particularly girls must be empowered to make better, informed decisions. Men should also be fully informed about different contraceptive methods used by women so as to support them when contraception is needed. Career guidance will help learners to stay focussed on their career goals. Bursaries, loans must be arranged by the schools through liaison with educational institutions and businesses to provide study opportunities for

learners. Each school should undertake their own research and keep statistics on teenage pregnancy, so that all the data can be put together by the Department of Education in order for them to devise a strategic plan to combat teenage pregnancy in schools.

5.3.4 Community and parental involvement

Communication about sex is limited in a home environment and often knowledge of sex develops from their peer relationship and through experimentation, which sometimes leads to far reaching consequences such as unwanted pregnancies. Seekoe (2005:20) propose that information regarding sexuality issues including contraceptive practices should be imparted early in the socialisation process of both girls and boys at homes, schools, and community places. Having such information during early stages of life could assist in equipping individuals with better skills to protect themselves against unintended pregnancies. There is therefore a need for parental intervention as far as teenage pregnancy is concerned. Gallant, Maticka and Tyndale (2004:1337-1351) emphasise that adults and youth should work together in formulating intervention aimed at addressing the youths' problems.

Family and community involvement should also be focussed on. The Government may have policies and strategies in place to deal with the problem of teenage pregnancies but the goals cannot be achieved by them alone. Strategies to reduce teenage pregnancy should focus on building social capital for teenagers in communities, applying the law on underage drinking and drug use, making information on contraception more accessible and offering programmes that empower girls in the area of sexuality.

5.4 Recommendations for further Research

- More research should be done on the effectiveness of family planning programs in Chatsworth, KwaZulu- Natal.

- More research should be done with parents to establish their needs in terms of training so that they can support, guide, and empower their children with knowledge regarding teenage pregnancy and its consequences. Contraceptive education and its importance must also be highlighted, as prevention is better than having to deal with an unwanted pregnancy as most parents are old fashioned and are not keen on their children using contraceptives until they are married or are adults.

- A survey on parents' perceptions of teenage pregnancy in the residential area of Chatsworth, KwaZulu- Natal should be carried out to gather parental input into the topic.

- Research into school drop outs post pregnancy is a plausible and interesting area which may be researched.

5.5 Limitations to the study

Burns and Grove (2007:545), describe limitations as 'theoretical and methodological restrictions in a study that may decrease the generalizability of the findings.' The health care centre used for the study was located in the residential area of Chatsworth, KwaZulu- Natal Province. These findings cannot be generalised to other areas as other provinces were not included in the sample, but may be transferable to similar communities in South Africa.

Language may also have been an issue, as the study was mainly conducted in English in an area where some people speak IsiZulu. Participants may have felt more comfortable and have been more open with an interviewer who spoke their first language and shared their cultural background. They may have been able to express themselves better if the interviews were conducted in their first language, although they were able to communicate well in English. All participants refused to permit the use of a tape recorder; the interview was therefore recorded by hand and some of the details and nuances may have been lost in the process although all measures were taken to be as accurate as possible.

Despite these limitations, this study explored the experiences of pregnant teenagers about their pregnancy.

5.6 Summary

The study was undertaken to explore the experiences of pregnant teenagers about their pregnancy due to the high rate of teenage pregnancy in South Africa and worldwide. This study assisted in gaining a better understanding of the challenges teenagers face as a result of unplanned and unwanted pregnancies.

Many social factors may prevent teenagers from fulfilling their personal and career goals and teenagers cannot be blamed totally for their pregnancies. The findings conclude that teenage pregnancy is, in fact, the result of a complex set of factors, largely related to the social conditions under which children grow up.

5.7 Conclusion

In this chapter, the findings of the study were discussed in relation to the study objectives and the research question. The purpose of the study was to explore the experiences of pregnant teenagers about their pregnancy. The study revealed many predisposing factors to teenage pregnancy such as poverty, alcohol and drug abuse, ignorance, and financial difficulties. The findings of the study are supported by Maslow's theory of motivation. Maslow (1968) advocates that if teenagers' basic needs are met, they become motivated to reach self-actualisation. In doing so, they are able to achieve all their personal and career goals. This applies to the conceptual framework (see section 2.7). It was clear that the participants have a good understanding of teenage pregnancy in South Africa and that they are aware about the causes, consequences and preventative strategies in respect of their own experiences, as pregnant teenagers.

Further research, is recommended, as explained in the section on limitations, as teenage pregnancy is South Africa is an on-going problem that needs urgent focus.

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ANNEXURES

ANNEXURE A: CONSENT FORM

	STELLENBOSCH UNIVERSITY **FACULTY OF HEALTH SCIENCES**	

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

ETHICS REFERENCE NO: N10/11/397

PRINCIPAL INVESTIGATOR: Mrs Julie Rangiah

ADDRESS: 463 Stella Road

Section 2

Malvern

4093

CONTACT NUMBER: 079 570 3256

Dear Participant you are, invited to take part in a research project (Experiences of pregnant teenagers about their pregnancy.)

Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied and you clearly understand what this research entails and how you could be involved. In addition, your participation is voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to drop out of the study at any point, even if you do agree to take part.

This study was approved by the Committee for Human Research at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

The Researcher wants to explore why teenagers get pregnant and what are their feelings about their pregnancies.

The following information is of importance to you as a participant:
A written consent is needed from you in order for you to take part in this study.

Your interview will be scheduled at a time convenient to you and will be approximately 45 minutes long.

All information will be managed by the researcher and supervisors only and will be stored in a locked cupboard and you will be informed about the results.

Your interview will be tape recorded, only with your permission so that the information can be put together at a later stage.

Why did the researcher invite you to participate?

This study is about pregnant teenagers and you are suitable to take part in it. The researcher would like you to answer a few questions regarding your experiences about your pregnancy.

What will your responsibilities be?

To give honest and correct answers to the questions asked by the researcher during the interview.

Will you benefit from taking part in this research?

The only benefit to you is that the knowledge gained by the researcher from this study, could assist other teenagers in preventing unplanned or unwanted pregnancies.

Are there any risks involved in your taking part in this research?

No risks are involved in the project as confidentiality/privacy will be maintained, and participation is voluntary.

If you do not agree to take part, what alternatives do you have?

The choice is yours; refusing to take part will not influence your treatment.

Who will have access to your medical records?

Your personal details will be kept anonymous, meaning that your name will not be mentioned to anyone. The information given by you will only be seen by the Researcher and supervisors.

Will you be, paid to take part in this study and are there any costs involved?

No, you will not, be paid to take part in the study and there are no costs involved.

Is there anything else that you should know or do?

You can contact Dr. E.L. Stellenberg at tel. (021) 938-9036 if you have any further queries or encounter any problems.

You can contact the Committee for Human Research at (021) 938-9207 if you have any concerns or complaints regarding any aspect of the research.

You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I …..... agree to take part in a research study entitled **'Experiences of pregnant teenagers about their pregnancy.'**

I declare that:

I have read or had read to me the information on this consent form and it is written in a language with which I am fluent and comfortable.

- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*)..... On (*date*) …..... 2011

Signature of participant…….. Signature of witness……

Declaration by investigator

I *(name)* ……..……. declare that:

I explained the information in this document to ……..

I encouraged her to ask questions and took adequate time to answer them.

I am satisfied that she adequately understands all aspects of the research, as discussed above.

I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*)..... On (*date*) …..... 2011

Signature of investigator…….. Signature of witness……..

ANNEXURE B: PARENTAL/LEGAL GUARDIAN CONSENT

	STELLENBOSCH UNIVERSITY **FACULTY OF HEALTH SCIENCES**	

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM FOR USE BY PARENTS/LEGAL GUARDIANS

TITLE OF THE RESEARCH PROJECT: "Experiences of pregnant teenagers about their pregnancy."

ETHICS REFERENCE NO: N10/11/397

PRINCIPAL INVESTIGATOR: Mrs Julie Rangiah

ADDRESS: 463 Stella Road

Section 2

Malvern

4093

CONTACT NUMBER: 079 5703256

Your child *(or ward, if applicable*), is invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how your child could be involved. In addition, your child's participation is **voluntary** and you are free to decline to participate. If you say no, this will not affect you or your child negatively in any way whatsoever. You are also free to withdraw her from the study at any point, even if you do initially agree to let her take part.

This study has been approved by the Health Research Ethics Committee at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for

Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

The Researcher wants to explore the experiences of teenagers about their pregnancy.

Why has your child been invited to participate?

Your child has been selected to be part of this study as she is a pregnant teenager and meets the criteria to participate.

What will your responsibilities be?

You are expected to give support to your child and encourage your child to give honest and correct answers.

Will your child benefit from taking part in this research?

There are no personal benefits to your child but the information gathered from this study will assist other teenagers to prevent unwanted/unplanned pregnancies.

Are there any risks involved in your child taking part in this research?

There are no anticipated risks.

If you do not agree to allow your child to take part, what alternatives does your child have?

Participation is voluntary and your child's care will in no way be compromised should you not agree to be part of this study.

Who will have access to your child's medical records?

The information collected will be treated as confidential, and protected. If it is used in a publication or thesis, the identity of your child will remain anonymous. Only the researcher and supervisors will have access to the information.

Will you or your child be paid to take part in this study and are there any costs involved?

You or your child will not be paid to take part in the study. There will be no costs involved for you if your child does take part.

Is there anything else that you should know or do?

You can contact Dr Stellenberg at tel: (021) 938-9036 if you have any further queries or encounter any problems.

You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your child's study doctor.

You will receive a copy of this information and consent form for your own records.

Declaration by parent/legal guardian

By signing below, I *(name of parent/legal guardian)* ……..…… agree to allow my child (name of child) …….. who is ……. years old, to take part in a research study entitled *(*Experiences of pregnant teenagers about their pregnancy.)

I declare that:

- I have read or had read to me this information and consent form and that it is written in a language with which I am fluent and comfortable.
- If my child is older than 7, years, he/she must agree to take part in the study and his/her ASSENT must be recorded on this form.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to let my child take part.
- I may choose to withdraw my child from the study at any time and my child will not be penalised or prejudiced in any way.

- My child may be asked to leave the study before it has finished if researcher feels it is in my child's best interests, or if my child does not follow the study plan as agreed to.

Signed at (*place*) .....…..…….. On (*date*) ……..……

..... **.....**

Signature of parent/legal guardian Signature of witness

Declaration by investigator

I *(name)* ……..…….. declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understand all aspects of the research, as discussed above
- I did/did not use an interpreter (i*f an interpreter is used, then the interpreter must sign the declaration below).*

Signed at (place) ..... on (date) ……..…….. 2011

.....

Signature of investigator

Declaration by interpreter (Only complete if applicable)

I (name) …….…… declare that:

- I assisted the investigator (*name*) …….. to explain the information in this document to (*name of parent/legal guardian*) ……..…….. using the language medium of Zulu.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the parent/legal guardian fully understands the content of this informed consent document and has had all his/her questions satisfactorily answered.

Signed at (*place*)…….. On (*date)*……..

.....

Signature of interpreter

ANNEXURE C: ASSENT FORM

	STELLENBOSCH UNIVERSITY **FACULTY OF HEALTH SCIENCES**	

PARTICIPANT INFORMATION LEAFLET AND ASSENT FORM

TITLE OF THE RESEARCH PROJECT: "Experiences of pregnant teenagers about their pregnancy."

ETHICS REFERENCE NO: N10/11/397

PRINCIPAL INVESTIGATOR: Mrs. Julie Rangiah

ADDRESS: 463 Stella Road

Section 2

Malvern

4093

CONTACT NUMBER: 0795703256

What is RESEARCH?

Research is something we do to find new knowledge about the way things (and people) work. We use research projects or studies to help us find out more about disease or illness. Research also helps us to find better ways of helping, or treating sick children.

What is this research project all about?

The Researcher would like to find out why teenagers get pregnant and what their feelings about being pregnant are.

Why did the researcher invite you to take part in this research project?

You were chosen because you are a teenager who is pregnant and will be suitable to assist the Researcher by answering a few simple questions.

Who is doing the research?

I, Mrs Julie Rangiah will be personally asking you some questions. I am a Midwife who works in a labour ward where teenagers like you come to have their babies.

What will happen to me in this study?

The Researcher will ask you some questions regarding pregnancy. You must give honest and correct answers. You have the right not to answer a question if you do not wish to.

Can anything bad happen to me?

Nothing bad can happen to you. All answers that you give to the Researcher will remain private, meaning that your name will not, be mentioned to anyone.

Can anything good happen to me?

Yes, you will be helping the nurses and doctors to understand why teenagers get pregnant and they in turn can help other teenagers like you to prevent pregnancy.

Will anyone know I am in the study?

Your name will remain private. Only the people involved in the study will be able to see the information that you give us.

Whom can I talk to about the study?

You can contact Dr. E.L. Stellenberg at tel. (021) 938-9036 if you have any problems or questions.

You can contact the Committee for Human Research at (021) 938-9207 if you have any concerns or complaints that have not been adequately addressed by the researcher.

What if I do not want to do this?

You can refuse to take part even your parents have agreed to their participation. You can stop being in the study at any time without getting in trouble.

Do you understand this research study and are you willing to take part in it?

YES NO

Has the researcher answered all your questions?

YES NO

Do you understand that you can pull out of the study at any time?

YES NO

_____ _____

Signature of Child Date

ANNEXURE D: INTERVIEW SCHEDULE

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY jou kennisvennoot • your knowledge partner	**Title** **Experiences of pregnant teenagers about their pregnancy.**

Interview Schedule

The following are a list of questions that will be asked during the interviews:

Section A: Demographic data:

- Age in years on your last birthday;
- Language: Afrikaans, English, Other;
- Family Status: Married, Single;
- Educational Level: Never literate, Primary School, Secondary school, tertiary level literate;
- Employment Status: Unemployed, Casual labourer, unskilled labourer, skilled labourer, professional;
- Socio-Cultural Group: White, Coloured, Black, others.....;
- Living with both parents, single parent, no parents at all;
- Cultural beliefs regarding teenage pregnancies?
- Access to financial support: Yes/No. Explain.

Section B: Experiences related to the pregnancy:

- Describe your experience of being pregnant;
- What do you know about contraceptives?

- How do you perceive the services rendered by the healthcare workers at the clinic?

Each participant will answer the same questions until data saturation. Questions will be asked in English. All responses will be recorded as field notes for analysis later. Individual, in-depth interviews will be conducted based on the phenomenological approach. If a participant feels that a question is too invasive and is infringing on their personal integrity, they will not be obliged to answer that question.

ANNEXURE E:

PERMISSION FROM R.K.KHAN HOSPITAL (DOH-KZN)

HEALTH
KwaZulu-Natal

R.K. KHAN HOSPITAL
Private Bag X004
Chatsworth
4030
Tel.:031-4596030, Fax.:031-4010505
www.kznhealth.gov.za

13 MARCH 2011

MRS. J. RANGIAH

RE: PERMISSION TO CONDUCT NURSING RESEARCH

I have pleasure informing you that permission is hereby granted to you to conduct nursing research at R.K. Khan Hospital.

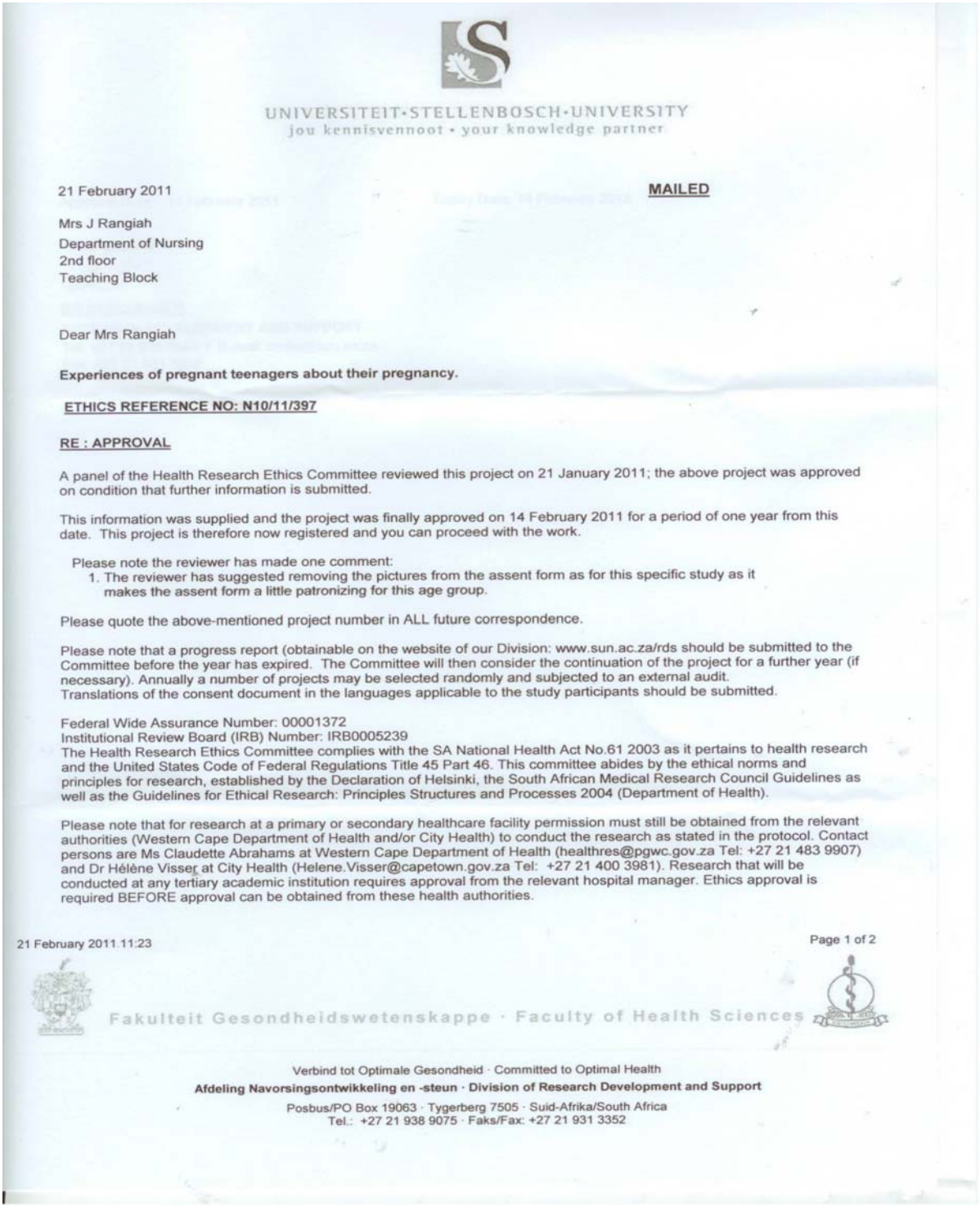
Thank you

DEPUTY NURSE MANAGER

R.K. KHAN HOSPITAL
DEPUTY NURSING MANAGER
14 MAR 2011
PRIVATE BAG X004
CHATSWORTH 4030

ANNEXURE F:

PERMISSION FROM THE COMMITTEE FOR HUMAN RESEARCH OF STELLENBOSCH UNIVERSITY



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21 February 2011 **MAILED**

Mrs J Rangiah
Department of Nursing
2nd floor
Teaching Block

Dear Mrs Rangiah

Experiences of pregnant teenagers about their pregnancy.

ETHICS REFERENCE NO: N10/11/397

RE : APPROVAL

A panel of the Health Research Ethics Committee reviewed this project on 21 January 2011; the above project was approved on condition that further information is submitted.

This information was supplied and the project was finally approved on 14 February 2011 for a period of one year from this date. This project is therefore now registered and you can proceed with the work.

Please note the reviewer has made one comment:
1. The reviewer has suggested removing the pictures from the assent form as for this specific study as it makes the assent form a little patronizing for this age group.

Please quote the above-mentioned project number in ALL future correspondence.

Please note that a progress report (obtainable on the website of our Division: www.sun.ac.za/rds should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.
Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239
The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 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).

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Hélène Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

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Fakulteit Gesondheidswetenskappe · Faculty of Health Sciences

Verbind tot Optimale Gesondheid · Committed to Optimal Health
Afdeling Navorsingsontwikkeling en -steun · Division of Research Development and Support
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Tel.: +27 21 938 9075 · Faks/Fax: +27 21 931 3352

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Approval Date: 14 February 2011

Expiry Date: 14 February 2012

Yours faithfully

MS CARLI SAGER
RESEARCH DEVELOPMENT AND SUPPORT
Tel: +27 21 938 9140 / E-mail: carlis@sun.ac.za
Fax: +27 21 931 3352

Fakulteit Gesondheidswetenskappe · Faculty of Health Sciences

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ANNEXURE G: LANGUAGE EDITING

29th November 2011

34 Dawood Place
PARLOCK
Durban

To Whom it May Concern

University of Stellenbosch

Re: Language Editing of Dissertation of Julie Rangiah for her Masters in Nursing Science

This is to certify that I have edited the dissertation titled "The Experiences of Pregnant Teenagers about their Pregnancy", for syntax, grammar and punctuation.

The editing is in no way intended to change the content and/or the context of the dissertation.

This dissertation is to the best of my knowledge ready for examination.

Khadija Kharsany

083 786 1503

khadijam@mweb.co.za