CONSTRUCTION OF A PROGRAMME FOR PREVENTION OF UNPLANNED
PREGNANCIES IN ADOLESCENT GIRLS IN HAMMANSKRAAL

PhD (Nursing Sciences)

M. M. MADUMO

2014
CONSTRUCTION OF A PROGRAMME FOR PREVENTION OF UNPLANNED PREGNANCIES IN ADOLESCENT GIRLS IN HAMMANSKRAAL

BY

MANKUKU MARY MADUMO

THESIS

Submitted in fulfilment of the requirements for the degree

DOCTOR OF PHILOSOPHY

In

NURSING SCIENCES

In the

Department of Nursing Science

School of Health care Sciences

University of Limpopo (Medunsa Campus)

SUPERVISOR: Dr Y Havenga

CO-SUPERVISOR: Prof EJ van Aswegen
DECLARATION

I, Mankuku Mary Madumo, declare that the thesis, CONSTRUCTION OF A PROGRAMME FOR PREVENTION OF UNPLANNED PREGNANCIES IN ADOLESCENT GIRLS IN HAMMANSKRAAL submitted to the University of Limpopo Medunsa Campus, for the degree of PhD Nursing Sciences is my own work and that all the sources that I have used or quoted in this study have been indicated and acknowledged by means of complete references and this work has not been submitted before for any degree at any other institution.

Date:

Place: University of Limpopo (Medunsa Campus)

Signature:

Student Number: 200818353
DEDICATION

I dedicate this thesis to my children, Thabiso, Lebogang and Boitumelo, and my son-in-law, Sandile, who helped me in many ways to face this study courageously.

Thank you for your support and encouragement throughout my journey of lifelong learning. You were there for me every step of the way, when I felt discouraged I knew that I could count on you to give me the hope and humour that I needed to carry on. When I faced the difficult parts of the study, you were there to give support, sometimes even guidance. Just a phone call was enough to pick me up personally, spiritually and emotionally. You many a times had to put your personal commitments, your work, and your own studies aside and assist me in the many ways that you did. I really appreciated that. Your words of encouragement and your belief in me and my potential helped me to persevere, stay focused and positive, and keep going in this journey. You provided me with the extra tools for this journey, encouraged me every step of the way; therefore, I finally was able to conquer.

I thank you and may the Almighty God bless you in your lives. I love you all.
ACKNOWLEDGEMENTS

I thank God for His love and grace, for giving me the strength and courage to complete this study and fulfil its requirements.

I would like to extend my sincere gratitude and recognition to:

- Dr Y Havenga and Prof EJ van Aswegen, my supervisors: thank you for being my mentors, for your support and encouragement throughout the study, and most of all for the contribution to my personal and professional growth.
- My children, Thabiso, Lebogang, Boitumelo and Sandile: thank you for believing in me and giving me space and support to pursue my passion.
- My parents and sister who have gone before me: I have learnt from each one of you and will always keep you dear in my heart.
- My brothers and sisters: thank you for your continued support and encouragement during the difficult times of my life.
- Dr. Annie Temani: thank you for taking time from your busy schedule and passionately coding data.
- Anzelle: thank you for hours spent with the language editing of the document.
- The hospital: thank you for allowing me to use the reproductive health clinic for data collection and for taking the time to be available as critical reviewers of the study.
- The professional nurse in the hospital: for assisting me with client selection at the reproductive health clinic.
- Participants of the study: for giving their time and sharing their experiences with me.
- The University of Limpopo Medunsa Campus: for the study leave granted and continued support during the study.
- UNEDSA and the Elma South Africa Foundation: for the PhD scholarship that I received.
- To all other role players, whom I cannot name all. Thank you all for taking part and making a difference in my life.
ABSTRACT

Unplanned adolescent pregnancy is an important public health issue. Although preventable, it remains common globally and is usually associated with negative health and socio-economic outcomes for the baby and the adolescents themselves. It also has implications for the family and society at large. Health care services are inundated with adolescent girls having unplanned pregnancies, some of whom drop out of school. Support for adolescent girls in choices about decision making on pregnancy prevention is often not available from the family, the school, the community or health care services.

Literature indicates that adolescent girls are influenced by intrapersonal, interpersonal and institutional factors in decision making about pregnancy prevention. Factors needed for adolescent girls to be able to make emancipated decisions in pregnancy prevention have been identified in literature as the presence of personal knowledge, empowerment, awareness of social norms, reflection and a flexible environment.

The purpose of this study was to construct a programme and implementation guidelines for the prevention of unplanned pregnancies in adolescent girls though emancipated decision making.

A qualitative, explorative, descriptive and contextual research design, based on the Wittmann-Price Theory of Emancipated Decision Making in women’s health issues, was utilised to achieve the above-mentioned purpose. Construction of the programme took place in four phases.

Phase one involved the situational analysis, which entailed describing the factors contributing to the occurrence of unplanned pregnancies in adolescent girls as well as exploring and describing the existing sources of information for decision making in pregnancy prevention in adolescent girls. The situational analysis further involved a description of the applicable models and theories used in decision making in the prevention of adolescent girls’ unplanned pregnancies. The findings of the study revealed that adolescent girls lack personal knowledge and empowerment, need a flexible environment and the ability to reflect, and are influenced by restrictive social norms to be able to make emancipated decisions to prevent unplanned pregnancies.
The findings of the study and the theories and models applicable in decision making in adolescent girls’ prevention of unplanned pregnancies formed the basis for the conceptual framework and culminated in the programme design and guidelines for the implementation of the programme.

The second phase focused on concept analysis and the conceptual framework. A concept analysis clarified the concepts of the Wittmann-Price Theory (Witmann-Price, 2004, 2006, 2008), on which the study was based. A conceptual framework guided by the logic model described the framework of the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls. The conceptual framework consisted of the inputs, programme activities, outputs and outcomes.

Phase three described the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls and the implementation guidelines. The programme activities, described as facilitation of the process of emancipatory education for the prevention of unplanned pregnancies in adolescent girls based on the conceptual framework, were discussed with reference to the relationship, work and termination phases.

Phase four entailed evaluation of the programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making. The researcher used the evaluation criteria of Chinn and Kramer (2011:196), namely, clarity, simplicity, generality, accessibility and importance.

Adolescent girls’ emancipated decision making in the prevention of unplanned pregnancies can be made a daily practice by health care professionals. Health care professionals have the responsibility to practice ethically, be guided by applicable public policies on adolescent girls’ pregnancy prevention, benchmark the best practices and engage in reflective dialogue with adolescent girls and colleagues to improve the programme and practice.

Key words: adolescent girls, emancipated decision making, emancipatory education, programme, unplanned pregnancies.
# TABLE OF CONTENTS

Declaration ................................................................................................................................. i
Dedication ................................................................................................................................. ii
Acknowledgements .................................................................................................................. iii
Abstract ....................................................................................................................................... iv
List of tables ............................................................................................................................... xii
List of figures ............................................................................................................................. xiii
List of annexures ....................................................................................................................... xiv
List of abbreviations ............................................................................................................... xv

## CHAPTER 1: INTRODUCTION AND OVERVIEW OF THE RESEARCH

1.1 Introduction ......................................................................................................................... 1
1.2 Background of the problem ............................................................................................... 2
1.3 Problem statement ............................................................................................................... 10
1.4 Research question ............................................................................................................. 12
1.5 Purpose of the study .......................................................................................................... 12
1.6 Objectives of the study ...................................................................................................... 12
1.7 Significance of the study .................................................................................................. 13
1.8 Paradigmatic perspective ................................................................................................. 13
1.8.1 Metatheoretical assumptions ....................................................................................... 13
1.8.2 Theoretical framework ............................................................................................... 16
1.8.3 Operational definitions ............................................................................................... 16
1.9 Research design and method ........................................................................................... 19
1.9.1 Research method ........................................................................................................ 20
1.9.2 Trustworthiness .......................................................................................................... 24
1.9.3 Ethical considerations .................................................................................................. 24
1.10 Division of chapters ........................................................................................................ 25
1.11 Conclusion ....................................................................................................................... 26
CHAPTER 2: RESEARCH DESIGN AND METHOD

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Introduction</td>
<td>27</td>
</tr>
<tr>
<td>2.2 The purpose of the study</td>
<td>27</td>
</tr>
<tr>
<td>2.3 Research design</td>
<td>27</td>
</tr>
<tr>
<td>2.3.1 Qualitative</td>
<td>28</td>
</tr>
<tr>
<td>2.3.2 Exploratory</td>
<td>28</td>
</tr>
<tr>
<td>2.3.3 Descriptive</td>
<td>29</td>
</tr>
<tr>
<td>2.3.4 Contextual</td>
<td>30</td>
</tr>
<tr>
<td>2.4 Research method</td>
<td>31</td>
</tr>
<tr>
<td>2.4.1 Phase one: Situational analysis</td>
<td>31</td>
</tr>
<tr>
<td>2.4.2 Phase two: Concept analysis and conceptual framework for the programme</td>
<td>53</td>
</tr>
<tr>
<td>2.4.3 Phase three: Description of the programme activities</td>
<td>54</td>
</tr>
<tr>
<td>2.4.4 Phase four: Evaluation of the programme</td>
<td>54</td>
</tr>
<tr>
<td>2.5 Reasoning strategies</td>
<td>55</td>
</tr>
<tr>
<td>2.5.1 Inductive reasoning</td>
<td>55</td>
</tr>
<tr>
<td>2.5.2 Deductive reasoning</td>
<td>56</td>
</tr>
<tr>
<td>2.5.3 Analysis</td>
<td>56</td>
</tr>
<tr>
<td>2.5.4 Synthesis</td>
<td>57</td>
</tr>
<tr>
<td>2.6 Measures to ensure trustworthiness</td>
<td>57</td>
</tr>
<tr>
<td>2.6.1 Credibility</td>
<td>58</td>
</tr>
<tr>
<td>2.6.2 Transferability</td>
<td>63</td>
</tr>
<tr>
<td>2.6.3 Dependability</td>
<td>64</td>
</tr>
<tr>
<td>2.6.4 Confirmability</td>
<td>64</td>
</tr>
<tr>
<td>2.6.5 Authenticity</td>
<td>65</td>
</tr>
<tr>
<td>2.7 Ethical principles</td>
<td>67</td>
</tr>
<tr>
<td>2.7.1 Respect for human dignity</td>
<td>67</td>
</tr>
<tr>
<td>2.7.2 Beneficence</td>
<td>72</td>
</tr>
<tr>
<td>2.7.3 Justice</td>
<td>74</td>
</tr>
<tr>
<td>2.7.4 Ensure that public reports of this study are honest and accurate</td>
<td>74</td>
</tr>
<tr>
<td>2.7.5 Objectivity, integrity and professional competence of research</td>
<td>74</td>
</tr>
</tbody>
</table>
2.7.6 Social responsibility ........................................................................................................ 75
2.8 Conclusion .......................................................................................................................... 75

CHAPTER 3: DISCUSSION OF FINDINGS AND LITERATURE CONTROL

3.1 Introduction ......................................................................................................................... 76
3.2 Description of the biographical data of participants .......................................................... 79
  3.2.1 The clinics ...................................................................................................................... 79
  3.2.2 Participants .................................................................................................................. 80
  3.2.3 Participants’ partners ................................................................................................... 90
  3.2.4 Living arrangements .................................................................................................... 95
3.3 Discussion of the findings and literature control ............................................................... 98
3.4 Themes, categories and sub-categories ............................................................................ 100
  3.4.1 Theme 1: Emancipated decision making factors ....................................................... 100
  3.4.2 Theme 2: Socio-economic factors influencing adolescent decision making in the prevention of unplanned pregnancies ............................................................... 126
  3.4.3 Theme 3: The existing sources of information for adolescent decision making about pregnancy prevention ................................................................. 132
3.5 Conclusion ......................................................................................................................... 141

CHAPTER 4: MODELS AND THEORIES USED IN DECISION MAKING FOR THE PREVENTION OF UNPLANNED PREGNANCIES IN ADOLESCENT GIRLS

4.1 Introduction ......................................................................................................................... 143
4.2 Description of theories and models .................................................................................. 143
4.3 Theories and models applied in the study ......................................................................... 144
  4.3.1 The Wittmann-Price Theory of Emancipated Decision Making in women’s health issues ................................................................. 145
  4.3.2 Dual-process models .................................................................................................... 147
  4.3.3 Developmental theories ............................................................................................... 149
  4.3.4 The ecological systems model .................................................................................... 153
4.4 Conclusion ......................................................................................................................... 158
CHAPTER 5: CONCEPT ANALYSIS

5.1 Introduction .............................................................................................................. 160
5.2 The procedure of concept analysis .......................................................................... 160
5.2.1 Selecting the concept ......................................................................................... 161
5.2.2 Determining the purposes of analysis ................................................................. 161
5.2.3 Identifying all uses of the concept ....................................................................... 162
5.2.4 Determining the defining attributes ..................................................................... 162
5.2.5 Identifying antecedents and consequences ......................................................... 162
5.2.6 Identifying a model case ...................................................................................... 163
5.3 Identifying the main concepts .................................................................................. 163
5.4 Definition of the main concepts ............................................................................... 164
5.4.1 Defining the concept ‘PERSONAL KNOWLEDGE’ ............................................. 164
5.4.2 Defining the concept ‘EMPOWERMENT’ ............................................................. 171
5.4.3 Defining the concept ‘FLEXIBLE ENVIRONMENT’ ......................................... 176
5.4.4 Defining the concept: ‘AWARENESS OF SOCIAL NORMS’ .............................. 180
5.4.5 Defining the concept ‘REFLECTION’ ................................................................. 185
5.4.6 Defining the concept ‘EMANCIPATION’ ............................................................. 190
5.4.7 Definition of the concept ‘DECISION MAKING’ .............................................. 193
5.5 Comprehensive definition of the concepts .................................................................. 197
5.6 Discussion of the exemplar case .............................................................................. 197
5.7 Core qualities of an emancipation programme ....................................................... 201
5.8 Conclusion ................................................................................................................. 201

CHAPTER 6: THE CONCEPTUAL FRAMEWORK FOR THE
EMANCIPATORY EDUCATION PROGRAMME FOR ADOLESCENT GIRLS
TO PREVENT UNPLANNED PREGNANCIES

6.1 Introduction .............................................................................................................. 203
6.2 The conceptual framework ...................................................................................... 203
6.2.1 The assumptions .................................................................................................. 205
6.2.2 The national level inputs .................................................................................... 207
6.2.3 The context: The primary health care (PHC) clinic ........................................... 212
6.2.4 The programme activities ................................................................. 214
6.2.5 Recipients of the programme ............................................................... 215
6.2.6 Facilitators of the programme ............................................................... 215
6.2.7 The programme outputs ....................................................................... 216
6.2.8 The programme outcomes .................................................................... 217
6.3 Conclusion ............................................................................................... 217

CHAPTER 7: DESCRIPTION OF PROGRAMME ACTIVITIES AND
IMPLEMENTATION GUIDELINES

7.1 Introduction .............................................................................................. 223
7.2 Overview of the emancipatory education programme activities .................. 223
7.3 Facilitation of the process of emancipatory education for the prevention of
unplanned pregnancies in adolescent girls ..................................................... 226
7.3.1 Facilitators in the process of emancipatory education .............................. 226
7.3.2 Adolescent girls in the process of emancipatory education ...................... 232
7.3.3 Facilitation of the process of emancipatory education .............................. 234
7.3.4 Planning for facilitation of the process of emancipatory education .......... 235
7.3.5 The phases of facilitation of the process of emancipatory education ........ 237
7.4 Guidelines for the implementation of the programme activities .................. 253
7.4.1 The relationship phase ........................................................................... 253
7.4.2 The work phase ..................................................................................... 255
7.4.3 The termination phase ........................................................................... 262
7.5 Conclusion ............................................................................................... 264

CHAPTER 8: PROGRAMME EVALUATION, CONCLUSIONS,
LIMITATIONS AND RECOMMENDATIONS

8.1 Introduction .............................................................................................. 265
8.2 Evaluation of the research ........................................................................ 265
8.2.1 Evaluation by critical reference group ................................................... 265
8.2.2 Evaluation by adolescent girls ............................................................... 268
8.3 The purpose and objectives of the study .................................................... 270
8.4 Conclusions of the research ...................................................................... 271
8.4.1 Empiric conclusions ........................................................................................................ 271
8.4.2 Conceptual conclusions .................................................................................................. 274
8.5 Limitations of the study ...................................................................................................... 275
8.6 Recommendations of the study .......................................................................................... 275
8.6.1 Recommendations for nursing practice ............................................................................ 276
8.6.2 Recommendations for nursing education ........................................................................... 276
8.6.3 Recommendations to nursing research ............................................................................ 276
8.7 Unique contribution of this research .................................................................................. 277
8.8 Reflections by the researcher ............................................................................................. 278
8.9 Conclusion .......................................................................................................................... 279
References .................................................................................................................................. 280
LIST OF TABLES

Table 1.1: The process of programme construction and objectives of the study ........... 20
Table 1.2: Division of the study .................................................................................... 25
Table 2.1: Record of the referral hospital reproductive health clinic unplanned pregnancies .......................................................... 36
Table 2.2: Diagrammatic representation of criteria for trustworthiness ................... 58
Table 2.3: Application of strategies for establishing trustworthiness in the study ....... 65
Table 3.1: Religion (n=16) .......................................................................................... 87
Table 3.2: Overview of themes, categories and sub-categories ................................ 98
Table 3.3: Adolescent girls’ lack of ‘personal knowledge’ ........................................ 101
Table 3.4: Empowerment of adolescent girls ............................................................... 106
Table 3.5: Prescriptive social norms ......................................................................... 111
Table 3.6: Limited flexibility of environment ............................................................... 115
Table 3.7: Challenges experienced by participants in the clinics .............................. 117
Table 3.8: Unavailability of services ......................................................................... 120
Table 3.9: Adolescent girls’ reflection ...................................................................... 122
Table 3.10: Socio-economic factors influencing adolescent decision making in the prevention of unplanned pregnancies .................................................. 127
Table 3.11: The existing sources of information about pregnancy prevention ......... 132
Table 3.12: Formal sources of information ................................................................. 133
Table 3.13: Informal sources of information ............................................................... 137
Table 4.1: The ecological systems model ................................................................ 137
Table 5.1: Essential attributes of the concept ‘personal knowledge’ ....................... 153
Table 5.2: Essential attributes of the concept ‘empowerment’ .................................. 174
Table 5.3: Essential attributes of the concept ‘flexible environment’ ...................... 179
Table 5.4: Essential attributes for the concept ‘awareness of social norms’ .......... 183
Table 5.5: Essential attributes of the concept ‘reflection’ ......................................... 187
Table 5.6: Essential attributes of the concept ‘emancipation’ ................................. 192
Table 5.7: Essential attributes of the concept ‘decision making’ ............................. 195
Table 6.1: Thinking map according to the logic model .............................................. 204
LIST OF FIGURES

Figure 3.1: Data analysis........................................................................................................78
Figure 3.2: Ages of participants (n=16) ...............................................................................81
Figure 3.3: Number of pregnancies (n=16) .........................................................................82
Figure 3.4: Number of sexual partners (n=16) .................................................................83
Figure 3.5: Marital Status: (n=16) .....................................................................................84
Figure 3.6: Level of education (n=16) ...............................................................................85
Figure 3.7: Employment status: (n=16) .............................................................................86
Figure 3.8: Ethnic groups ....................................................................................................89
Figure 3.9: Ages of participants’ partners (n=16) .............................................................90
Figure 3.10: Participants’ partners’ levels of education (n=16) ........................................92
Figure 3.11: Participants’ partners’ employment status (n=16) ........................................93
Figure 3.12: Participants' partners' involvement in the unplanned pregnancy (n=16) ... 94
Figure 3.13: Living arrangements (n=16) .......................................................................95
Figure 5.1: Emancipated decision making in adolescent girls for the prevention of unplanned pregnancies .................................................................164
Figure 6.1: The conceptual framework for the emancipatory education programme for the prevention of unplanned pregnancies of adolescent girls.................................207
Figure 6.2: Activities ........................................................................................................214
Figure 6.3: Recipients ......................................................................................................215
Figure 6.4: Facilitators ....................................................................................................215
Figure 6.5: The outputs ..................................................................................................216
Figure 6.6: The outcomes ...............................................................................................217
Figure 7.1: The programme activities .............................................................................225
Figure 7.2: The process of emancipatory education .......................................................237
LIST OF ANNEXURES

Annexure A Ethical clearance certificate University of Limpopo Medunsa Campus.... 281
Annexure B Ethical clearance certificate Tshwane Metsweding Region .................. 281
Annexure C Consent by participants and parents ................................................... 281
Annexure D Interview schedules: English and Setswana ....................................... 281
Annexure E Transcribed interview and field notes .................................................... 281
Annexure F Letter from the independent coder ....................................................... 281
Annexure G confidentiality agreement ..................................................................... 281
Annexure H Letter from the language editor ............................................................ 281
## LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LO</td>
<td>Life Orientation</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MLPP</td>
<td>Managing Learner Pregnancy Policy</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>SGB</td>
<td>School Governing Body</td>
</tr>
</tbody>
</table>
CHAPTER 1
INTRODUCTION AND OVERVIEW OF THE RESEARCH

1.1 INTRODUCTION

Despite the widespread availability and affordability of pregnancy prevention methods as well as information about these methods, unplanned pregnancy, especially concerning adolescent girls, still poses a challenge to health care services. Adolescent girls are young and vulnerable, and lack adequate knowledge about reproductive health (Maja, 2007:8) to enable them to make informed decisions about their lives to prevent unplanned pregnancies.

Young people are a great potential for the nation and the future, with new ideas, hopes and technology which will see the nation growing and developing. Their reproductive health should be a priority in homes, schools and health planning nationwide. Adolescent girls are regarded as a vulnerable group, partly because of the oppressive social norms on women and their stage of development, which is characterised by risky experimentation of sexual behaviour (Department of Health, 2001:5; Ehlers, 2003b:229) which places them at risk in decision making about pregnancy prevention.

For many adolescents, sex has become morally equivalent to other casual, free time activities that they enjoy together (De Villiers & Kekesi, 2004:21). However, Lehana and Van Rhyn (2003:26) caution that in Lesotho, pregnancies outside marriage are regarded as antisocial and carry a stigma which may put the unmarried adolescents at risk of developing adverse psychological and behavioural problems which can affect their lives. De Villiers and Kekesi (2004:21) further warn that, until the problem of unplanned adolescent pregnancies is effectively controlled, adolescent girls will increasingly risk disease, early death of their children and poor career opportunities.

Chigona and Chetty (2008:18) report adolescent pregnancy in South African public schools as female sexuality out of control, a representation of rebellion against parents and other adults, and dropping out of school. The Western Cape Education Department formulated the Managing Learner Pregnancy Policy (MLPP) in an effort to guarantee
that education of adolescent mothers continues with as little disruption as possible (Chigona & Chetty, 2008:18). The MLPP, which has been implemented in all public schools in South Africa in response to the high rate of adolescent pregnancy in schools, recommends that matters relating to learner pregnancy must be treated with great sensitivity and confidentiality, and that pregnant learners should be considered to be learners with special needs and be granted access to professional counselling. However, the MLPP does not support adolescent girls in making emancipated decisions about pregnancy prevention, but merely assists pregnant adolescents to remain in school.

Support for adolescent girls in decision making on pregnancy prevention is often not available from the family, school, community or health care professionals (Brindis & Davis, 1998:129). Women who are financially, materially or socially dependent on men usually have limited power to exercise decision making in relationships, such as negotiating pregnancy planning (Maja, 2007:10). The practice of female dependency on males about decision making is carried over across generations and young girls often find themselves unable to negotiate or have control over their bodies as opposed to their male counterparts, which puts them at risk of having unplanned pregnancies.

The Wittmann-Price Theory of Emancipated Decision Making in women’s health gives a background of how important emancipation and emancipated decision making is (Wittmann-Price, 2004:441) in the prevention of unplanned pregnancy in adolescent girls. The purpose of the study is thus to construct a programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.

1.2 BACKGROUND OF THE PROBLEM

Adeyinka, Oladimeji, Adekanbi, Adeyinka, Falope and Aimakhu (2010:785) state that until recently adolescent pregnancy was considered to be a problem of non-white and lower income groups, yet, globally, 15 million girls aged 15 to 19 have babies yearly. Adolescents account for approximately 10% of all births worldwide. Sipsma, Ickovics, Lewis, Ethier and Kershaw (2011:110) align themselves with the above, indicating that national data of the USA have suggested an increase in the annual rate and number of
births to adolescents. In 2007 alone, 445 000 babies were born to young women aged 15 to 19 in the USA.

The African continent, like other continents, is experiencing the global challenge of unplanned adolescent pregnancies. Ehlers (2010:14) reports that adolescent pregnancies are posing serious challenges in Zimbabwe where maternal deaths are five per cent higher for females younger than sixteen years of age than for those in their twenties. In South Africa, Maholo, Maja and Wright (2009:47) state that one in three adolescents becomes pregnant every year before the ages of eighteen and nineteen.

Many women around the globe face significant challenges to their sexual and reproductive health, including lack of access to reproductive health services (Wright, 2007:1). Access to information on sexual matters, including contraception, is often neglected in some South African cultures, for fear of promiscuity, cultural barriers and respect for elders where a mother can never discuss menstruation with the adolescent girl (Maja, 2007:1; Mudhovozi, Ramarumo & Sodi, 2012:130). Although reproductive health services, mostly clinics, are functional most of the time, they are not always accessible to adolescent girls. The attitudes of health care professionals are such that adolescent girls cannot always be offered contraceptives and are regarded as too young to be sexually active. These attitudes make adolescent girls fearful of the reproductive health services and expose them to the risk of poor decision making in preventing unplanned pregnancies (Maja, 2007:1).

Ehlers (2003a:13) alludes to the fact that, although contraceptive services are available free of charge in the Republic of South Africa, adolescent girls need more knowledge about them, especially emergency contraceptives, to be able to make decisions about using them. The same author argues that adolescent girls need to perceive the reproductive health services as safe and adolescent-friendly to be able to effectively and freely utilise the methods provided.

The emergency contraceptive option to prevent unplanned pregnancy after unprotected sexual intercourse or due to rape is available in both private and public sector primary health care clinics. Emergency contraceptive pills should be initiated within 72 hours
after unprotected sex and are most effective when initiated within the first 12 hours (Department of Health, 2012b:73). In South Africa, the emergency contraceptive is rated as a core contraceptive option and recognised as a useful method for young people because at that age sexual activity is usually unplanned and sporadic, and may therefore be unprotected. The emergency contraceptive can prevent unplanned pregnancy in women who do not use or have no continuous access to particular contraceptive methods (Maharaj & Rogan, 2008:351). Most adolescent girls with unplanned pregnancies fail to use available contraceptives, including emergency contraceptives (Maholo et al., 2009:47).

The use of oral contraceptives in adolescent girls has always been associated with high failure rate due to forgetfulness, leaving contraceptives at home while going partying and engaging in casual sex (Ehlers, 2003a:13), and the consequent occurrence of unplanned pregnancies. In support of this, Parkes, Wight, Henderson, Stephenson and Strange (2009:55) indicate that adolescents use oral contraceptives less efficiently, and this is characterised and confirmed by vulnerability to unplanned pregnancies by those using oral contraceptives. The study further suggests that alternative contraceptive strategies such as condoms should be considered for these girls to prevent the occurrence of unplanned pregnancies.

Incest is taboo and a neglected social problem, especially during adolescence, which is a very sensitive period of development. Most incest sexual abuse and rape are only discovered when they result in unplanned pregnancies. Of the three cases of paternal incest rape involving adolescent daughters reported in Yuksel, Kilic, Akin, Tasdemir, Uzunlar and Mollamahmutoglu (2008:53), the outcomes of the pregnancies differed: one delivered a healthy baby, one had an abortion and the last the baby died before the first birthday. The authors’ assertion is that the cases presented and those presented by others are just a tip of the iceberg, as the incidence of incest is much higher but unfortunately kept a secret by victims for a lifetime and not shared with other people. Rape victims, especially adolescent girls, are not free to share the experience of incest rape with other people (Yuksel et al., 2008:53).
There are contradictory opinions as to whether unplanned pregnancies resulting from rape should be terminated for the sake of the victim’s quality of life. Some authors think that most women would consider having an abortion after the second trimester, while others think that the notion that the assumption of willingness to terminate pregnancy for incest and rape is not correct and victims rarely agree to an abortion (Yuksel et al., 2008:53). In support of this Steward and Trussel (2000:228), allude to the fact that the tragic contribution of rape and unplanned pregnancy has received little public health attention, despite the fact that sexual assaults are common. Few women who have been raped therefore receive medical attention, which includes counselling and post-exposure prophylaxis (including pregnancy prevention), after rape. In this study, the programme construction aims also at addressing decision making in adolescent pregnancies resulting from sexual violence.

For some adolescents, relationships with older men may be viewed as more advantageous than relationships with male peers. When daily needs such as food, clothing and money are not met by care-givers, adolescents may feel forced to seek out others to provide these resources that are lacking. Disclosure of such relationships with older men only occurs when an unplanned pregnancy results from such a relationship (Harner, 2005:22). Harner (2005) further states that policies developed to protect young people from victimisation, including mandatory reporting and statutory rape laws, should be evaluated for their consistent application to all adolescents and children, regardless of age, race, gender or pregnancy status.

The individual’s right of universal access to sexual and reproductive health services and information, and to use the services with privacy and confidentiality, is essential for achieving many, if not all, of the Millennium Development Goals (MDGs). Access to safe and effective family planning services and contraception empowers women, including adolescent girls, to have more control over when to have children (World Health Organisation (WHO), 2011:13).

Despite the goal of global achievement of MDGs by 2015, discussion of issues around sex and sexuality is considered taboo in many cultures and the perceived stigma and
embarrassment around these issues usually lead to reluctance in discussions around such sexual health issues. The secrecy regarding sexual issues deprives the youth of an opportunity to get the knowledge and information from their families and other social institutions.

Early in history, women assumed the role of caregiver, allowing men time for scientific study that empowered them with professional knowledge. In some communities, women feel secure and accept the professional or social opinion of inferior status to their male partners because of the expectation that males are superior and have superior knowledge (Wittmann-Price & Bhattacharya, 2008:228). Adolescent girls who are the products of this culture are unable to negotiate or have control over their own bodies as opposed to their male counterparts, and it is even difficult for them to negotiate condom use with their male partners (Mothiba & Maputle, 2012:3). This is a common contributory factor to the occurrence of resultant unplanned pregnancy. Adolescent girls’ lack of bargaining power about health promotion activities including family planning due to the paternalistic nature of society has been corroborated by Grietens, Gies, Coulibaly, Ky, Somda, Toomer, Ribera and D’ Allessandro (2010:5) as a contributory factor to the occurrence of unplanned pregnancies.

The contributory factors pregnant adolescents give for not making decisions to use contraceptives effectively or not using them and having unplanned pregnancies are problems such as failure of family planning services to meet their individual and reproductive health needs, high fertility at that age, the incorrect use of condoms, deficient knowledge about reproductive physiology leading to inappropriate use of the calendar method, poor compliance, inadequate information about some contraceptive methods, poor communication regarding sexuality issues among adolescents and their parents, services unfriendly to the youth, and gender issues (Amy, 2007:300; Mothiba & Maputle, 2012:3; Sheeder, Tocce & Steven-Simon, 2009:296). Gender norms in many societies tend to make men superior and women passive in relationships. Women who are financially, materially or socially dependent on men usually have limited power to exercise decision making, such as negotiating pregnancy planning, in relationships (Maja, 2007:10). The practice of female dependency on males about decision making is
carried over across generations and young girls often find themselves unable to negotiate or have control over their bodies as opposed to their male counterparts, which puts them at risk of having unplanned pregnancies.

Societal power and domination over women causes oppression and denies equality. Oppression causes an intellectual, emotional and psychological enslavement that develops into fear of freedom in exchange for perceived security (Wittmann-Price & Bhattacharya, 2008:228). Adolescent girls who grow up in this patriarchal society characterised by male domination, where behaviour is moulded by oppressive social norms and culture, find it difficult to have full control over their sexual lives – a factor which contributes to their lack of decision making power in preventing unplanned pregnancies. Wittmann-Price (2004:440) recognises that human behaviour is inseparable from environmental influences. Pressured by a social environment which consists of family, friends, peers, sexual partners and the powerful health care services, adolescent girls find themselves unable or restricted to make free choices in pregnancy prevention and falling victims of unplanned pregnancies at an early age in their development.

Critical social theory maintains that oppression is maintained by social institutions in order to control people (Wittmann-Price, 2004:440). The theory indicates that liberation stems from development of self-awareness and knowledge with the resulting power over forces of control (Mooney & Nolan, 2005:241). Feminist theory concurs and specifically concentrates on the oppression of women, and indicates that power or domination over women causes oppression and denies equality or ‘voice’. Feminist theory proposes equal rights and equal treatment as the basis for caring and emancipation (Mooney & Nolan, 2005:241; Wittmann-Price, 2004:440). It is within the same context of empowerment of women that the researcher intends to construct a programme which will empower adolescent girls with, among other things, information to be able to make emancipated decisions in preventing unplanned pregnancies. The power of knowledge will enable adolescent girls to have equality in decision making in preventing unplanned pregnancies.
The Wittmann-Price Theory of Emancipated Decision Making in women’s health (Wittmann-Price, 2004:440), the conceptual framework of which forms the basis for this study, emphasises emancipated decision making in women’s health. Key concepts in the theory which form important elements of the decision making process are empowerment, personal knowledge, social norms, reflection and flexible environment. A description of the key concepts of the Wittmann-Price Theory of Emancipated Decision Making in women’s health theory gives a background of how important emancipation and emancipated decision making are (Wittmann-Price, 2004:441) in the prevention of unplanned pregnancy in adolescent girls.

Although the literature of Africa increasingly adopts a gendered approach to sexual and reproductive health issues, gender ideals are grounded in traits that reinforce poor sexual negotiation dynamics and place adolescent girls at risk of early and unplanned pregnancy (Varga, 2004:161). A significant proportion of young women in Ghana experience forced and coerced marriage. Reproductive health programmes in this area (Ghana) are reported as rarely addressing issues such as lack of power and decision making capability on issues of sexuality in women, including adolescent girls (Wright, 2007:1).

In support of adolescent pregnancy prevention programmes, Taylor, Levi and Simmonds (2010:363) indicate that little has been done by the public sector in the USA to formulate adolescent pregnancy prevention programmes and guidelines to provide adolescent girls with continuous and adolescent-friendly programmes. In spite of the frequency and high cost of unplanned pregnancies, adolescent pregnancy prevention programmes have received less attention in research and the development of clinical and preventive health care strategies than other similarly important health threats. This oversight can be attributed to the fragmented services in reproductive health care, which have contributed to persistently high rates of unplanned pregnancies, especially in adolescents (Taylor et al., 2010:363).

In addition, Hattingh, Dreyer and Roos (2012:121) indicate that most pregnancy prevention programmes in South Africa are not available after 16H00 or over weekends.
when adolescents are free to utilise the services. Such programmes which are also not addressing emancipated decision making have not been effective in managing unplanned adolescent pregnancies. There is a need for an efficient programme for preventing and managing unplanned pregnancies in adolescent girls through emancipated decision making. Commendador (2007:621) further states in agreement that nurse practitioners need to take an active role in creating strategies to facilitate competent decision making and to be involved in research, including measures of development and decision making, as well as ways to assist the adolescents engaged in the relationship context in which sexual and contraceptive decision making occurs.

The importance of using several strategies, such as family life education; an appreciation of cross-cultural similarities and differences across the nation; enhancement of self-esteem; promotion of decision making and behaviour change communication; an increase in the number of support services, including counselling, health and social services; and the increase of other formal links between schools and community clinic resources for young girls, have been stressed for preventing unplanned adolescent pregnancies (Brindis & Davis, 1998:129; Mothiba & Maputle, 2012:5). The same authors further suggest that adolescent girls need information and access to reproductive health services that will increase their capability for decision making in planning child bearing, thus preventing early unplanned pregnancy.

Adolescent girls need contraceptive counselling and services in order to make decisions about preventing unplanned pregnancies at an early age (Lebese, Davhana & Obi, 2010:33; Mngadi, Zwane, Ahlberg & Ransjö-Arvidson, 2003:137). Communication among parents and their daughters needs to be encouraged in order to help adolescent girls in decision making about preventing early unplanned pregnancies. Adolescent girls need to be empowered through education and knowledge, and supported by societal structures such as family, school and church. De-socialisation of these community structures is necessary to equalise power in society between dominant and deprived groups. De-socialisation should address the power imbalance in society which oppresses women as well as the imbalance between information givers and receivers in schools and health care settings which will allow adolescent girls unopposed enactment
of their chosen alternatives (Wittmann-Price, 2004:442) in pregnancy prevention. Health care professionals need to be available and create a flexible environment that will facilitate emancipated decision making (Wittmann-Price, 2004:441) in the prevention of unplanned pregnancies.

A comprehensive, well-run pregnancy prevention programme with clinical guidelines for the adolescent girls will empower adolescent girls and enable them to make informed and emancipated decisions about their sexual lives and prevent the occurrence of unplanned pregnancies. The purpose of the study is therefore to construct such a programme.

1.3 PROBLEM STATEMENT

Unplanned adolescent pregnancy is an important public health issue. Although it is preventable, it remains common globally and is usually associated with negative health and socio-economic outcomes for the baby and the adolescents themselves. It also has implications for the family and society at large. Health care services are inundated with adolescent girls having unplanned pregnancies; some of these adolescent girls drop out of school. Support for adolescent girls in decision making on pregnancy prevention is often not available from family, school, community or health care services (Langille, 2007:1601; Maholo et al., 2009:46).

Hammanskraal is a small semi-rural community within the Northern Tshwane district, which has developing infrastructure and an increasing number of young people (City of Tshwane, 2012:18). Fundamental norms of society, characterised by male domination and respect for elders which precludes discussions around sexuality with elders, still dominate in this community (Maja, 2007:11). Health care services in this community are overwhelmed with adolescent girls having unplanned pregnancies; some of these adolescent girls drop out of school and some request termination of pregnancy (refer Table 2.1).

Oppression by societal norms and a high rate of unplanned pregnancies in adolescent girls was noted by Maja (2007:11) in a study on factors impacting on contraceptive use
among the youth in Northern Tshwane. The above situation of high rates of unplanned adolescent pregnancies is echoed by the researcher, who witnessed high rate of unplanned adolescent pregnancies in Hammanskraal during the accompaniment of nursing students during clinical practice. The influence of restrictive societal norms on adolescent girls' decision making about pregnancy prevention was confirmed by clients and professional nurses working at the reproductive health clinics in Hammanskraal during conversations with the researcher.

During the 2008 compilation of the proposal for the Women and Child Health project which is being implemented in Hammanskraal, the researcher, who was a participant in the project, realised that the number of adolescent girls with unplanned pregnancies was very high. About 50 adolescents with unplanned pregnancies were seen at the reproductive health clinic of the referral hospital per month and even more after the December holidays. The referral hospital's reproductive health clinic is a catchment area for ten clinics in Hammanskraal for referral of patients with reproductive health needs, including unplanned pregnancies. This tendency for high rates of unplanned pregnancy in adolescent girls was confirmed by Naidoo (2010:1) in the West Cape News, which reported a sharp increase in the number of school girls aged between 12 and 18 having unplanned pregnancies during December school holidays, due to sexual experimentation with no information or inadequate knowledge and decision making about contraception and pregnancy prevention.

The researcher, who uses the referral hospital for clinical placement of students, had time to look at the statistics of unplanned pregnancies in the reproductive health clinic. The reproductive health clinic statistics (January 2011-June 2012) confirmed the researcher's concern about unplanned adolescent pregnancies, indicating about 100 women, about 50 of whom were adolescents, reporting at the clinic with unplanned pregnancies per month. The need for a programme to prevent the occurrence of unplanned pregnancies in adolescent girls through emancipated decision making in Hammanskraal community became apparent to the researcher.
Institutions of education are a starting point of emancipated societies. The outcome of an emancipated education is to equalise power between information giver and receiver (Wittmann-Price & Bhattacharya, 2008:226). Education and information from various sources should become an essential component for emancipated decision making (Wittmann-Price & Bhattacharya, 2008:226) in preventing the occurrence of unplanned pregnancies in adolescent girls. The constructed programme will assist adolescent girls to make emancipated decisions in preventing unplanned pregnancies.

1.4 RESEARCH QUESTION

In light of the above problem the following research question arose:

What should a programme and implementation guidelines for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making consist of?

1.5 PURPOSE OF THE STUDY

The purpose of the study was to construct a programme and implementation guidelines for the prevention of unplanned pregnancy in adolescent girls through emancipated decision making.

1.6 OBJECTIVES OF THE STUDY

The following objectives were formulated to achieve the overall purpose of the study:

1.6.1 To explore and describe the factors contributing to the occurrence of unplanned pregnancies in adolescent girls.
1.6.2 To explore and describe the existing sources of information for decision making about pregnancy prevention in adolescent girls.
1.6.3 To describe applicable models and theories used in decision making in the prevention of unplanned pregnancies in adolescent girls.
1.6.4 To describe the programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.
1.6.5 To develop guidelines for implementation of the programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.

1.6.6 To evaluate the programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.

1.7 SIGNIFICANCE OF THE STUDY

The findings of the study will assist other researchers in further addressing unplanned pregnancies as a health threat and assist the education sector in placing and implementing the teaching of emancipated decision making as a component of reproductive health at different levels of education to prevent unplanned pregnancies. The findings of the study will add emancipated decision making in adolescents for the prevention of unplanned pregnancy to the existing body of knowledge. The findings will further guide the health planners to plan reproductive health services, including emancipated decision making in adolescents for the prevention of unplanned pregnancies, and have guidelines and strategies that will effectively address the problem. The power imbalance caused by the powerful health care system consisting of nurses and the multidisciplinary health care system in emancipated decision making about pregnancy prevention in adolescents will be addressed.

1.8 PARADIGMATIC PERSPECTIVE

A paradigm is regarded as a worldview or ideology, a set of basic beliefs about human beings, the relationship between the enquirer and the known; it implies criteria for assigning value to both the processes and products of a discipline, as well as the methods of knowledge development within the discipline (Chinn & Kramer, 2011:157; Denzin & Lincoln, 2008:31). The researcher’s paradigmatic perspective is explained below based on the metatheoretical and theoretical assumptions.

1.8.1 Metatheoretical assumptions

A metatheory is defined by Chinn and Kramer (2011:299) and Walker and Avant (2011:7) as the theory about the nature of the theory and the process of its
development. Babbie and Mouton (2001:20) refer to a metatheory as a critical reflection of the nature of scientific inquiry, addressing the nature and structure of scientific theories, the nature of scientific growth, the meaning of truth, explanation and objectivity. The metatheoretical assumptions of this study are based on the Wittmann-Price Theory of Emancipated Decision Making in women’s health care (Wittmann-Price, 2004:437). The Wittmann-Price Theory has its theoretical basis grounded in critical social theory and feminist theory (Wittmann-Price, 2004:437).

The Wittmann-Price Theory affirms the patient-centred paradigm and considers gender differences (Wittmann-Price, 2004:437). The belief in this study is based on the premise that gender is a central construct in society that privileges men and marginalises women, and encourages the critique of social norms and the effect they may have on women (adolescent girls) who are in the process of decision making about health care issues (Wittmann-Price, 2004:437). The study is further based on the belief that oppression in decision making is a phenomenon that is identified in women’s health care when women feel obliged to choose from the most socially accepted options rather than to choose the option that best suits them (Wittmann-Price & Bhattacharya, 2008:225).

According to the Wittmann-Price Theory, oppression where there are constraints and restrictions diminishes and immobilises people and fashions them into subordination (Mooney & Nolan, 2005:241). Oppression is a constant phenomenon that penetrates decision making in women’s health care (Denzin & Lincoln, 2008:314; Wittmann-Price, 2004:440). Probing the pressures and constraints that are present in society and assisting adolescent girls to respond by challenging what are often restrictive norms of society to be able to make emancipated decisions (Kuokkanen & Leino-Kilpi, 2000:237; Wittmann-Price & Bhattacharya, 2008:225) in the prevention of unplanned pregnancies is a conceptual premise in this study.

Power or domination over women (adolescent girls) causes oppression and denies equality or ‘voice’; therefore, the study proposes equal rights, equal treatment and a caring, authentic ‘voice’. To have a ‘voice’ requires a safe space and a flexible
environment for decision making (Wittmann-Price, 2004:441). Adolescent girls’ voices must be heard to allow them equality in making informed, emancipated decisions about the prevention of unplanned pregnancies.

According to Wittmann-Price and Bhattacharya (2008:226), the decisional environments are an extension of the social system which puts pressure on women (adolescent girls) who are in a process of decision making. The Wittmann-Price Theory maintains that human beings and the environment are inseparable; therefore, awareness of social norms refers to a woman’s knowledge of the opinions held by the larger environment about the health care options that are presented to her. The larger environment includes health care professionals, government health care initiatives and public opinion, as well as family, friends and the community (Wittmann-Price & Bhattacharya, 2008:225). Adolescent girls who are young women find themselves having to make decisions about the prevention of unplanned pregnancies within the opinions held by the larger environment consisting of health care professionals, church, the community, sexual partners, family and friends.

A person and the environment are in constant interaction. The person (adolescent girl) attempts to maintain emancipation by equalising power against persons, groups or systems and environments that attempt to impose oppression. Freedom of choice may be hindered if social norms and the environments are negatively affecting a woman's (adolescent girl’s) health decision making process (Wittmann-Price & Bhattacharya, 2008:226). Adolescent girls are in constant interaction with restrictive social norms of the church, the community, family and friends, as well as the health care system. These social structures may hinder their freedom of choice in preventing unplanned pregnancies.

The Wittmann-Price Theory maintains that oppression in decision making in women (adolescent girls) who are in the process of decision making needs to be replaced with a humanistic philosophy based on the value of freedom which begins with the right to choose freely when making decisions in the prevention of unplanned pregnancies (Kuokkanen & Leino-Kilpi, 2000:237; Wittmann-Price & Bhattacharya, 2008:225).
1.8.2 Theoretical framework

The theoretical framework in this study is guided by the Wittmann-Price Theory of Emancipated Decision Making in women’s health care. The purpose of the theory in this study is to enable women (adolescent girls) to arrive at decisions that they are satisfied with (Wittmann-Price, 2004:437) regarding unplanned pregnancy prevention.

Critical elements of the Wittmann-Price Theory which form the basis for emancipation in decision making are: **personal knowledge, empowerment, awareness of social norms, flexible environment and reflection** (Wittmann-Price, 2004, 2006; Wittmann-Price & Bhattacharya, 2008). These concepts informed the framing of the interview questions and formed the framework for the programme for the prevention of unplanned pregnancies in adolescent girls through **emancipated decision making**.

These key concepts of the Wittmann-Price Theory are operationally defined below with other key concepts used throughout the study.

1.8.3 Operational definitions

- **Personal knowledge**

Personal knowledge has been defined as the ability to understand one’s self and to make a person aware of how knowledge affects situations and influences everything one does. Personal knowledge has further been defined as a combination of tacit knowledge and explicit knowledge (Reinders, 2010:28; Siefring, 2012:4; Wittmann-Price, 2004:441). For the purpose of this study, personal knowledge implies personal knowledge of adolescent girls about making emancipated decisions in the prevention of unplanned pregnancies.

- **Empowerment**

Empowerment is an interactive process that provides the tools, resources, and environment to develop and build, and increases the ability and effectiveness of others to set and reach goals for individual and social ends (Commission on Women and Development, 2007:9; Wittmann-Price, 2004:442). Empowerment in this study involves
the empowerment of adolescent girls for making emancipated decisions in the prevention of unplanned pregnancies.

- **Awareness of social norms**

  Awareness of social norms implies conscious, dynamic knowledge and reflection about the past, present, future, and potential features of social norms as standards by which behaviour of members of society may be judged as correct or incorrect (Detel, 2008:470; Rettie, 2003:2). Awareness of social norms indicates an awareness that social norms are inevitable and allows the person to appraise those norms appropriately in relation to personal knowledge through reflection within a flexible environment (Wittmann-Price, 2004:442). Awareness of social norms in this study illustrates awareness by adolescent girls that social norms set standards against which behaviour of members of society is judged when making emancipated decisions in the prevention of unplanned pregnancies.

- **Flexible environment**

  A flexible environment has been described as a non-judgemental, integrative and evolving physical, social and psychological environment with a resilient response to change (August-Brady, 2000:7). According to Wittmann-Price (2004:441), flexible environments result in greater diversity of choice, effectiveness and efficiency, empowerment, reflection, personal knowledge and emancipation. In this study, a flexible environment refers to an environment that allows adolescent girls to make emancipated decisions regarding the prevention of unplanned pregnancies.

- **Reflection**

  Reflection is regarded by Wittmann-Price (2004:441) as a consciousness or a learned method of perceiving society and its oppressive influence, a form of critical thinking or cognitive awareness, developing a perception of questioning practices that are based solely on tradition or authority. MOSEP (2009:1) describes reflection with reference to reflection on action (at a distance from the actual event that requires reflection) and reflection in action (tied to the context in which an event occurs). Reflection in this study
entails reflection by adolescent girls when making emancipated decisions in preventing unplanned pregnancies.

- **Emancipated decision making**

  Emancipated decision making is described by Wittmann-Price (2006:378) as a theoretical concept indicating the process of reaching a more positive state of being, a state of freedom in choice, by first acknowledging the effective experience of oppression. Wittmann-Price and Bhattacharya (2008:225) proposes that the five sub-concepts of the theory, namely, **personal knowledge, empowerment, awareness of social norms, flexible environment and reflection**, need to be present in order for women to reach a state of **emancipated decision making**. In this study, emancipated decision making denotes the ability of adolescent girls to make emancipated decisions in the prevention of unplanned pregnancies.

- **Construction of a programme**

  A programme has been defined as a set of related, flexible and coordinated activities in order to deliver the stated outcomes and benefits (Department for Business, Innovation & Skills, 2010:2). Walker and Avant (2011:23) define construction as a building process, using concepts, statements and theories as elements for construction. In this study, construction of a programme indicates a series of phases which were followed in constructing a programme using concepts, theories and models as the elements of programme construction for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.

- **Prevention**

  Edelman and Mandle (2009:14) define prevention as averting the development of a disease in the future, which consists of all measures, including definite therapy, to limit disease progression. Prevention is further defined according to the three levels of prevention, namely, primary prevention, secondary prevention and tertiary prevention (Edelman & Mandle, 2009:14). Prevention in this study refers to the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.
• **Adolescence**

Swartz, De la Rey, Duncan and Townsend (2008:86) define adolescence as a distinctive stage in the lifespan, marked by a clear biological change. It is a period that begins with the onset of puberty and ends with graduation from high school (roughly age 18). The later stage starts at eighteen years and continues for another three to four years. It is viewed as that stage of human development that follows middle childhood, and serves as the transition from childhood to adulthood. Guest (2007:229) concurs by stating that developing adolescents cope with physical changes that combine a mature body and an immature mind. Because adolescence is associated with increasing independence and responsibility, adolescents seem both powerful and vulnerable; thus, society is compelled to give adolescents care (Guest, 2007:229).

Because there is no cut-off age for adolescence, adolescent girls in this study are girls from ages 12 to 21 years, as these are the ages where most adolescents have been identified in the clinical settings reporting with unplanned pregnancies.

• **Unplanned pregnancies**

Unplanned pregnancies are those pregnancies that occur when a couple has not made a decision to conceive; pregnancy leads to life-altering consequences (Rosenthal, Rowe, Hardiman & Kirkman, 2009:11). In this study, unplanned pregnancy means pregnancy in adolescent girls reporting at the hospital reproductive health services, stating that they had not made a decision to conceive and seeking professional health advice about their pregnancies.

1.9 **RESEARCH DESIGN AND METHOD**

The programme construction followed a qualitative, explorative, descriptive and contextual research design, which focuses on exploring and describing phenomena in real life situations to gain more information on the particular field of study (Burns, Grove & Gray, 2013:44; Denzin & Lincoln, 2011:129).

The research design and methods are described in greater detail in Chapter 2.
1.9.1 Research method

Construction of a programme involves taking decisions about what to offer, how to offer it and how to evaluate the programme. Programme construction for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making was conducted in the following four phases:

Phase one: Situational analysis
Phase two: Concept analysis and the conceptual framework
Phase three: Description of the programme and development of implementation guidelines
Phase four: Programme evaluation

Table 1.1: The process of programme construction and objectives of the study

<table>
<thead>
<tr>
<th>PHASE</th>
<th>DATA COLLECTION</th>
<th>DATA ANALYSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHASE ONE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situational analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Explore and describe the factors contributing to the occurrence of unplanned pregnancies in adolescent girls.</td>
<td>One-to-one interviews</td>
<td>Analysis</td>
</tr>
<tr>
<td>2. Explore and describe the existing sources of information about the prevention of pregnancy in adolescent girls.</td>
<td>Observation</td>
<td>Coding</td>
</tr>
<tr>
<td>3. Describe applicable models and theories used in decision making for the prevention of unplanned pregnancies.</td>
<td>Field notes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Audio recording</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Literature control</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Literature review on models and theories</td>
<td></td>
</tr>
</tbody>
</table>
# Chapter 1

**Overview of the research**

<table>
<thead>
<tr>
<th>PHASE</th>
<th>DATA COLLECTION</th>
<th>DATA ANALYSIS</th>
</tr>
</thead>
</table>
| PHASE 2 | Concept analysis from the Wittmann-Price theoretical framework  
Conceptual framework deduced from the findings and literature control, applicable models and theories in phase one | Deduction  
Coding |

**PHASE 3**

**Description of the programme activities and implementation guidelines**

4. Describe the programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.

5. Describe the guidelines for implementation of the programme.

|   | Reflecting on data collected and analysed  
Reflecting on literature reviewed  
Reflecting on concept analysis and the conceptual framework  
Consensus discussions with supervisors  
Self-evaluation |   |
|---|---|

- Deduction
- Synthesis
1.9.1.1 Phase one

In phase one, a situational analysis was done as follows:

The study was undertaken at the referral hospital’s reproductive health clinic which is a catchment area for ten clinics in Hammanskraal for referral of patients with reproductive health needs. Data was collected using one-to-one interviews using semi-structured questions (Burns et al., 2013:271; Gerrish & Lacey, 2010:346). The factors contributing to the occurrence of unplanned pregnancies in adolescent girls and the existing sources of information about pregnancy prevention were explored and described. Audio-recording, field notes and reflective notes (Polit & Beck, 2012:548) were used during data collection.
Verbatim transcribed interviews and field notes were analysed following the thematic method of qualitative data analysis according to Polit and Beck (2012:562). The findings (Burns et al., 2013:46; Polit & Beck, 2012:564) were used to decide on what should or should not go into the programme for the prevention of unplanned adolescent pregnancies through emancipated decision making. Data analysis requires creativity, conceptual sensitivity and is a foundation on which to build the instruction (Polit & Beck, 2012:564). It is therefore a mandatory part of programme construction. A literature control was conducted to verify and contextualise the findings. Literature of the models and theories applicable in decision making in the prevention of unplanned adolescent pregnancies was also reviewed. Reasoning strategies, namely, inductive, deductive, analysis and synthesis, were used during data collection, data analysis and throughout the study (Chinn & Kramer, 2011:214; Corbin & Strauss, 2008:135; Gravetter & Forzano, 2009:17; Polit & Beck, 2012:1).

1.9.1.2 Phase two

The second phase focused on concept analysis (Walker and Avant, 2011:157). Key concepts of the Wittmann-Price Theory (Wittmann-Price, 2004, 2006; Wittmann-Price & Bhattacharya, 2008) which were used in this study to frame the inquiry were analysed for their attributes and characteristics to give their finer descriptive meanings. These concepts of the Wittmann-Price Theory are: personal knowledge, empowerment, awareness of social norms, flexible environment and reflection (Wittmann-Price, 2004, 2006; Wittmann-Price & Bhattacharya, 2008).

Based on the concept analysis, the conceptual framework for the programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making was described. The conceptual framework that underpins the programme in this study made use of the logic model (Lewin Group, 2007:9; McCawley, 2013:4). The logic model describes the logical linkages among the programme resources, context, activities and outcomes related to a specific problem (in this study, emancipated decision making in pregnancy prevention) (Lewin Group, 2007:9; McCawley, 2013:4). The logic model was therefore used to indicate the relationship among the Wittmann-
Price theoretical concepts (Wittmann-Price, 2004, 2006; Wittmann-Price & Bhattacharya, 2008) identified in this study and to guide programme construction.

### 1.9.1.3 Phase three

The outcomes of the concept analysis and the conceptual framework led to phase three, the description of the programme activities. During this phase, the researcher reflected on the concept analysis, conceptual framework, data collected and analysed, and literature reviewed. The programme activities were described in this phase. Guidelines for implementation of the programme were also described in this phase.

### 1.9.1.4 Phase four

In this phase, evaluation of the programme was done using a critical reference group which consisted of experts from the clinical setting, colleagues, experts in programme development and qualitative research, adolescent girls and discussion with supervisors. The researcher used the evaluation criteria of Chinn and Kramer (2011:197), namely, clarity, simplicity, generality, accessibility and importance. Based on the feedback of all the stakeholders and reflection on the feedback by the researcher, changes were made to the programme as advised by recommendations.

Detailed discussion of the study design and method follow in Chapter 2.

### 1.9.2 Trustworthiness

The measures to ensure trustworthiness were based on Lincoln and Guba’s (1985:296-327) framework, also described in Burns and Grove (2009:545-547), Creswell (2009:190-193) and Polit and Beck (2012:584). The specific criteria in assessing and ensuring trustworthiness are credibility, transferability, dependability, confirmability and authenticity. The strategies are described in Chapter 2.

### 1.9.3 Ethical considerations

This study included a vulnerable population as they were minors who were pregnant and were accessing health services at the time. Their vulnerability is confirmed by the following characteristics: limited economic development, limited treatment and health
care options, being pregnant women and being children (Van den Berg, Timmermans, Ten Kate, Van Vugt & Van der Wal, 2005:115).

Due to their vulnerability, researchers are hesitant to include children and adolescents in research. The researcher’s decision to include adolescent girls stemmed from her paradigm of inclusion of the voice (Calvert & Emerson, 2008:1) of those who have often been marginalised by designing a study that would allow them to participate. Also, the researcher believed that failing to include adolescents in this study would deny them of the knowledge and benefits of participating in a study (Iltis, 2013:336) that would inform a programme to prevent unplanned pregnancies for them. The researcher had to carefully manage the legal and ethical requirements that arose from a study with pregnant minors. The study was carefully designed and grounded in the ethical principles of the Belmont Report, namely, respect for persons, beneficence and justice (Burns et al., 2013:164; Polit & Beck, 2012:152) (refer Annexure C).

For a full description of the ethical considerations, refer to Chapter 2.

1.10 DIVISION OF CHAPTERS

Table 1.2: Division of the study

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>CHAPTER CONTENT</th>
<th>PHASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 1</td>
<td>Introduction and overview of the research</td>
<td></td>
</tr>
<tr>
<td>Chapter 2</td>
<td>Research design and method</td>
<td></td>
</tr>
<tr>
<td>Chapter 3</td>
<td>Discussion of findings and literature control</td>
<td>Phase one</td>
</tr>
<tr>
<td>Chapter 4</td>
<td>Theories and models used in adolescent decision making in the prevention of unplanned pregnancies</td>
<td>Phase one</td>
</tr>
<tr>
<td>Chapter 5</td>
<td>Concept analysis</td>
<td>Phase two</td>
</tr>
<tr>
<td>Chapter 6</td>
<td>The conceptual framework for the programme</td>
<td>Phase two</td>
</tr>
<tr>
<td>Chapter 7</td>
<td>Description of the programme activities and implementation guidelines</td>
<td>Phase three</td>
</tr>
<tr>
<td>Chapter 8</td>
<td>Evaluation of the programme, conclusions, limitations and recommendations of the study.</td>
<td>Phase four</td>
</tr>
</tbody>
</table>
1.11 CONCLUSION

In this chapter, an overview of the research was presented. The background of the study, problem statement, purpose of the study, objectives of the study, paradigmatic perspective, metatheoretical assumptions, theoretical assumptions, research design and methods, as well as the sequence of chapters were presented.

In the next chapter, the research design and methods, reasoning strategies, ethical considerations and trustworthiness of the study are discussed.
CHAPTER 2
RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

In Chapter 1, an overview of the research was given. In this chapter, the research design and method upon which this study is based are described. The purpose of the study was to construct a programme and implementation guidelines for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making. In order to achieve the overall purpose of the study, a qualitative, descriptive and contextual design was followed. Data were gathered by on-to-one interviews utilising an interview schedule. Data analysis and literature control formed the basis for programme construction.

2.2 THE PURPOSE OF THE STUDY

The purpose of the study was to construct a programme and implementation guidelines for the prevention of unplanned pregnancy in adolescent girls through emancipated decision making.

2.3 RESEARCH DESIGN

A research design is a blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings of the study. The design outlines the procedure and logic of the research and guides the researcher in planning and implementing the research to ultimately achieve the aim of the study (Burns et al., 2013:43). Creswell (2009:3) further describes research design as plans and procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis. Two major aspects have to be considered in a research design: it must be clear what is to be explored, and the most efficient way to conduct the exploration must be determined (Babbie & Mouton, 2001:71). A qualitative, descriptive, exploratory and contextual design was followed in programme construction in this study.
2.3.1 Qualitative

Qualitative research is a systematic, interactive, subjective approach used to describe life experiences, to promote understanding of human experiences and to give them meaning. It is an inquiry process based on exploring and understanding the meaning individuals or groups ascribe to social or human problems. Qualitative research is a holistic approach that allows participants in a research study to describe their life experiences (Burns et al., 2013:57; Creswell, 2009:3). A qualitative study allowed adolescent girls having unplanned pregnancies in this study to describe the factors contributing to unplanned pregnancies and the sources of information for pregnancy prevention within their social contexts.

Qualitative research stresses the socially constructed nature of reality, the relationship between the researcher and the phenomenon under investigation and the context that shapes the inquiry (Denzin & Lincoln, 2011:10). It accepts the complex and dynamic quality of the social world and allows for greater flexibility which may be valuable for operationalisation and contextualisation (Babbie & Mouton, 2001:270) in this study. The researcher in this qualitative study attempted to study adolescent girls' decision making (Babbie & Mouton, 2001:270) in the prevention of unplanned pregnancy as the basis for programme construction. Denzin and Lincoln (2008:3) describe qualitative inquiry as an interdisciplinary, transdisciplinary and sometimes counter-disciplinary field. This multiparadigmatic focus was suitable for the multiparadigmatic approach (Denzin & Lincoln, 2008:3) necessary for programme construction for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.

2.3.2 Exploratory

Exploratory research begins with the phenomenon of interest, investigates the full nature of the phenomenon, the manner in which it manifests and other factors to which it is related to gain new insights into the phenomenon (Polit & Beck, 2012:18). The researcher in this study explored, through full participation and experiences of adolescent girls, what the programme for enhancing emancipated decision making in the prevention of unplanned pregnancies should consist of. There is no programme for
the prevention of unplanned pregnancies through emancipated decision making in Hammanskraal for adolescent girls. Adolescent girls are regarded as a vulnerable group for falling pregnant without planning; therefore, a prevention programme through emancipated decision making was seen as a necessary tool to address the problem.

For exploratory studies to be successful, the researcher has to enter the participants’ ‘life world’ to be able to open up to new ideas and possibilities that may arise (De Vos, 2011:317). This was accomplished in this study by the process of bracketing, which implies identifying and holding in abeyance preconceived beliefs and opinions (Burns & Grove, 2009:545; Polit & Beck, 2012:488) about the factors that contribute to the occurrence of unplanned pregnancies in adolescent girls.

Although some researchers do not believe that bracketing is possible (Burns et al., 2013:60), the researcher in this study kept a reflective journal (Polit & Beck, 2012:495) throughout the data collection process. A reflective journal was used in an effort to bracket the researcher’s own opinions and beliefs about unplanned adolescent pregnancies as identified and put in writing at the beginning of the study. Beliefs, assumptions and preconceptions of the researcher about emancipated decision making in adolescent girls’ unplanned pregnancies prevention were reflected upon (Burns et al., 2013:60), and during data collection the researcher tried to take a deliberate stance of complete openness and receptivity to a deep knowledge about the occurrence of unplanned pregnancies. The researcher kept an open receptiveness to different meanings, interpretations and perceptions (Chinn & Kramer, 2011:139) of adolescent girls about the occurrence of unplanned pregnancies and sources of information about pregnancy prevention.

### 2.3.3 Descriptive

Descriptive studies are designed to gain more information about the characteristics of a particular field of study in order to provide a picture of the phenomenon as it naturally occurs. A descriptive study may be used to develop a theory, identify problems in the current situation or determine what others are doing in similar situations (Burns et al., 2013:49). Descriptive studies describe groups, activities, situations or events with a
focus on structure, attitude or behaviour. In descriptive studies, the researcher knows something about the topic under study before collecting data, so the intended outcome is a relatively accurate and precise picture of the situation (Adler & Clark, 2011:14). In this descriptive study, the researcher knew something about the topic of emancipated decision making in the prevention of unplanned pregnancy in adolescent girls in Hammanskraal; thus, the endeavour to construct a prevention programme and implementation guidelines was undertaken.

The researcher in this study described what participants identified as factors contributing to the occurrence of unplanned pregnancies and the existing sources of information about pregnancy prevention in adolescent girls. Literature was used to compare what others used as solutions to the problem of decision making in the prevention of unplanned pregnancies. Information from the data analysis was used as the basis for the construction of a programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.

### 2.3.4 Contextual

Contextual study involves situating the phenomenon under study within the immediate setting. It is regarded as the particular set of events or incidents pertaining to the particular set of conditions within which the action/interaction strategies are taken to manage, handle and respond to a particular phenomenon. The context also includes the environment in which the phenomenon emancipated decision making in unplanned pregnancy prevention is occurring, as experienced by pregnant adolescent girls and observed by the researcher (De Vos, 2011:316). The benefit of contextualising the study is to guard against inappropriate application (Huff, 2009:226). Adolescent girls' emancipated decision making in the prevention of unplanned pregnancies is a significant phenomenon, and efforts are made to address the problem in this study.

The research context in this study is therefore bound to the context of exploring and describing the factors that contribute to the occurrence of unplanned pregnancies in adolescent girls in Hammanskraal and the existing sources of information on pregnancy prevention in order to construct a prevention programme and implementation
guidelines. Adolescent girls were allowed to share their experiences in describing the factors that contributed to the occurrence of their unplanned pregnancies and the sources of information about pregnancy prevention.

2.4 RESEARCH METHOD

Construction of a programme involves taking decisions on what to offer, as well as how the programme will be offered and evaluated. The following four phases were followed in programme construction in this study:

Phase one: Situational analysis and literature control
Phase two: Concept analysis and conceptual framework for the programme
Phase three: Description of the programme activities and implementation guidelines
Phase four: Programme evaluation

Each phase of the programme construction, commencing with a situational analysis, is discussed below.

2.4.1 Phase one: Situational analysis

Phase one consisted of a situational analysis done in order to explore and describe what the programme for the prevention of unplanned pregnancies in adolescent girls in Hammanskraal should consist of. The situational analysis included the setting, population and sampling, data collection, data analysis and literature control. Literature was also reviewed of the models and theories applicable to decision making in the prevention of unplanned adolescent pregnancies (refer Chapter 4). The factors contributing to the occurrence of unplanned pregnancies in adolescent girls and the existing sources of information for decision making about pregnancy prevention in adolescent girls were explored and described using one-to-one interviews with adolescent girls. An audiotape was used during data gathering to ensure that no data detail was lost. The researcher made field notes during the interviews to reflect on her thoughts, feelings, observations and experiences.

Below is a discussion of the situational analysis with reference to the setting, population and sampling, data collection, data analysis and the role of the researcher.
2.4.1.1 The setting

The setting for the study is described below with reference to geographical characteristics, socio-economic profile and health facilities.

2.4.1.1 (a) Geographical characteristics

The study was undertaken at the referral hospital reproductive health clinic and gynaecological ward in Hammanskraal. The reproductive health clinic is a referral centre for ten clinics in Hammanskraal. All women with unplanned pregnancies reporting at any of the ten clinics are referred to the reproductive health clinic in the hospital for counselling about their pregnancies.

Hammanskraal is a small town in the Northern Tshwane district, north of Gauteng Province. It is part of Region 2 of the City of Tshwane, which has 7 regions and is centred between the western and north east quadrants of the City of Tshwane (City of Tshwane, 2012:18). The City of Tshwane, found within the Gauteng Province, is bordered by Limpopo to the north, Mpumalanga to the east, the Ekurhuleni and City of Johannesburg Metropolitan Municipalities to the south, and North West Province to the west. Hammanskraal is situated between two major freeways: to the east is the national freeway (N1) and to the west is the Mabopane freeway (PVM9). Hammanskraal lies 38 km north of Pretoria and 70 km south of Bela-Bela. It was named after Hamman, a cattleman who set up a stockade in this area in order to protect his cattle (Hammanskraal, 2012). Hammanskraal serves a large rural community.

The socio-economic profile of Hammanskraal is described below.

2.4.1.1 (b) Socio-economic profile

- Population

The City of Tshwane has a population of approximately 2,1 million people, which translates to 911 536 households according to the 2011 census. This translates to 3,1% population growth per annum for the period between 2001 and 2011. The majority of the population of the city is made up of young people aged between 15 and 39 years and a working age group of 15 to 64 years (City of Tshwane, 2013:11).
According to the report of the situational analysis (2005) conducted by the City of Tshwane, Hammanskraal had a population of approximately 206 000 (2001 census). There was a total of 51 600 households (census 2001) living in the area. About 99.6% of the community was Black, 0.2% White and about 0.2% Coloured (City of Tshwane, 2005). The 2011 statistics on the Hammanskraal population could not be found.

- **Language**

  The dominant language in Hammanskraal is Setswana, followed by Sepedi (City of Tshwane, 2005), which is why the interview guide in this study was also translated into Setswana. Because Setswana and Sepedi are closely related languages and because the researcher can speak both languages, translation into Sepedi was not necessary in the study.

- **Gender and age distribution**

  The male to female ratio is 49:51, and 43.2% of the population fall within the age bracket of 26-64 years, yet 53.2% of the population is considered as young (≤24 years) (City of Tshwane, 2005) which constitutes the population under study. Although the female population outnumbers the males, Hammanskraal is still a patriarchal community with traditional male domination over decision making (Maja, 2007:11).

- **Education**

  The majority of the population of the city has some form of education, with only 4% of the population having no schooling. There was an increase in the people with matric and higher education in the city for the period 2001 to 2011. The higher level of education in the city is attributed to the nature of economy of the city which is founded in the government services and institutions of higher learning. The institutions of higher learning attract matriculants from other parts of the country (City of Tshwane, 2013:13).

  In Hammanskraal, it was estimated that 13% of the population older than 20 years had no formal schooling background and another 31.3% had only some primary school education. In 2005, a total of 52% of the total population had a qualification at primary
school level or lower and only 17.8% completed their school careers and had higher education training (City of Tshwane, 2005).

The right to education enshrined in the South African Constitution (1996) as amended is upheld by the City of Tshwane by implementing programmes such as out-of-school learning to support improved education outcomes (City of Tshwane, 2013:14). The level of education is important in decision making about preventing unplanned pregnancy in this study.

- **Mode of transport**

The 2008 Tshwane Household Survey showed that the predominant modes of transport were private motorcars, walking and making use of private minibuses (City of Tshwane, 2013:19). Hammanskraal is predominantly a pedestrian community with about 57% of the population travelling by foot and about 14.8% and 19% by taxi and bus respectively (City of Tshwane, 2005). The fact that most of the population travel by foot even to the clinic is one of the reasons cited by adolescents as a cause of unplanned pregnancies, as some clinics are far to access for family planning services.

- **Economy and employment**

The infrastructure landscape of Region 2 of the City of Tshwane varies, with the northern parts of the region, which include Hammanskraal, lacking infrastructure to support development. Although the provincial unemployment as well as youth unemployment levels had improved, the incomes received in the region was very low on average, falling beneath the average Tshwane household income of R15 566 per month (City of Tshwane, 2013:19; South African Cities Network, 2014:9). One of the main focus areas for the City of Tshwane which is in line with the local and national government manifesto is elimination of poverty and inequality. Access for people, which includes access to social services and the youth in particular and access to adequate education and training to enable them to participate productively in the economy and society, is seen as the mode of implementing the City’s manifesto (City of Tshwane, 2013:19).
• Housing

Meeting housing demands remain one of the City’s biggest challenges. The estimated number of households in informal settlements is around 104 000 and informal settlements are likely to continue to grow. The city has developed a programme that is not only aimed at ensuring access to basic services to households in informal settlements, but has also facilitated housing development (City of Tshwane, 2013:19).

• Access to basic services

Currently, 97 000 households are registered as indigent in the city’s database. The indigent households receive free basic services including water and electricity at a cost of almost half a billion rand. Furthermore, the city provides food parcels supplied by Food Bank and invests in food gardens to ensure food security for poor households, especially child-headed households. Other forms of support to poor households include up-skilling and job placement for poor households to ensure that they become self-sustaining (City of Tshwane, 2013:16). According to a 2004 Human Science Research Council (HSRC) study that constructed a developmental index for the city (Erasmus, 2004:19), the ten most vulnerable and under-serviced wards were located in the far northern areas of the city (City of Tshwane, 2013:16) where Hammanskraal is located. Inequity and poverty remains a critical focus of the City. The 2011 Quality of Life Survey conducted in Gauteng City regions indicated that poverty was located in the previously disadvantaged areas of the city (City of Tshwane, 2013:16), with Hammanskraal located in one of these previously disadvantaged areas.

2.4.1.1 (c) Health facilities

The Tshwane health district is one of three metropolitan areas within Gauteng and serves a total population of 2 708 702 (23% of the provincial population), of which 2 010 048 (74.2%) do not have health insurance. This means that the majority of the population is likely to depend on state-provided health care, which amplifies the need to provide an integrated and efficient public health system across the spheres of government (City of Tshwane, 2013:19).
In 2005, Hammanskraal had a spatial distribution of health facilities which included six clinics and one district hospital. According to WHO cited in City of Tshwane (2005:50), this indicated a backlog of 21 clinics. Currently, the Moretele district where Hammanskraal is located has 32 clinics, all of which utilise the district hospital as catchment facility for all the referral of patients who need secondary levels of care. Of these 32 clinics, 10 refer patients with reproductive health needs, including unplanned pregnancies, to the reproductive health clinic in the hospital.

- **The referral hospital**

The referral hospital is the only hospital serving the Hammanskraal community. It is a catchment area for all the clinics in Hammanskraal, including the ten clinics that refer patients to the reproductive health clinic. The hospital offers comprehensive health care to the population around Hammanskraal. Patients who need specialised care are referred to the nearby academic hospital.

The reproductive health care clinic is situated within the hospital. The clinic offers family planning, unplanned pregnancy counselling and support, as well as termination of pregnancy services. The clinic attends to about 100 women with unplanned pregnancies seeking counselling per month. Of the 100 women attended to, about 50% are adolescents. The researcher made an observation of the record of women reporting at the hospital reproductive health clinic with unplanned pregnancies from January to December 2011 and January to June 2012. Table 2.2 illustrates the number of women having unplanned pregnancies who reported at the referral hospital reproductive health clinic from January 2011 to June 2012.

**Table 2.1: Record of the referral hospital reproductive health clinic’s number of unplanned pregnancies**

<table>
<thead>
<tr>
<th>MONTH</th>
<th>TOTAL NUMBER OF WOMEN SEEN</th>
<th>TOTAL NUMBER OF ADOLESCENTS SEEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2011</td>
<td>90</td>
<td>39</td>
</tr>
<tr>
<td>February 2011</td>
<td>87</td>
<td>32</td>
</tr>
<tr>
<td>March 2011</td>
<td>99</td>
<td>49</td>
</tr>
</tbody>
</table>
The referral hospital reproductive health clinic was chosen for the following reasons:

- The hospital is used by the researcher for clinical accompaniment of nursing students and an observation has been made of the high rate of unplanned pregnancies in the Hammanskraal area among adolescent girls.
- The hospital is a Women and Child Health project area and the researcher is a participant in the project.
- The referral hospital reproductive health clinic is a referral centre for ten clinics in the Hammanskraal area for patients who need counselling and further management and care of unplanned pregnancies and other reproductive health needs.

### 2.4.1.2 The study population and sample

Population is defined by Polit and Beck (2012:273) as the entire set of individuals with similar characteristics in which the researcher is interested. Burns et al. (2013:44) describe the study population as all the elements (individuals, objects, substances) that
meet certain criteria for inclusion in a given universe. Therefore, in this study, all adolescent girls who met the sampling criteria for inclusion in the study, that is, having unplanned pregnancies and visiting the district hospital reproductive health clinic from any of the ten clinics in Hammanskraal during the data collection period, were included. The population for the study was regarded as vulnerable because:

- Their stage of development is characterised by risky experimentation of sexual behaviour which places them at risk in decision making about preventing unplanned pregnancies.
- They had unplanned pregnancies.
- There are oppressive social norms (Wittmann-Price, 2004:442) on women as confirmed by women in Hammanskraal visiting the reproductive health clinic. The participants were treated as vulnerable subjects (Refer Ethical consideration).

Sampling is described by Burns et al. (2013:44) as the selection of people, events, behaviour or elements with which to conduct the study. Sampling is regarded by Polit and Beck (2012:275) as the process of selecting cases to represent an entire population so that inferences can be made about the population. It is the actual process of selecting a portion of the population of interest to the researcher which conforms to a designated set of specifications (De Vos, 2011:223).

Purposive sampling (De Vos, 2011:232) was used in order to ensure that specific elements were included in the sample. Purposive sampling employs a high degree of selectivity where the researcher selects a sample composed of attributes of the population that serves the purpose of the study. Purposive sampling or judgemental sampling (Polit & Beck, 2012:279) uses the researcher's knowledge about the population to select the sample members. The researcher decided to select people who were judged to be typical of the population and who were particularly knowledgeable about the phenomenon under study (Polit & Beck, 2012:279), which is decision making in the prevention of unplanned pregnancies. The predicament was brought about by their inability to be assertive and make sensible decisions about the phenomenon under investigation. Pregnant adolescents were selected because their experiences of having
unplanned pregnancies would assist in determining the factors which contributed to the occurrence of their unplanned pregnancies and the sources of information for pregnancy prevention, which were the requirements for programme construction in this study.

Adolescent girls between the ages of 12 and 21 of age with unplanned pregnancies formed the sample for the study. The adolescent girls were purposively selected because they had information about the factors contributing to the occurrence of unplanned pregnancies, which include the barriers to the effective use of contraceptive methods, and they could share their experiences of having unplanned pregnancies. Sinclair (1995) defines experience as the accumulation of knowledge or skills that results from direct participation in events or activities. Pregnant adolescents shared their experiences about the factors contributing to unplanned pregnancy. Information gathered was used to give direction as to what to include in the programme for the prevention of unplanned pregnancies through emancipated decision making.

Pregnant adolescents were the target for emancipated decision making in the construction of the programme to prevent unplanned pregnancies therefore, they were purposively selected to participate in this study.

- **Sampling procedure**

Sampling procedure indicates the process followed by the researcher to get sample participants who meet the criteria for participation in in the study (De Vos, 2011:224; Polit & Beck, 2012:273). The following process of purposively selecting the sample was followed in this study (Burns et al., 2013:374; De Vos, 2011:226):

With the assistance of the professional nurse working at the reproductive health clinic, adolescent girls who visited the reproductive health clinic during the data gathering period having unplanned pregnancies and requiring counselling about their pregnancies were approached and recruited. Recruitment was done with a group of adolescent girls while they were in the waiting room, as advised by the professional nurse working in the clinic. This was done to ensure that the researcher did not waste adolescents’ time for
assessment and counselling by the professional nurse, the doctor and the lay counsellor.

The purpose, objectives and significance of the study were explained to them. Their role in participation was further explained and it was explained that participation was voluntary; hence, they could withdraw from participation any time during the interview if they so felt. Consent for participating in the study was then obtained (refer Annexure C).

Appointments for interviews were then made with individual adolescent girls. The interviews were scheduled with individual adolescent girls on the same day as the day given by the clinic for follow-up. A list of sampled participants who volunteered to participate in the study was drawn by the researcher in line with the clinic record with the dates and times when they were to be interviewed.

A list of adolescent girls who met the sampling criteria who were admitted in the gynaecological ward having had failed abortions from ‘back street’ abortionists during data collection was made available to the researcher. The researcher visited the adolescent girls in the ward and recruited them individually to participate in the study. These adolescent girls were both interviewed from the ward in their single rooms away from other patients for privacy after informed consent was obtained.

- **Sample size**

According to Polit and Beck (2012:521), there are no fixed rules for the sample size in qualitative studies, but sample size should be based on information needs with the guiding principle on sample size being data saturation. Fouché and Schurink (in De Vos, 2011:350) argue that the number of participants to be interviewed should not be established ahead of time; therefore, in this study, sufficient numbers of participants and sites where participants came from in Hammanskraal were selected. Interviews continued until data saturation was reached (De Vos, 2011:350).

The interviews commenced with an initial number of ten adolescents and, based on the semi-structured interview schedule, one-to-one interviews were conducted with them to elicit what they considered to be the factors contributing to the occurrence of unplanned
pregnancies and the sources of information about pregnancy prevention. The interviews continued until data was saturated evidenced by repeating themes (Creswell, 2009:190). The sample size was thus determined by the researcher based on the number of participants interviewed at the time of saturation and confirmed by the supervisors and the independent coder. The sample size for this study was thus sixteen adolescent girls, at which stage saturation was reached as confirmed by the independent coder.

- **Sampling criteria**

According to Burns et al. (2013:374), sampling criteria list the characteristics essential for membership in the target population. Sampling criteria determine the target population and further indicate that the sample is selected from the accessible population (Burns et al., 2013:374).

Participants included in this study had to comply with the following **sampling inclusion criteria:**

- They had to have an unplanned pregnancy or have had an unplanned pregnancy.
- They had to be between the ages of 12 and 21.
- They had to use the hospital referral reproductive health clinic in Hammanskraal for unplanned pregnancy health needs.
- They had to be willing to voluntarily participate in the study.
- They could belong to any racial or ethnic group.

All other women not included in the above criteria were **excluded** from participation in the study.

Data collection is described below.

**2.4.1.3 Data collection**

Data collection is described as the gathering of information that is relevant to address a research question or hypothesis (Polit & Beck, 2012:534; Stommel & Wills, 2004:362).
Burns et al. (2013:271) reiterate by describing data collection as the process of selecting subjects and gathering data with specific steps according to the study and the research design. In this qualitative, explorative, descriptive and contextual design, where the experiences of adolescent girls about the factors that contribute to the occurrence of unplanned pregnancy and the existing sources of information about pregnancy prevention were gathered, data collection is discussed with reference to one-to-one interviews, establishing rapport, the role of the researcher, communication techniques and field notes.

2.4.1.3 (a) One-to-one interviews

Interviews involve verbal communication between the researcher and the participants, during which information is provided to the researcher (Burns et al., 2013:271). Interviews are an intentional way of finding out how people feel and what they think about their world as well as their experiences (Creswell, 2009:181). Depending on the phenomenon under study, the researcher can decide how structured the interview should be (Stommel & Wills, 2004:244). Qualitative interviewing is defined by Sewell (in De Vos, 2011:342) as an attempt to understand the world from the participants’ point of view, to unfold the meaning of people’s experiences and to uncover their lived world prior to scientific explanations.

One-to-one interviews (Creswell, 2009:179) were conducted with adolescent girls using semi-structured interview questions to gather information about factors contributing to the occurrence of unplanned pregnancies and the existing sources of information about pregnancy prevention. Socio-demographic data of adolescent girls were also gathered about clinics where data were collected, participants, participants’ partners and living arrangements to further get a complete picture of participants.

One-to-one interviews produce qualitative data that provide insight about the participants’ experiences, attitudes and perceptions, and allow the researcher control over the line of questioning (Burns et al., 2013:57; Creswell, 2009:179). Interviews were regarded as appropriate as they elicit individual experiences, opinions and feelings in
addressing the sensitive topic of unplanned pregnancies in adolescent girls in programme construction in this study.

Semi-structured interviews were used to gain a detailed picture of participants’ beliefs and perceptions of the topic and this gave the researcher and participants more flexibility without imposing a set of rules (De Vos, 2011:351). Semi-structured interviews were well suited for exploring the phenomenon as they provide an opportunity to probe for more information as well as to clarify answers (Stommel & Wills, 2004:244). Semi-structured interviews also lend themselves to increasing response rates by applying both open-ended and closed-ended questions. The questions in this study were open-ended, thus allowing participants an opportunity to structure their responses in any of the several dimensions. Participants shared in the direction the interview took and even brought issues the researcher had not thought of. Adolescent girls were perceived as experts on the subject ‘decision making in unplanned pregnancy prevention’ and were thus given maximum opportunity to tell their stories (De Vos, 2011:352).

The interviews were conducted in English, but for those participants who could not speak English or preferred to express themselves in Setswana, which is the predominantly spoken language in Hammanskraal, the questions were asked in Setswana. The interview guide was translated in both English and Setswana. The researcher, whose vernacular is also Setswana, conducted the interviews with ease in both languages (refer Annexure E).

An interview guide with pre-determined questions was used to guide the researcher to engage adolescent girls. The presence of the interview guide helped the researcher to think explicitly about what had to be covered in the interview, the logical order to address the questions and the sensitive areas of the interview which were handled last in the interview (De Vos, 2011:352). The interview guide with semi-structured questions based on the Wittmann-Price theoretical framework (Wittmann-Price, 2004, 2006; Wittmann-Price & Bhattacharya, 2008) was used to gather information about emancipated decision making in adolescent girls’ prevention of unplanned pregnancies.
The questions were posed to participants during the interview without imposing a set of rules or leading participants (refer Annexure D).

A quiet room in the reproductive health clinic within the referral hospital, where no interruptions occurred, was chosen for conducting interviews with the assistance of the professional nurse working in the reproductive health clinic. The room where interviews were conducted ensured privacy and was not threatening to adolescent girls (De Vos, 2011:350). Distractions such as telephones were switched off. The time for the interviews was agreed upon with participants and the professional nurse working in the reproductive health clinic before the interview date (Greef in De Vos, 2011:350). The interviews continued until no more new information was elicited, that is, saturation was reached (Creswell, 2009:183).

Information gathered and analysed from the data formed the basis of the programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.

The researcher, who is a lecturer in the Nursing Science Department, collected data from adolescent girls with unplanned pregnancies to gather data about the factors that contribute to the occurrence of unplanned pregnancies and the sources of information about this phenomenon. The researcher has experience in conducting one-to-one interviews from a previous master’s study as well as independent research. She further attended a workshop on qualitative data collection held by the Department of Nursing Science in July 2010 for an update. The supervisor and co-supervisor, who are experts in qualitative research, verified the appropriateness of the interview questions and were available for assistance when needed.

2.4.1.3 (b) Establishing rapport

Establishing rapport in order to gain information from participants is one of the challenges that may be encountered by the researcher while conducting qualitative research interviews (De Vos, 2011:343). Establishing rapport and trust is essential for the researcher to get quality data. The following interviewing techniques and tips as
highlighted in De Vos (2011:343) were followed by the researcher to be able to get as much data as possible:

Participants were allowed to do most of the talking (90%) with the researcher listening most of the time. Minimal remarks were made by the researcher to allow participants to tell their stories, which was the whole purpose of the interview.

Single, open-ended questions were asked one at a time. This order of asking questions and the use of open-ended questions ensured that participants were not confused, answers were not predetermined and participants were allowed to respond in their own way.

Questions were sequenced from general (biographical data) to specific. Although the phenomenon under study, emancipated decision making in the prevention of unplanned pregnancies in adolescent girls, was sensitive, sensitive questions were avoided as much as possible except for those questions which were addressing the research purpose.

2.4.1.3 (c) The role of the researcher

The scientific approach is essentially the building of a knowledge base; therefore, the role of the researcher is to consume the research findings and to read with understanding in order to utilise the research findings (De Vos, 2011:12).

The researcher in qualitative research is the primary instrument of data collection (Hennink, Hutter & Bailey, 2011:9). In order to prepare themselves, researchers have to engage in thorough self-reflection as well as master interpersonal and communication techniques (De Vos, 2011:345). To this effect, the researcher used ‘personal knowing’ (Chinn & Kramer, 2011:115), described as interpersonal interactions, relationships and transactions, in data collection to be able to describe the factors that contribute to the occurrence of unplanned pregnancies in adolescent girls and the existing sources of information about pregnancy prevention in adolescent girls as follows:
**Bracketing:** The researcher identified and suspended personal preconceived beliefs and opinions (Burns et al., 2013:60; Polit & Beck, 2012:496) about unplanned pregnancies and collected data. During data collection, use was made of the audiotape and field notes, allowing participants to unfold their experiences about unplanned pregnancies. Participants gave consent to be audiotaped and allowed the researcher to take notes during the interview (refer Annexure C). The researcher also kept a reflective diary throughout the study in an effort to bracket.

**Intuition:** The researcher remained open to the meanings attributed (Chinn & Kramer, 2011:114) to decision making in unplanned pregnancies prevention in adolescent girls by allowing participants to share their experiences; thus, the researcher remained naive, used semi-structured questions in the interviews and avoided steering the interviews in a particular direction. This was followed by **analysis** where categorisation (Creswell, 2009:186) of the essential meaning of the occurrence of unplanned pregnancies in adolescent girls was formed to guide the researcher on the type of programme needed for the prevention of unplanned pregnancies through emancipated decision making. The programme and the implementation guidelines for the use of the programme were then described (Polit & Beck, 2012:496).

Use was made of communication techniques to clarify and get detail where necessary (Greef in De Vos, 2011: 343).

**2.4.1.3 (d) Communication techniques**

Active and effective interviewing is not confined to asking questions and recording answers (Greef in De Vos, 2011:345). As with other conversations, the effectiveness of interviews relies on attentiveness, monitoring and responsiveness. The following communication techniques described by Greef (in De Vos, 2011:345) were utilised in the interviews for construction of a programme in this study in order to elicit valid, reliable and useful data:
• **Minimal verbal responses**

Minimal verbal responses indicate that the researcher is listening to and following what is being said. This can be indicated by the researcher’s occasional nodding of the head: ‘*Mm-mm, yes, I see*’ (De Vos, 2011:345).

• **Paraphrasing**

This involves the verbal response in which the researcher enhances meaning by stating the participant’s words in another form with the same meaning (De Vos, 2011:345).

• **Probing**

Probing is an open-ended attempt to obtain more information from participants. The purpose of probing is to deepen the response to a question, to increase the richness of the data being obtained and to give cues to participants about the level of response required. It is a technique used to persuade participants to give more information. Probing was used in obtaining information from adolescent with unplanned pregnancy using the following methods of probing:

*Linking* of participants’ comments with information that the researcher wanted to know, giving compliments to encourage participants to carry on, and *acknowledgement* through repeating participants’ answers to show attention. Probing was done in a non-threatening, non-judgemental manner and statements such as ‘*tell me more*’ were used (De Vos, 2011:345; Polit & Beck, 2012:310).

• **Clarifying**

This embraces a technique used to get clarity on unclear statements. This technique was used and statements such as ‘*could you go over that again*’, were used to get more clarity of information (De Vos, 2011:345).

• **Reflection**

This focuses on the researcher reflecting back on something important the participant may have said or omitted, feelings, non-verbal behaviour, in order to get the participant
to expand on an idea. Statements such as ‘so you believe that unplanned pregnancies should not occur’ were used in the study (Chinn & Kramer, 2011:115).

- **Responsive listening**

Responsive listening refers to attending to verbal and nonverbal messages (for example, eye contact, body language, gestures and posture) and the apparent underlying thoughts and feelings of the interviewee. It implies genuine understanding (empathy), acceptance and concern, and is essential to establish rapport. The researcher should have superb listening skills to obtain useful data (De Vos, 2011:345). The researcher listened attentively to adolescent girls as they unfolded their stories on factors contributing to unplanned pregnancies and sources of information for decision making about pregnancy prevention with minimal verbal responses.

- **Summarising**

By summarising, the researcher synthesised what was communicated and highlighted major themes (cognitive and affective). In this manner, the researcher also was able to do member checking with adolescent girls to confirm that information gathered were the real statements by the participants (De Vos, 2011:345).

- **Silence**

Silence was used when applicable to give the participants time to express emotions, to reflect on an issue or to slow down the pace of the participants (De Vos, 2011:345).

During the interviews, the researcher also jotted down some field notes over and above the audio recording of the interviews.

**2.4.1.3 (e) Field notes**

Field notes are a written account of the things the researcher hears, sees, experiences and think about in the course of the interviewing. They represent the researcher’s efforts to record information, and synthesise and understand data. Field notes were written as soon as possible after interviews and observations. They were part of the investigative
process, and acted as a memory tool to help the researcher to remember and explore the process of the interviews (De Vos, 2011:372; Polit & Beck, 2012:548).

Field notes are the backbone of data collection and analysis. Description of events, activities, key phrases, quotes, easily forgotten details, ideas, impressions, personal feelings, emotional reactions, conclusions, reflections, analytical ideas and inferences which occurred during data collection were jotted down (De Vos, 2011:372; Stommel & Wills, 2004:286). Field notes are composed of several levels, noted as observation notes, theoretical notes, methodological notes and personal notes (Polit & Beck, 2012:548; Stommel & Wills, 2004:286). These notes were collected during data gathering by the researcher and used in the study to give meaning and detail to the investigation (refer Annexure E).

- **Observational notes**

Observational notes are attempts to describe people, events or interactions in neutral language and adhere to observable detail (Stommel & Wills, 2004:286). They contain the what, where and who of a situation, and contain as little interpretation as possible (De Vos, 2011:335). The researcher used all the senses to record physical surroundings as well as verbal and non-verbal responses. Responses such as the pitch of voice and emotional expressions were recorded (refer Annexure E).

- **Theoretical notes**

Theoretical notes represent the first deliberate attempts at conjecture about the larger meaning of particular events. They are purposeful attempts to derive meaning from observational notes. The researcher interpreted and inferred the meaning of observations of adolescent girls during the interview sessions based on cultural knowledge and clues from the context (Polit & Beck 2012:549; Stommel & Wills, 2004:286). An attempt was made by the researcher to identify patterns that were frequently found in the course of the study.
• Methodological notes

Stommel and Wills (2004:286) indicate that methodological notes are often written in the form of reminders to observed behaviour to follow up on an observed pattern. They may contain comments about successful and unsuccessful approaches to the fieldwork. Methodological notes are instructions to oneself, a critique of one’s tactics and a constant reminder about methodological approaches that might be fruitful (Polit & Beck, 2012:549).

• Personal notes

Polit and Beck (2012:549) describe personal notes as comments about the researcher’s own feelings while in the field. They are referred to as the qualitative researcher’s reflections and comments about personal and emotional reactions to the fieldwork and progress in the field. It is an opportunity for the researcher to record personal thoughts such as suppositions, feelings, problems, ideas, intuition, impressions and biases (Stommel & Wills, 2004:286). It provides the researcher with an opportunity for catharsis and maintaining contact with own internal environment. These notes were kept in the reflective diary away from the actual data to ensure the success of the study (Polit & Beck, 2012:549).

2.4.1.4 Data analysis

Data analysis is described by Polit and Beck (2012:556) as the systematic organisation and synthesis of research data in order to organise, provide structure to, and elicit meaning from data. Denzin and Lincoln (2008:215) concur by stating that the qualitative researcher uses inductive reasoning strategies in analysis of data which means that categories, themes and patterns come from the data.

Creswell (2009:183) describe data analysis as a process of making sense out of the text and image. It involves preparing data for analysis, conducting differential analysis, moving deeper and deeper into understanding data, representing data and making an interpretation of the larger meaning of data. The categories that emerged from field
notes, documents and interviews were therefore not imposed prior to data collection, nor were they the opinions of the researcher (Creswell, 2009:183) in this study.

Qualitative data analysis focuses on the understanding rather than the explanation of a phenomenon in a particular context or setting, analysing of significant statements, keeping up with the concepts the participants use to describe and understand phenomena, constructing accounts that retain internal meaning and coherence, conceptualising valid accounts of social life and phenomena, and developing themes, categories and subcategories (Creswell, 2009:184).

Recorded one-to-one interviews about the following were transcribed and analysed following the thematic method of qualitative data analysis according to Polit and Beck (2012:562):

- the biographical data of adolescent girls having unplanned pregnancies,
- the emancipated decision making (Wittmann-Price Theory) factors contributing to the occurrence of unplanned pregnancies in adolescent girls and
- the existing sources of information for decision making about pregnancy prevention

Thematic analysis (Polit & Beck, 2012:562) is an approach in qualitative data analysis which involves discovering commonalities as well as seeking natural variations. It is a rigorous, inductive approach involving a set of procedures designed to identify and examine themes from textual data in a way that is transparent and credible. Thematic content analysis is used by researchers using different theories such as grounded theory, ethnographic and phenomenology. This study, based on the Wittmann-Price Theory (Wittmann-Price, 2004, 2006; Wittmann-Price & Bhattacharya, 2008), also utilised thematic content data analysis. Polit and Beck (2012:562) further indicate that qualitative studies that focus on dynamic experiences such as decision making using thematic analysis develop flow charts indicating major decision points and factors affecting the decision. In this study whose purpose was to construct a programme for the prevention of unplanned pregnancies in adolescent girls through emancipated
decision making, the following seven steps of thematic content analysis were followed (Polit & Beck, 2012:563):

1. All the interview data were read for an overall understanding. Although the interview questions were based on the Wittmann-Price theoretical framework (Wittmann-Price, 2004, 2006; Wittmann-Price & Battacharya, 2008), an inductive approach to thematic analysis allowed themes to emerge from data rather than searching for pre-defined themes. The researcher maintained an open mind and did not force data to fit the themes but allowed data to dictate the themes. Notes were made of major issues as they came to mind in order to acquire a sense of the various topics embedded in data.

2. Interpretive summaries of each interview were written. Text was examined closely, line by line, to facilitate micro analysis of data. This promoted open coding which identified any new information by decontextualising bits of data embedded within the data.

3. The researcher found the most descriptive wording for the topics and turned them into categories. The researcher endeavoured to reduce the total list of categories by grouping together topics that related to each other. Lines were drawn between categories to show interrelationships. Common meanings were identified by comparing and contrasting the text. Similar topics were organised into categories.

4. Relationships among themes emerged. A provisional name and flexible definition was created for each emerging theme. Because the researcher maintained an open mind and did not force data to fit the theme but allowed data to dictate the themes, an additional theme, socio-economic factors contributing to the prevention of unplanned pregnancies, emerged.

5. A set of transcribed and translated data was provided to the independent coder, who has experience in qualitative data analysis, for inter-coder agreement. The researcher and the independent coder analysed the
transcribed interviews independently. The researcher and the independent coder completed independent analysis and then held a consensus meeting to clarify discrepancies and identify similarities.

6. A draft of the themes with examples from the text was presented at a consensus discussion meeting between the researcher and the independent coder.

7. Disagreements on interpretations were resolved by going back to the text. Responses and suggestions about the themes, categories and subcategories were incorporated into the final draft. Finally, the independent coder and the researcher agreed on the themes, categories and sub-categories used in this study.

A literature control on the findings was done as a benchmark to highlight similarities and differences from other similar researches. A literature review of applicable models and theories of decision making in the prevention of unplanned adolescent pregnancies was included (refer chapter 4).

2.4.2 Phase two: Concept analysis and conceptual framework for the programme

During this phase, concept analysis which entailed describing the attributes and characteristics of the concepts of the Wittmann-Price Theory (Wittmann-Price, 2004:440) was done. The Wittmann-Price theoretical concepts: personal knowledge, empowerment, flexible environment, reflection and awareness of social norms, as well as emancipated decision making on which the study is based, were described and analysed for their finer descriptive meanings.

A full analysis of these concepts follows in Chapter 5.

The conceptual framework for the programme was formed based on the findings of the concept analysis. The conceptual framework indicates the logical grouping of related concepts (Chinn & Kramer, 2011:246) – in this study, the Wittmann-Price theoretical concepts. The conceptual framework in this study was based on the logic model which
has its components reflected as the assumptions, inputs, context, activities, outputs and outcomes (Lewin Group, 2007:9; McCawley, 2013:4) to guide the process of programme construction.

A full description of the conceptual framework for the programme is outlined in Chapter 6.

2.4.3 Phase three: Description of the programme activities

Based on the concept analysis and the conceptual framework for the programme, the programme activities discussed as facilitation of the process of emancipatory education in the prevention of adolescent girls' unplanned pregnancies was discussed. Facilitation of the process of emancipatory education for adolescent girls in the prevention of unplanned pregnancies was discussed with reference to the facilitators of the programme and the adolescent girls. Facilitation of the process unfolded through the relationship phase, the work phase and the termination phase (Yalom & Leszcz, 2005:310).

Phase three, the programme activities, is discussed in detail in Chapter 7.

2.4.4 Phase four: Evaluation of the programme

The strategy used to evaluate the programme in this study was the use of a critical reference group consisting of supervisors, peers, experts in the clinical field and the adolescent girls. The evaluation criteria of Chinn and Kramer (2011:197), namely, clarity, simplicity, generality, accessibility and importance, were used for evaluation of the programme by critical reference group. The programme was further evaluated by adolescent girls using the evaluation criteria of feasibility, relevance, importance and acceptance (International Federation of Red Cross and Red Crescent Societies, 2011:17; Shapiro, 2013:14).

Evaluation of the programme is described in full in Chapter 8.

Reasoning strategies used during data collection, data analysis and throughout this study follows below.
2.5 REASONING STRATEGIES

Reasoning refers to the process of developing solutions for problems by thought processes; drawing conclusions from facts. It is a problem-solving method that combines experience, intellectual faculties and formal systems of thought (Polit & Beck, 2012:11). Reasoning strategies refer to a special kind of thinking as problems are solved and conclusions are drawn from premises (Chinn & Kramer, 2011:215). The data collection process generates large quantities of information; therefore, reasoning plays an important role both in qualitative and quantitative research in managing the information from research data and making it useful (Polit & Beck, 2012:11).

The reasoning strategies used during data collection, data analysis and throughout this qualitative research include: inductive reasoning, deductive reasoning, analysis and synthesis.

2.5.1 Inductive reasoning

Arguments and reasoning are traditionally and generally divided into two types, namely, inductive and deductive reasoning (Chinn & Kramer, 2011:214). The core difference between the two lies in the strength of the claim about the relationship between the premise of the argument and its conclusions. In inductive reasoning, conclusions are drawn from specific observations to more general rules (Polit & Beck, 2012:11). Particular instances are observed to be consistently part of the larger whole or a set of particular instances is merged with the larger whole. Inductive reasoning provides support for the conclusions; therefore, conclusions follow from the arguments (Chinn & Kramer, 2011:214). It involves using a relatively small set of specific observations as the basis for forming a general statement about the larger set of observations (Gravetter & Forzano, 2009:17). The concept inductive reasoning is often applied in qualitative research (Corbin & Strauss, 2008:135).

The researcher approached the study using the Wittmann-Price Theory (Wittmann-Price, 2004, 2006; Wittmann-Price & Bhattacharyya, 2008) and worked inductively by interviewing adolescent girls with unplanned pregnancies to get the factors contributing to the occurrence of unplanned pregnancies and the existing sources of information for
pregnancy prevention. Information gathered and analysed was used as the basis for programme construction. During data analysis, the researcher further worked inductively using the thematic method of qualitative data analysis to arrive at the themes, categories and sub-categories. The inductive reasoning approach increases the chances for problem-solving outcomes, creativity and innovation (Chinn & Kramer, 2011:214), and was essential to programme construction in this study.

2.5.2 Deductive reasoning

Polit and Beck (2012:11) describes deductive reasoning as the process of developing specific predictions from general principles. It is different from inductive reasoning in that conclusions are deduced from conclusive proof of arguments. Deductive reasoning begins with general (universal) statements and then makes specific deductions (Gravetter & Forzano, 2009:19). According to Hennink et al. (2011:42), we deduce what is going on based on data, our assumptions about life, colleagues consulted, literature reviewed and existing theories. In deduction, therefore, cognisance of the human element must be taken into consideration and the potential for distortion is acknowledged.

Deduction as a reasoning strategy (Gravetter & Forzano, 2009:19; Polit & Beck, 2012:11) was used by the researcher in the study in analysing and interpreting data collected, identifying themes, categories and sub-categories (Chinn & Kramer, 2008:184; Denzin & Lincoln, 2008:31) based on the Wittmann-Price theoretical framework of emancipated decision making (Wittmann-Price, 2004, 2006; Wittmann-Price & Bhattacharya, 2008). The researcher further used the conclusions to construct the programme and implementation guidelines for the programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.

2.5.3 Analysis

Corbin and Strauss (2008:45) define analysis as examination of a substance and its components in order to determine their properties and functions, then using the acquired knowledge to make inferences about the whole. It is the recognition and structuring of information by breaking it down into its constituent parts and specifying
the relationship between parts. In this study, it was important to break up the phenomenon under investigation into its different parts and analyse them independently. This assisted in a better understanding of the whole phenomenon (Bastable, 2008:395) of construction of a programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.

Data generated in this study were analysed in order to promote understanding and meaning and how each would fit in to the programme construction. Evaluation of the programme for the prevention of unplanned pregnancies in adolescent girls was done by expert colleagues and experts in the practice to further give an analysis of the appropriateness of the programme.

2.5.4 Synthesis

Synthesis is defined as the process of building up separate elements or ideas into a connected whole, to develop a theory or system (Reader’s Digest Association, 1996:1584). It implies the integration of two or more aspects or concepts which results in a new and higher-level creation. Through putting aspects together, a new higher level of reasoning, truth, answers about reality are created (Bastable, 2008:395). Through formation of themes, categories and sub-categories, combining these in the construction of a programme for the prevention of unplanned pregnancies through emancipated decision making, synthesis was reached in this study. This was the stage in the study where the purpose of the study was achieved.

Measures to ensure the trustworthiness of the study are discussed below.

2.6 MEASURES TO ENSURE TRUSTWORTHINESS

In qualitative research designs, validity, reliability and generalisation are described through strategies for trustworthiness (Lincoln & Guba, 1985). The measures to ensure trustworthiness were based on Lincoln and Guba’s (1985:296-327) framework, also described in Babbie and Mouton (2001:276), Burns and Grove (2009:545-547), Creswell (2009:190-193), and Polit and Beck (2012:584). The specific criteria in
assessing and ensuring trustworthiness are credibility, transferability, dependability, confirmability and authenticity.

The strategies are described with reference to each of the five above-mentioned categories as summarised in Table 2.2.

Table 2.2: Diagrammatic representation of criteria for trustworthiness

<table>
<thead>
<tr>
<th>STRATEGIES TO ESTABLISH TRUSTWORTHINESS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Credibility</strong></td>
</tr>
<tr>
<td>• Prolonged engagement and persistent observation</td>
</tr>
<tr>
<td>• Triangulation</td>
</tr>
<tr>
<td>• Reflexivity</td>
</tr>
<tr>
<td>• Peer debriefing</td>
</tr>
<tr>
<td>• Authority of the researcher</td>
</tr>
<tr>
<td>• Structural coherence</td>
</tr>
<tr>
<td>• Referential adequacy</td>
</tr>
<tr>
<td>• Member checking</td>
</tr>
<tr>
<td><strong>Transferability</strong></td>
</tr>
<tr>
<td>• Thick and rich description</td>
</tr>
<tr>
<td>• Purposive sampling</td>
</tr>
<tr>
<td><strong>Dependability</strong></td>
</tr>
<tr>
<td>• Dense description of the research methods</td>
</tr>
<tr>
<td>• Dependability trail</td>
</tr>
<tr>
<td>• One research team</td>
</tr>
<tr>
<td>• Independent coder</td>
</tr>
<tr>
<td>• Triangulation</td>
</tr>
<tr>
<td>• Peer examination</td>
</tr>
<tr>
<td><strong>Confirmability</strong></td>
</tr>
<tr>
<td>• Confirmability audit trail</td>
</tr>
<tr>
<td>• Triangulation</td>
</tr>
<tr>
<td>• Reflexivity</td>
</tr>
<tr>
<td>• Peer examination</td>
</tr>
<tr>
<td>• Bracketing</td>
</tr>
<tr>
<td><strong>Authenticity</strong></td>
</tr>
<tr>
<td>• Reflexivity</td>
</tr>
<tr>
<td>• Referential adequacy</td>
</tr>
<tr>
<td>• Bracketing</td>
</tr>
</tbody>
</table>

2.6.1 Credibility

Credibility is comparable to internal validity, the goal of which is to demonstrate that the inquiry is conducted in such a manner as to ensure that the subjects have been accurately identified (De Vos, 2011:419). It refers to the way in which the study has been done in order to increase the probability that the description of the findings is credible (Lincoln & Guba, 1985:296). In this study, the adolescent girls with unplanned pregnancies were accurately identified and described.

The following strategies were implemented to enhance credibility (Babbie & Mouton, 2001:277; De Vos, 2011:420; Lincoln & Guba, 1985:301):
2.6.1.1 Prolonged engagement and persistent observation

Prolonged engagement refers to spending sufficient time with each participant in order to promote trust (Lincoln & Guba, 1985:301), staying in the field until data saturation occurs (Babbie & Mouton, 2001:277) and obtaining an in-depth understanding of the phenomenon under study (Creswell, 2009:192). The purpose of persistent observation is to identify those characteristics during the interview that are most relevant and exploring them in detail (Lincoln & Guba, 1985:304).

Prolonged engagement and persistent observation was ensured by:

- Meeting with participants before data gathering commenced and during the selection of participants, as well as obtaining consent for participation.
- Spending ample time with each participant during the interview to ensure that a relationship of trust was promoted, that they fully comprehended each interview question and that they were free to respond fully without being coerced.
- Perusing verbatim-transcribed audio recordings after the sessions for increased understanding and writing of descriptive reflective field notes.

2.6.1.2 Triangulation

Triangulation is based on the principle of convergence of multiple perspectives for mutual confirmation of data. Various forms of triangulation exist, of which triangulation of data, sources, persons (investigators) and theories (Burns & Grove, 2009:231; Creswell, 2009:19; Polit & Beck, 2012:590) were used in this study.

In this study, triangulation of sources was ensured as follows:

- Through the use of theoretical, methodological, reflective, field notes and audio recordings (Polit & Beck, 2012:549).
- De Vos (2011:350) argues that the number of participants to be interviewed should not be established ahead of time; therefore, in this study, sufficient numbers of participants and sites where participants came from in
Hammanskraal were interviewed until saturation of information was reached (De Vos, 2011:350).

- Through the use of field notes compiled by the researcher during the interview sessions (Polit & Beck, 2012:549).
- Through the use of the record of unplanned pregnancy in the Jubilee hospital reproductive health service.

Data triangulation involves the collection of data from multiple sources to obtain diverse views of the phenomenon under study for validity (Babbie & Mouton, 2001:277; Burns & Grove, 2009:231). This was ensured in this study through:

- Interviewing sufficient numbers of participants from different clinics in Hammanskraal until saturation of information was reached, as it is argued that the number of participants to be interviewed should not be determined ahead of time (De Vos, 2011:350).

Investigator triangulation, which is regarded by Burns and Grove (2009:231) as the involvement of two or more investigators with diverse research training and backgrounds to examine the same phenomenon, was ensured through:

- Involving an independent coder during data analysis (Creswell, 2009:191).
- Consulting with supervisors for guidance throughout development of the study.
- Consulting with peers for review of perceptions, insights and analysis (Babbie & Mouton, 2001:277).

Burns and Grove (2009:231) describe theoretical triangulation as the use of theoretical interpretations as the framework for the study. This was ensured in this study by:

- Defining related concepts from dictionaries and subject-specific theories in order to determine the essential meaning, as well as to create contextual meaning of these concepts.
- Including literature control for cross-validation.
• Concept analysis of the Wittmann-Price Theory (Wittmann-Price, 2004:441), which forms the theoretical basis for this study.

2.6.1.3 Reflexivity

Reflexivity refers to introspection and critical thought processes by the researcher (Burns & Grove, 2009:545), as well as acknowledgement of the researchers’ personal biases, values, interest, feelings and experiences and how these shape the study, as the personal self cannot be separated from the researcher’s self (Creswell, 2009:177).

In this study, reflexivity was ensured through:

• Keeping a reflective diary and field notes, and keeping progress notes during the process of data generation (Polit & Beck, 2012:548).
• Bracketing during data generation of the researcher’s opinions and feelings about decision making about unplanned pregnancy prevention (Polit & Beck, 2012:496; Burns & Grove, 2009:545).
• Reflective peer discussions during the design of the study, generation of data analysis, description of the programme and guidelines and the evaluation of the programme (Babbie & Mouton, 2001:277; Burns & Grove, 2009:545).

2.6.1.4 Peer debriefing

Peer debriefing refers to the process whereby researchers expose themselves to objective peers who have no direct interest in the study (Creswell 2009:192). It is done with an expert colleague in the phenomenon under investigation who is outside the context of the study for review of perceptions, insights and analysis (Babbie & Mouton, 2001:277)

In this study, this was ensured through:

• Peer meetings during the process of the study development.
• Peer consultations during analysis and data coding.
• Peer evaluation of the programme.
• Literature control.
2.6.1.5 Establishing the authority of the researcher

The authority of the researchers should be established as the research team is viewed as a measurement tool. The researchers can strengthen the credibility of the study by supporting their authority relating to their investigative skills (Creswell, 2009:177).

Authority of the researcher has been ensured in this study in the following ways:

- The researcher is an experienced advanced community health nurse who has theoretical preparation in research methodology.
- Research supervision by the supervisor and co-supervisor who are experts in research methodology and qualitative research in particular.
- The utilisation of an independent coder.

2.6.1.6 Structural coherence

This provides credibility of the research arguments, ensuring that there is no unexplained inconsistency between data and their interpretation (Creswell, 2009:192).

In this study this was ensured by:

- Using the same interview guide with the same questions throughout the interviews to prevent inconsistency as well as explaining key concepts.
- Reflecting on the findings of the study within the current available literature as well as within the Wittmann-Price Theory (2004) in particular and other related theories.

2.6.1.7 Referential adequacy

Referential adequacy involves inclusion of sufficient evidence for what is explained in the findings of the study (Babbie & Mouton, 2001:277).

In this study, referential adequacy was ensured by:

- Using an audio recorder and documenting field notes.
- Including verbatim quotes in the description of the findings.
• Including a transcribed interview session as an annexure in the completed study.

2.6.1.8 Member checking

Member checking is a process whereby data, categories, interpretations and conclusions are tested with members from whom data were originally collected, to check the accuracy of qualitative data and determine the accuracy of findings (Creswell, 2009:192; Lincoln & Guba, 1985:301). In this study, due to the fact that participants may not have been available again for validation of data, the researcher verified the information for accuracy with each participant at the end of the interview sessions.

2.6.2 Transferability

Transferability, which is comparable to external validity, refers to the generalisability of the findings (De Vos, 2011:350). It refers to the provision of an adequate database in order to be able to make the findings transferable to other settings or other respondents (Babbie & Mouton, 2001:277).

Transferability was ensured by:

• Providing a thick description of the background of the adolescent girls participating in the study, the context, the research design, the method and the findings of the study.
• Using an independent coder and reaching inter-coder agreement on themes, categories and subcategories (Creswell, 2009:190).
• Triangulating data, sources, investigator and theories (Burns & Grove, 2009:231; Creswell, 2009:19; Polit & Beck, 2012:593).
• Purposive sampling by purposely selecting the context and participants to maximise the range of specific information which can only be obtained from adolescent girls in a particular context (Hammanskraal) (Babbie & Mouton, 2001:277).
2.6.3 Dependability

Dependability, which is comparable to reliability (Babbie & Mouton, 2001:278) relates to the consistency of the findings if the study were to be repeated with other adolescents with unplanned pregnancies in a similar context. According to Lincoln and Guba (in Babbie and Mouton, 2001:278), there can be no validity without reliability; thus, no credibility without dependability.

In this study, dependability was ensured through:

- Providing a rich, thick description of the research design and methods to enable an audit of the research process and findings at the end of the study (Creswell, 2009:190).
- Using an independent coder and reaching inter-coder agreement on themes, categories and subcategories (Creswell, 2009:190).
- Using a semi-structured interview schedule (De Vos, 2011:351).
- Peer examination.
- Maintaining a dependability audit trail, which is a documentation of the entire researcher’s continuous critical analysis of all decisions and actions taken during the entire research process (De Vos, 2011:422).

2.6.4 Confirmability

This refers to the objectivity or neutrality of data and the interpretation thereof, not the neutrality or the biases of the researcher (Babbie & Mouton, 2001:278).

In this study, confirmability was ensured through:

- Securing a confirmability audit trail (Burns & Grove, 2009:546) by the safekeeping of all appropriate documents as a trail of evidence. These documents include the research proposal, consent letters and raw data.
- Triangulation as described above.
• Peer examination (Creswell, 2009:190).
• Reflexivity, where the researcher stated her personal reflection in the field notes as well as observation notes (Polit & Beck, 2012:548).
• The researcher’s bracketing of her beliefs, assumptions and opinions about adolescent girls’ emancipated decision making about the prevention of unplanned pregnancies (Burns & Grove, 2009:545; Polit & Beck, 2012:496).

2.6.5 Authenticity

This refers to the extent to which the researcher fairly and faithfully shows a range of different realities (Polit & Beck, 2012:599). It indicates the realness with which the findings of the study reflect the phenomenon under study as opposed to the researcher’s opinion and reality. Through authenticity in this study, the researcher demonstrated the multiple realities (Polit & Beck, 2012:599), thus representing the voice of both the adolescent girls with unplanned pregnancies and the researcher.

In this study, authenticity was ensured through:

• The process of reflexivity.
• The researcher’s bracketing of her own beliefs, assumptions and pre-conceptions about emancipated decision making in unplanned pregnancy prevention.
• The inclusion of quotes and transcription of an interview as an annexure.

The above strategies as applied to establish trustworthiness are summarised in Table 2.3. The criteria for each strategy and their application to the study are listed.

Table 2.3: Application of strategies for establishing trustworthiness in the study

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>CRITERIA</th>
<th>APPLICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CREDIBILITY</td>
<td>Prolonged engagement</td>
<td>• Meeting with participants before commencement of data collection.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Spending ample time with participants to ensure that they fully comprehended the questions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Perusing transcribed verbatim audio recording after each session.</td>
</tr>
<tr>
<td>STRATEGY</td>
<td>CRITERIA</td>
<td>APPLICATION</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Triangulation</td>
<td></td>
<td>• Using personal, theoretical and observation notes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Using audio recording.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Involving the independent coder.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consulting with supervisors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Defining related concepts from dictionaries and subject-specific theories.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The inclusion of literature control.</td>
</tr>
<tr>
<td>Reflexivity</td>
<td></td>
<td>• Keeping theoretical, personal and observational field notes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bracketing of researcher’s opinions and feelings about the topic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reflective peer discussions.</td>
</tr>
<tr>
<td>Peer debriefing</td>
<td></td>
<td>• Consulting with the independent coder.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Research supervision and literature control.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Peer meetings during the process of the study development.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Presentation of the study at conferences.</td>
</tr>
<tr>
<td>Establishing the authority of</td>
<td></td>
<td>• The researcher is an experienced advanced community health nurse who has</td>
</tr>
<tr>
<td>the researcher</td>
<td></td>
<td>theoretical preparation in research methodology.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Research supervision and utilisation of an independent coder.</td>
</tr>
<tr>
<td>Structural coherence</td>
<td></td>
<td>• Use of the same interview guide with the same questions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Explanation of key concepts.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reflection of the findings of the study within the current available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>literature.</td>
</tr>
<tr>
<td>Referral adequacy</td>
<td></td>
<td>• Use of the audio recorder, documenting field notes and direct observation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inclusion of transcribed interview session as an annexure in the completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>study.</td>
</tr>
<tr>
<td>Member checking</td>
<td></td>
<td>• Verification of information for accuracy with each participant at the end</td>
</tr>
<tr>
<td></td>
<td></td>
<td>of the interview.</td>
</tr>
<tr>
<td>Rich and thick description of</td>
<td></td>
<td>• Description of the background, the context and the research design and</td>
</tr>
<tr>
<td>methodology</td>
<td></td>
<td>method of the study.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use of an independent coder and reaching inter-coder agreement on themes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Triangulation and peer examination.</td>
</tr>
<tr>
<td>Rich and thick description of</td>
<td></td>
<td>• Provision of a dense description of the research design, methods and</td>
</tr>
<tr>
<td>methodology</td>
<td></td>
<td>findings at the end of the study.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use of an independent coder and reaching inter-coder agreement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Triangulation and peer examination in the study.</td>
</tr>
</tbody>
</table>
2.7 ETHICAL PRINCIPLES

The study included a vulnerable population, namely, minors. They were furthermore pregnant and accessing health services. The researcher had carefully considered all aspects related to the legality and ethics of doing research with pregnant minors after consultation with her supervisors and a bioethicist. The ethical principles on which standards of ethical conduct in research with adolescents and children are based were adhered to in this research (Adler & Clark, 2011:42; Burns & Grove, 2009:352; Hennink et al., 2011:63; Polit & Beck, 2012:152). These principles, based on the ethical principles of the Belmont Report, namely, respect for persons, beneficence and justice (Burns et al., 2013:164; Polit & Beck, 2012:152), and their applications in this study are discussed below.

2.7.1 Respect for human dignity

This principle is based on the view that all persons are autonomous and have the right to self-determination and full disclosure. An autonomous person is one who is “capable of deliberation about personal goals and of acting under the direction of such deliberations” (Botma, Greeff, Mulaudzi & Wright, 2010:3). There has been much debate about minors’ ability to act under the direction of their deliberations, in other words, having the capacity to make decisions. The ethical considerations have revolved around who should make decisions about children and how these decisions should be made (Iltis, 2013:333). Parents have traditionally made decisions for their children, but a more recent trend has viewed minors as persons with rights; one of these being the right to be involved in decisions and having their perspectives considered (United Nations Convention on the Rights of the Child, 1989). There has also been a
perspective that mature or emancipated minors, such as those who are married, live alone or have their own children, are autonomous and should be granted greater decisional authority (Iltis, 2013:333; Kling, 2011:219). Whatever the case may be, no minor should be forced to participate in research (Human Science Research Council, 2012:3).

Conditions and actions taken to ensure respect for adolescent girls’ dignity were:

- **Informed consent**

  Valid informed consent implies that a participant received adequate information regarding the study, comprehended the important implications of the decision to participate in the research and voluntarily agreed to such participation (Hennink et al., 2011:63; Polit & Beck, 2012:154). Informed consent can only be given by a person capable in law of doing so, implying that they have reached the legal age threshold and have decisional capacity (Medical Protection Society, 2010:5).

  Various law reforms took place during the period of this study which was conceptualised in 2010, data collected in 2011 and completed in 2014. These are reflected on below.

  At the time of data collection, before 12 March 2012 when Section 71 of the National Health Act (2003) was enacted, the legal framework did not specifically address health-related research with adolescents. In that framework, adolescents were allowed to participate in and consent to research if it posed no more than minimal risk, the parents, legal guardians or community were unlikely to object to it, and adolescents’ inclusion and reason for consenting was justified (Zuch, Mason-Jones, Mathews & Henley, 2012:1). Based on this guideline, the researcher argued that there was no more than minimal risk for emotional discomfort, and that the information could not be obtained from adults but had to be obtained from the adolescents themselves, as their realities differed from those of persons in the adult phase of human development.

  The researcher further believed that, if she had required parental consent from all, she might have done harm as adolescents who did not want to disclose their pregnancy to their parents would not be able to participate, and the dynamics surrounding these
parent-child relationships were important for the study. The researcher also believed that obtaining parental consent would lead to low enrolment in the study (Knox & Burkhart, 2007:310). The researcher did, however, decide to include parental consent as far as possible if adolescents were accompanied by a parent at the time and agreed to such.

In March 2012, Section 71 of the National Health Act (2003), which requires that research with minors for therapeutic purposes must be done in the minor’s best interest with the consent of the parent of guardian and, if the minor is capable of understanding, with his/her consent too, came into effect. Research for non-therapeutic purposes should be done with the consent of the Minister, the parent or guardian of the minor and the minor, if he or she is able to understand the consent. This implies that all persons under the age of 18 who participate in research require parental/guardian consent and for that ministerial consent is required for non-therapeutic research. This led to considerable debate as it was in conflict with Section 134 of the Children’s Act (2005) (as amended by Act 41 of 2007), where minors 12 years and older could consent to medical services and contraceptives without parental consent. According to this Act, a minor is defined as a person under the age of 18 years. In addition, the Choice on Termination of Pregnancy Act (1996) makes provision that a woman of any age can consent to a termination of pregnancy and that only her consent is required. In October 2014, the Minister of Health Delegated the powers to consent for research or experimentation to be conducted with a minor for non-therapeutic purposes as prescribed by section 71(3)(A)(II) of the National Health Act (2003) to health research ethics committees registered with the national health research ethics council (Motsoaledi, 2014:1). Parental consent for minors is still required.

In this study, consent was obtained from the pregnant adolescent girls who were 18 years old and older after a full explanation of what the study entailed. The six participants aged 15 or 16 and the four aged 17 all had parents present and the researcher therefore obtained consent from them as well as from the adolescent girls.
To enable this form of self-determination through consent, adolescent girls had the right to full disclosure about the study, to decide voluntarily whether to participate, to ask questions, to refuse to give information or to withdraw from the study at any time without providing a reason. This refusal and withdrawal would not lead to any negative consequences for them and health services would be provided as before. Full disclosure in this study entailed that the researcher fully described the nature of the study, the adolescents’ right to refuse to participate and the researcher’s responsibilities (Polit & Beck, 2012:154). Information about the purpose of the study, the right to decline or terminate prematurely, the foreseeable discomfort, benefits and limits of anonymity when doing individual interviews were explained, as well as that the researcher was available for questions about the research. This information was given in English and, for those who did not understand English, the researcher could explain in Setswana as this is the predominantly spoken language in Hammanskraal. The researcher further informed all minors about her reporting obligation if she had knowledge of or concluded (depending on the Act) that abuse or neglect was present in accordance with section 110 of the Children’s Act (2005) as amended and the Sexual Offences Act (2007) as amended.

In the Sexual Offences Act (2007) as amended, it was an offence for children aged 12 to 15 to engage in consenting sexual acts ranging from kissing to penetration and required any person who had such knowledge to report such acts to the police (Jamieson & Lake, 2013:66). Ironically, the Children’s Act (2005) as amended allows children to consent to the use of contraceptive from the age of 12 and the Choice on Termination of Pregnancy Act (1996) has no age limit to consenting to the termination of pregnancy. This confronted the researcher with an ethical dilemma, as this would imply that the researcher had to report all participants younger than 16 to the police as they were pregnant and did therefore engage in sexual acts. In this study, there was only one participant who was younger than 16 years of age – she was 15 years old at the time of the interview. This participant was accompanied by her parent (who consented to the study) and on the researcher’s questioning of the age of her sexual partner, she stated that she was not certain but she thought that he was also 15 years of age as he was in her grade and class in school. This participant also confirmed that the sex was
consensual. The health care providers at the health service and the consenting parent were aware of her pregnancy and the consensual sex with this male partner. In her capacity, the researcher did not report this to the police, as she believed reporting this to the police had the potential to do more harm than good – leading to criminalisation of the participant, violating her dignity and potentially causing her not to access much-needed health services in the future. This participant’s contribution to the study was important and this could not be provided by an adult as the researcher needed to understand from this participant in this specific age group which factors contributed to the unplanned pregnancy. In support of the decision taken by the researcher, the Constitutional Court found in October 2013 that these sections of the Sexual Offences Act (2007) criminalising consensual sex between adolescents aged 12-15 were a “deep encroachment on the right to human dignity and privacy as well as the best interest principle” and that “this infringement on children’s rights to dignity and privacy could not be justified in the name of protecting adolescents from psychological harm, sexually transmitted diseases and pregnancy because less restrictive and more effective means to reduce the risk of adolescents engaging in unhealthy sexual activities” (Teddy Bear Clinic for abused children and RAPCAN Minister of Justice and Constitutional development and other CCT12/13 [2013]ZACC35 in Jamieson & Lake, 2013:68-69). The Constitutional Court ordered a “moratorium on all investigations into, arrests of, and criminal and ancillary proceeding against adolescents in relation to sections 15 and 16 of the Sexual Offences Act until parliament has amended this act”. The implication for health care professionals (and researchers) are that they are not obliged to report consensual sexual acts between adolescents 12-15 years of age but should still report any person 16 years and older who has sex with younger adolescents and any other form of sexual abuse (Jamieson & Lake, 2013:69).

Consent letters were available in both English and Setswana as Setswana is the predominantly spoken language in Hammanskraal (refer Annexure C).

- **Privacy, anonymity and confidentiality**

Privacy is the individual’s right to determine the time, extent and general circumstances under which personal information will be shared. It means that sensitive research
information is not linked to a specific person and that persons have the right to keep sensitive or other information from the researcher (Burns & Grove, 2009:194; Polit & Beck, 2012:156). In this study, privacy was maintained by accepting adolescent girls’ refusal to participate if they so wished. Furthermore, participants were allowed to withdraw at any point in the study process. The services of the counsellor who is available on daily basis in the reproductive health service were enlisted for those participants who became upset due to the circumstances of their unplanned pregnancies.

Anonymity means that no one, including the researcher, should be able to identify a given response with a given participant (Babbie & Mouton, 2001:523; De Vos, 2011:120). In this study, complete anonymity was not possible as the researcher knew who the participants were. However, in further reporting of this information, anonymity was ensured though measures to ensure confidentiality. Participants were informed of these limitations to anonymity.

Confidentiality implies the researcher’s management of sensitive, identifiable information collected for research purposes. Confidentiality further implies that research information will not be shared with others without the authorisation of participants (Burns & Grove, 2009:196; Hennink et al., 2011:63).

Confidentiality and anonymity were maintained by omitting names and identifying data from any documentation produced for public information. During interviews, use was made of alphabet letters to identify participants. Only the researcher and the supervisors of the study had access to the audio recorders and the transcripts, and these were kept in a safe, locked place.

2.7.2 Beneficence

The principle of beneficence is described as an obligation to secure the well-being of participants, which includes the conviction that research should be designed to maximise potential benefits and minimise potential risks. This principle covers
dimensions of right of freedom from harm and discomfort, and right to protection from exploitation (Hennink et al., 2011:63; Polit & Beck, 2012:152).

Beneficence was ensured in this study by designing the study in such a manner that potential benefits were maximised and risks minimised. The proposal was reviewed and approved by the relevant review boards of the University of Limpopo Medunsa Campus and ethical clearance was obtained (MREC/H/201/2010). In addition, permission to conduct the study was requested and obtained from the Northern Tshwane Ethics Committee where the research was conducted (Annexure B) and consent and assent were also obtained from the participants’ parents (as explained previously) (refer Annexure C).

The benefits would be the development of a programme informed by adolescent girls in this context. The risks were the potential for exploitation, emotional discomfort and having to report sexual acts that could lead to criminal investigations (as explained before). The researcher implemented measures to reduce potential risk through parental consent, full disclosure and ensuring that services were available for the adolescent girls if they did experience emotional distress.

In this study, risk was minimised and benefit maximised by protecting adolescent girls through adhering to confidentiality throughout the study. Data collection was done in a comfortable room, telephones were switched off, and a ‘do not disturb’ sign was put up to minimise distractions, make adolescent girls feel relaxed and at ease, enable them to concentrate and encourage free conversation (Burns & Grove, 2009:352). The researcher is a professional nurse with 38 years of experience. Before the interviews were conducted, the interview schedule was piloted to ensure that the researcher was able to competently conduct the interviews and to do so in a non-judgemental and accepting environment. The services of a counsellor were made available to those participants who may have become upset during the interviews. There was also a psychologist available in the hospital where the interviews were conducted. However, this was not necessary as participants did not experience such emotional distress that
they required referral and many in fact mentioned that they experienced relief from the discussion with the researcher.

If any participants would have disclosed having unplanned pregnancies from rape, they would have been referred to the crisis centre of the hospital where the victims of sexual violence are managed and the reporting obligations would have been adhered to (as explained earlier). The researcher had an ethical obligation to inform the participant and thus informed them prior to disclosure of such information that it would be reported to the South African Police for the adolescent girl to make an informed choice. In this study, no participants mentioned that they were raped.

2.7.3 Justice

Justice includes participants’ right to fair treatment and their right to privacy. Justice also imposes the duties to neither neglect nor discriminate against individuals and groups who may benefit from research, as it was indicated that women and minors were being unfairly excluded from many clinical studies in the United States (Polit & Beck, 2012:173). This confirms Calvert and Emerson’s (2008:1) assertion that children and young people’s voices should be heard in research, and that it is therefore unethical to exclude classes of people who are likely to benefit from research participation, or to whom the findings of a specific kind of research are likely to be applied. This supports the researcher’s decision to involve adolescent girls having unplanned pregnancies in the construction of a programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.

2.7.4 Ensure that public reports of this study are honest and accurate

Objectivity, integrity and professional competence in the research process and scientific accountability in this study were assured as principles to guide the researcher’s actions to report this study in an honest and accurate manner (Adler & Clark, 2011:42).

2.7.5 Objectivity, integrity and professional competence of research

Objectivity, integrity and professional competence in this study was implemented according to Adler and Clark (2011:42) by:
• Adhering to the highest possible technical standards of research in the study.
• Fully describing the research design, strategy and methods.
• Reporting the findings of the study fully, not the biases of the researcher.
• Indicating the limitations of the study’s methodology and findings in the conclusion of the study.
• Utilising the appropriate scientific, professional, technical and administrative resources available in the study to remain professionally competent.
• Consulting with supervisors, peer colleagues and other experts for guidance.

2.7.6 Social responsibility

The findings of the study were reported fully and openly to the scientific community (Adler & Clark, 2011:42) in the form of this thesis and articles which will emanate from this study will be published in accredited and peer reviewed journals. Papers from this study will be presented at conferences nationally and internationally. The study was conducted under expert supervision.

2.8 CONCLUSION

In this chapter, the research design and methods were discussed. A qualitative, explorative, descriptive and contextual study design was used to explore and describe the phenomenon emancipated decision making in the prevention of unplanned pregnancies in adolescent girls. Data gathering was done using one-to-one interviews with semi-structured interviews based on the Wittmann-Price theoretical framework. Measures to ensure trustworthiness and ethical considerations were addressed. In Chapter 3, the findings of the study are discussed and literature control is done as a measure for validation of the findings.
CHAPTER 3
DISCUSSION OF FINDINGS AND LITERATURE CONTROL

3.1 INTRODUCTION

This chapter, phase one of the process of the construction of a programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making is introduced. The chapter addresses objectives one and two, which are:

1. To explore and describe the factors contributing to the occurrence of unplanned pregnancies in adolescent girls.

2. To explore and describe the existing sources of information for decision making about pregnancy prevention in adolescent girls.

In this chapter, the findings of the individual interviews and biographical data are presented. The discussion of the findings is based on multiple sources of data, which are transcribed individual interviews conducted with adolescent girls, field notes and a description of the biographical profile of the participants. The total number of participants was 16 adolescent girls from different clinics in Hammanskraal. Data saturation was reached at participant interview number twelve according to the independent coder; four more interviews were conducted to confirm that no more new information emerged. Sixteen participants were thus interviewed and all data were used to ensure rich description of the findings.

Field notes, described by Holloway and Wheeler (2010:117) as detailed descriptions of the research setting and the behaviour of participants, were recorded. In field notes, observations are translated into written records which the researcher takes while observing or immediately afterwards (Holloway & Wheeler, 2010:117). The researcher’s own reflections on and feelings about the situation are also recorded in field notes. The researcher kept an account of all things heard, seen, experienced and thought of in the course of collecting and reflecting on data (De Vos, 2011:372). This was for the purpose of remembering, retrieving and analysing data.
Holloway and Wheeler (2010:117) suggest that recording events as they happen means that the memory of the researcher is fresh and details are not lost. Without field notes, data will be lost, and without data, analysis cannot occur. These notes were submitted to the independent coder and consensus was reached that they be included in the discussion of findings (refer Annexure F).

The findings of the study are thus from one-to-one interviews, where semi-structured interview questions based on the Wittmann-Price theoretical framework (Wittmann-Price, 2004:440) were used to be able to get information-rich data from the interviews. Biographical data and field notes formed part of data for analysis.

Themes, categories and sub-categories emerged from one-to-one interviews with participants using the thematic method of qualitative data analysis according to Polit and Beck (2012:562). Verbatim quotes from interviews (Holloway & Wheeler, 2010:325) were inserted as narratives at appropriate places to show some of the data from which the findings emerged. The quotes were used to:

- Illustrate the arguments of the researcher.
- Help the reader in judging how the findings were derived from the data to help establish credibility of the themes, categories and subcategories that emerged.
- Provide a means of auditing these themes, categories and subcategories (Creswell, 2009:193; Holloway & Wheeler, 2010:325).

Verbatim quotes have been indicated in *italics* in the study.

Figure 3.1 below illustrates the process of data analysis in this study.
Figure 3.1: Data analysis

Data Analysis

INTERVIEWS:
- One-to-one interviews
- 30-60 minutes
- Audio recorded
- 16 Adolescent girls
- Field notes

BIOGRAPHICAL DESCRIPTION OF SAMPLE:
- The clinics where data was collected
- Participants
- Participants' partners
- Living arrangements

FINDINGS:
- Biographical description of sample
- Themes, Categories, Sub-category
3.2 DESCRIPTION OF THE BIOGRAPHICAL DATA OF PARTICIPANTS

The analysis of the biographical data of research participants reflects important characteristics, and is described with reference to:

- Clinics where data were collected
- Participants
- Participants’ partners
- Living arrangements

The sample participants were selected from a target population of adolescent girls aged between 12 and 21 years having unplanned pregnancies, reporting at the referral hospital reproductive health clinic from the different clinics in Hammanskraal, Gauteng Province. Although the participants’ home languages were Setsonga, Sepedi and Setswana, Hammanskraal is a predominantly Setswana-speaking community; thus, all participants could speak Setswana. Interviews were therefore conducted in Setswana. Participants were all Black adolescent girls as Hammanskraal is a predominantly Black residential area.

Fourteen adolescent girls interviewed were from different clinics in Hammanskraal and two adolescent girls, who had had a failed abortion from ‘back street’ abortionists, and were admitted to hospital for treatment and care, were interviewed from a gynaecological ward in the referral hospital.

3.2.1 The clinics

Interviews were conducted in the reproductive health clinic as well as in the gynaecological ward from a purposively sampled group of adolescent girls with unplanned pregnancies.

There are ten clinics in Hammanskraal which refer women with reproductive health problems to the hospital reproductive health clinic. Fourteen adolescent participants from seven of these clinics who reported with unplanned pregnancies during the data
gathering period and who met the sampling criteria were interviewed. Two participants were interviewed from the hospital gynaecological ward.

Hammanskraal is a semi-rural community where traditional practices such as respect for elders and the church on issues of sexuality and sexual activities still govern patterns of behaviour among the youth, as stated by participants during interviews.

These were some of the quotes:

“Clinics are very far, footpaths are through bushes so we are afraid as some of these places are rural.” [Participant D]

“My mother is old fashioned has these cultural things that we should not know about prevention, she is never open with me about prevention and relationship and sex, she believes that I am still young.” [Participant P]

### 3.2.2 Participants

Participants’ biographical data are described with reference to their age, number of pregnancies number of sexual partners, marital status, level of education, employment status, religion and ethnic group.

Figure 3.2 below illustrates participants’ ages.
The ages of adolescent girls ranged between 15 and 21. Six of these girls were under the age of 18 and one was 15. These are young ages, where girls up to age 15 or the end of grade 9, whichever comes first, are supposed to still be at school according to the South African Schools Act of 1996 (Mahery & Proudlock, 2008:12). In support of the ages of adolescent participants, the study conducted by Adeyinka et al. (2010:785) in Nigeria indicates that adolescent pregnancies was considered to be a problem of non-white and lower income teenagers, yet globally 15 million girls aged between 15 and 19 have babies yearly; therefore, adolescents account for approximately 10% of all births worldwide. Jewkes and Christofides (2008:2) concur with the ages of participants, indicating that the incidence of teenage pregnancy in South Africa is much higher amongst the 18- and 19-year-olds than those in the earlier teenage years.

**Number of pregnancies**

The number of pregnancies of participants ranged between first and third pregnancies. Figure 3.3 below reflects the number of pregnancies participants had.
Figure 3.3: Number of pregnancies (n=16)

Twenty five percent (n=4) of participants were having their first pregnancy, 25% (n=4) were having the second pregnancy and 50% (n=8) of the sampled adolescent participants were having a third pregnancy. The number of pregnancies of participants indicates that these adolescent girls started to be sexually active at an early age despite the availability of pregnancy prevention methods. Sipsma et al. (2011:110) concur with the number of pregnancies of adolescents in this study by indicating that the national data of the US suggests increases in the annual rate of the number of births to adolescent mothers, with over 450 0000 babies born to young mothers between the ages of 15 and 19 years old in 2007 alone. In the Tshwane Metropolitan Council of South Africa, the study by Ehlers (2003a:13) in agreement with number of pregnancies indicates that adolescent mothers aged 19 and younger who gave birth to their babies failed to utilise contraceptives, emergency contraceptives or termination of pregnancy (TOP) services.

- **Number of sexual partners**

Figure 3.4 indicates the number of sexual partners the participants had had since starting fertility.
The data revealed risk-taking sexual behaviour of multiple sexual partners since starting fertility. Participants indicated changing sexual partners as shown by the 13% (n=2) participants who had had one partner, 18% (n=3) who had had two sexual partners, 18% (n=3) participants who had had three sexual partners, 13% (n=2) participants who had had four partners and 38% (n=6) who had had five or more sexual partners since starting fertility and even lost count of the number. A study by Esere (2008:120) on the effects of a sex education programme on risk-taking sexual behaviour of school-going adolescents in Nigeria found that adolescents who had intercourse before the age of 16 had more sexual partners during their lifetime and more partners per year, and started sexual activity earlier than those who became sexually active after the age of 16.

- **Marital status**

Of the 16 adolescent girl participants interviewed, 7% (n=1) was married and 93% (n=15) were single. Figure 3.5 below illustrates the marital status of adolescent girls who participated in the study.
Figure 3.5: Marital Status: (n=16)

The one adolescent girl who was married was within the legal age of getting married without parental consent, which is 18 years and above (Mahery & Proudlock, 2008:15).

In their study on outcomes of adolescent pregnancies, Adeyinka et al. (2010:785) are in agreement with the marital status of the sampled adolescents participants in this study, stating that most adolescent pregnancies are unwanted, unplanned and out of wedlock.

- **Level of education**

Figure 3.6 below reflects the level of education of adolescent girls who participated in this study.
The levels of education of participants ranged from grade 9-12 (high school) to tertiary education. Of the 16 adolescent girls interviewed, 87% (n=14) had high school education and 13% (n=2) were currently at tertiary education institutions. 56% (n=9) of the adolescent participants were currently at high school, and 31% (n=5) had dropped out of school due to pregnancy and could not continue with education.

All participants interviewed had at least the compulsory level of school education, which is grade 9 according to the South African Schools Act of 1996 (Mahery & Proudlock, 2008:12).

In support of these findings on level of education, Mchunu, Peltzer, Tutshana and Seutlwadi (2012:432) indicate that individual predictors such as poverty and low level of education contribute to adolescents' engaging in risky sexual behaviour, resulting in unplanned pregnancies. The implementation of the Managing Learner Pregnancy Policy (MLPP) in South Africa, although affected by many social discourses of adolescent mothers perceived as being contaminated, wrong and irredeemable, can be positively viewed in terms of the number of adolescent mothers attending and completing school.
(Chigona & Chetty, 2008:23). The policy allows pregnant adolescent girls to continue with schooling until they give birth, thus addressing school drop-out and allowing adolescent girls an opportunity to continue with education (Chigona & Chetty, 2008:23).

- **Employment status**

Figure 3.7 below indicates the employment status of adolescent girls interviewed.

![Employment status chart](image)

**Figure 3.7: Employment status: (n=16)**

Of the 16 participants interviewed, 56% (n=9) were currently at school, 31% (n=5) were not at school and unemployed, and 13% (n=2) were employed. The 31% who were not at school and unemployed were above the minimum school leaving grade (grade 9), and above the minimum age at which the child may perform labour which is 15 years according to section 43 of the Basic Conditions of Employment Act (Mahery & Proudlock, 2008:7). Of the two participants who were employed, one was in the clothing industry as a machine operator and one aged eighteen was self-employed as a traditional healer, registered with the South African Traditional Healers Society.

Maholo et al. (2009:46) align themselves with the employment status of adolescents in the study, revealing that adolescent pregnancies result in dropping out of school, poor
scholastic performance and scarce employment opportunities. Langille (2007:1601) reiterates, stating that teenage mothers are socially isolated; more often than others and have fewer educational and employment opportunities.

- Religion

Religion, which is broadly defined as a set of institutionalised beliefs in a higher power and includes statutes or regulations to guide one’s life (Edwards, Fehring, Jarrett & Haglund, 2008:448), is an important determinant in decision making about issues of sexual practices.

Table 3.1 below indicates the religious denominations of adolescent girls who participated in this study.

<table>
<thead>
<tr>
<th>RELIGION</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apostolic</td>
<td>5</td>
<td>31</td>
</tr>
<tr>
<td>Zion Christian Church (ZCC)</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Born Again Christians</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Jehovah’s Witness</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Dutch Reformed Church</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Roman Catholic Church</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Not belonging to any religious denomination</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>TOTAL</td>
<td>16</td>
<td>100</td>
</tr>
</tbody>
</table>

Eighty seven percent (n=14) of the sampled adolescent girls who participated in this study belonged to religious denominations. However, 13% (n=2) of the participants indicated not belonging to any religious denomination.

These were quotes from participants:

“The church does not believe in young girls falling pregnant, worse having an abortion.”

[Participant C]
“I agree with the church that “it’s a sin” to have a baby before marriage but most of the times people have children before marriage, or... should I say it’s a mistake (shake shoulders...) I don’t know. I agree with the church that marriage before one can have babies.” [Participant L]

In support of the role of religion in adolescent pregnancy, a study by Magadi and Ogwanda (2008:422) indicates that the Roman Catholic Church is protective against pregnancy for never-married sexually active adolescents through factors such as strongly advocating the natural method of family planning or less frequent sex. In support of religion as an important factor for adolescent decision making about pregnancy prevention, Behn and Grey (2011:51) argue that the church guides the adolescent girls and family members to provide support to adolescent girls’ decision-making about the prevention of unplanned pregnancies, consistent with adolescent girls’ faith/religious beliefs.

- **Ethnic group**

Culture and ethnicity plays an important role in decision making about pregnancy prevention in adolescent girls through norms and values of the particular culture. The ethnic groups of adolescent girls’ participants are illustrated in Figure 3.8 below.
Fifty percent (n=8) of the participants belonged to the Batswana ethnic group, 25% (n=4) belonged to Bapedi, and 25% (n=4) to Batsonga.

Hammanskraal is a predominantly Batswana ethnic group area, indicated by the 50% of adolescent girls interviewed who belonged to the Batswana ethnic group.

The following are from quotes from participants:

“I am not open with my mother about boyfriend stuff because of the cultural thing that I am still young I discuss them with my sister and my aunt.” [Participant G, Batswana ethnic group]

“I think if at home if they can be open with me about boyfriend issues I would have listened to them, but now at home they are afraid of talking to us about such things, they say it is not right in our culture because it will teach us to sleep around.” [Participant J, Bapedi ethnic group]

In their study of the population of Botswana, Mookodi, Ntshebe and Taylor (2012:3) indicate that the patriarchal system, which relegates males to positions of power and women to subordinates within the context of cultural belief and practices, still
predominates in issues of sex and relationships in Botswana. Cardoza, Documét, Fryer, Gold and Butler (2011:136) studied sexual health behaviour interventions for Latino adolescents and in support stated that adolescent sexual health is affected by the social contexts in which they live; therefore, consideration of adolescents’ ethnic, racial and cultural background is important when addressing sexual risk-taking behaviour.

3.2.3 Participants’ partners

According to Wittmann-Price (Wittmann-Price, 2004:440), emancipated decision making is an important phenomenon in women (adolescent girls) who are in the process of decision making. Sexual partners play an important role in decision making about pregnancy prevention in adolescents. Participants’ partners are discussed with reference to their age, level of education, employment status and involvement in the unplanned pregnancy.

- Ages of participants’ partners

Figure 3.9 indicates the ages of participants’ partners.

![Bar chart showing ages of participants' partners (n=16)](image)

**Figure 3.9: Ages of participants' partners (n=16)**

The ages of partners were between 15 and 30 years. The 30-year-old male had an adolescent girl partner aged 20. The pregnant 15-year-old adolescent participant did not
disclose the age of her partner as she was not sure, but indicated that they were in the same class at school; thus, the partner was presumed to be the same age as the participant. The 20-year-old adolescent participant who had a 30-year-old partner had this to say:

“I thought that maybe I should get an older man as a boyfriend who will be able to look after me and my children as I never had a father. My boyfriend is 10 years older than me. My boyfriend started to abuse me after I fell pregnant and has now left me with his child and this pregnancy after realising that I am pregnant again.” [Participant A]

Harner’s (2005:22) assertion that relationships with older men may be viewed as more advantageous than relationships with male peers when daily needs such as food, clothing and money are not met by care-givers, concurs with the findings of the adolescents who had relationships with older men. The same author indicates that adolescents may feel forced to seek out others to provide these resources of daily living. Lowenthal and Lowenthal (1997:30) concur, indicating that many teen pregnancies involve fathers who are older than the mothers because adolescent mothers are poor – they therefore view the relationship with an older man as an escape from poverty.
• Participants' partners' levels of education

The levels of education of participants’ partners are indicated in Figure 3.10.

![Level of Education](image)

**Figure 3.10: Participants' partners' levels of education (n=16)**

Forty four percent (n=7) of the participants’ partners were still at school with them, 12% (n=2) were at tertiary education institutions and 44% (n=7) of participants were not sure about the level of education of their partners.
• Participants’ partners’ employment status

Participants’ partners’ employment status is illustrated in Figure 3.11.

![Participants partner's employment status chart](image)

**Figure 3.11: Participants’ partners’ employment status (n=16)**

Thirteen percent (n=2) of the participants’ partners were employed, 56% (n=9) were currently at school and 31% (n=5) were unemployed and could thus not assist the participants financially to look after the child/children and were depending on government social grants.

In their study, *Teenage births: Outcomes for young parents and their child*, Schuyler Center for Analysis and Advocacy (2008:4) concurs with adolescents’ dependence on a government social grant in this study, stating that teen mothers are less likely to graduate from high school; they are more likely to live in poverty and rely on welfare.

• Participants’ partners’ involvement in the unplanned pregnancy

The involvement of participants’ partners in the current unplanned pregnancy is reflected in Figure 3.12.
Figure 3.12: Participants’ partners’ involvement in the unplanned pregnancy (n=16)

Of the 16 adolescent girls interviewed, 63% (n=10) indicated that their partners were not involved in the current unplanned pregnancies and 37% (n=6) indicated that their partners were involved. Of the ten not involved, two indicated that the partners were not even informed about the pregnancy, and eight stated that the partners ended the relationship after realising that the girl was pregnant. According to the adolescent girls, the male partners who ended the relationships expressed that they were not ready to be parents. The involvement of the six adolescent girls’ partners in the current unplanned pregnancy was as follows:

- The one married adolescent was staying with her husband.
- The partners of the two adolescent girls who were employed were still staying with them.
- The partners of the three school-going adolescent girls whose partners were still in their lives encouraged them to have the pregnancy terminated.
Fast Facts (2012:n.p.) indicates that adolescent fathers have remained an understudied and underserved population, and that there are fewer research studies which look at the unique needs of teen fathers and fewer programmes that address their unique needs. The study further indicates that there is increasing evidence that teen fathers want to be involved with their children, though this involvement may not always include financial support. The study conducted by Lowenthal and Lowenthal (1997), *Teenage parenting: Challenges, interventions and programs*, concur, indicating that adolescent fathers are overlooked in many programmes that assist adolescent mothers. Their needs as well as their responsibilities have been ignored. The researcher is in agreement with the findings of these studies about adolescent fathers as it was difficult to find literature on adolescent fatherhood.

### 3.2.4 Living arrangements

Figure 3.13 reflects the living arrangements of adolescent girls who participated in this study.

![Living Arrangements](image)

*Figure 3.13: Living arrangements (n=16)*

Fouty-six percent (n=7) of the adolescent participants lived with one parent, 27% (n=4) lived with both parents, 7% (n=1) lived with grandparents, 13% (n=2) lived with their boyfriends and 7% (n=1) lived in a child-headed family where they depended on the
Child Support Grant. Participants who lived with their boyfriends did so for financial support.

The 18-year-old participant who was staying with a boyfriend had this to say:

“I was staying with the father of my first child who was taking care of both of us at home. Now my boyfriend left us so I am alone with my child without anybody to support us.” [Participant A]

All participants, except one who had older children, were receiving social grants for their children. The one participant who did not receive the social grant did not have an identity document and the child did not have a birth certificate and she had no income.

This is what this 18-year-old participant said during the interview:

“I do not have an identity document; my child does not have a birth certificate that is why I cannot even apply for a social grant. I do not have parents who can help me get the ID because I also do not have a birth certificate. My mother died and my father is staying with another woman and has children all over. The money my boyfriend earns cannot afford two families as his family also expect him to give them something when he gets paid.” [Participant N]

The participant living with grandparents depended on the Old Persons Grant of the grandparent and the Child Support Grant for their children. According to the Social Assistance Amendment Act (No.5 of 2010), the following poverty alleviation strategies have been developed and are available for South African citizens who meet the criteria:

Aged persons grant: An amount of R1 140 paid to women over sixty years and men over sixty five years who are South African citizens and qualify for such a grant.

Child support grants: the amount of R280 paid to the primary care-giver of the child. The grant enables parents to take care of their children thus alleviating poverty.

Foster care grant: An amount of R1 140 paid to the foster parents.
These amounts are reviewed annually.

The current Child Support Grant from April 2012 is R280 per child per month paid to the primary care-giver of the child and the amount is reviewed annually. A primary care-giver according to the South African Government (2012) is a person who takes responsibility for the daily needs of a child, must be older than 16 years and may or may not be related to the child. The Child Support Grant is there to provide for the basic needs of South African children under the age of 15 years.

Adolescent girls who have children due to teenage pregnancy and are primary care-givers of their children can access an amount of R280 as Child Support Grant according to the South African Social Security System (Steele, 2006:ii). The findings in the study by Steele (2006:2) indicated that adolescent girls who already had other children were receiving the child support grant. The report on the incentive structures of social assistance grants in South Africa (2006), however, reported that the social security grant policy might be reviewed following claims from many quarters of society that girls fall pregnant to get the money due to poverty (Steele, 2006:2).

In support of these findings about living arrangements of adolescent mothers, Schuyler Center for Analysis and Advocacy (2008:4) and the US Department of Health and Human Services (2000:1) report that many teenage mothers have a difficult time juggling the dual role of parent and teen. These roles and responsibilities are often undertaken in the context of a stressful environment, characterised by poverty, poor housing, domestic violence and abuse. This report is in line with the findings of this study as one 18-year-old had this to say:

“We are living in a shack which my boyfriend’s family gave to him. My mother died and my father is staying with another woman, I am a parent self.” [Participant N]

Goicolea (2010:2) concurs with the living arrangements of low socio-economic conditions of adolescent participants of this study, stating that adolescent motherhood has been associated with lower socio-economic and educational attainment. In support, Mollborn and Dennis (2012:63) report that children of teenage mothers are more
disadvantaged across a variety of domains, some of the factors being that the home environment may be problematic and their mothers’ parenting skills and behaviours are not always rated favourably.

The findings of the study and related literature to validate them are discussed below.

**3.3 DISCUSSION OF THE FINDINGS AND LITERATURE CONTROL**

Discussion of factors contributing to the occurrence of unplanned pregnancies in adolescent girls and the existing sources of information about pregnancy prevention in adolescent girls is presented in a narrative format based on the outline provided in Table 3.2. Themes, categories and sub-categories were arrived at following the thematic method of qualitative data analysis as outlined in Polit and Beck (2012:562). Each discussion is followed by a literature control in order to place the findings in context of other research findings similar to the study problem.

Current literature, published after the year 2000, on factors influencing the occurrence of unplanned pregnancies and the existing sources of information on pregnancy prevention both nationally and internationally has been explored as control to validate the study findings. Some of the categories which emerged during data analysis in this study were not well researched and thus current literature published after the year 2000 was not available; therefore, studies undertaken before the year 2000 have in some instances been used to illustrate the findings.

Table 3.2 outlines an overview of the themes, categories and sub-categories in this study.

**Table 3.2: Overview of themes, categories and sub-categories**

<table>
<thead>
<tr>
<th>THEMES</th>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.1 Emancipated decision making factors</td>
<td>3.4.1.1 Adolescent girls’ lack of <strong>personal knowledge</strong> about pregnancy prevention</td>
<td>• Intuitive knowledge&lt;br&gt;• Lack of knowledge and experience&lt;br&gt;• Myths and negative attitudes</td>
</tr>
</tbody>
</table>
### Chapter 3
Findings and literature control

<table>
<thead>
<tr>
<th>THEMES</th>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
</tr>
</thead>
</table>
| 3.4.1.2 Lack of **empowerment** of adolescent girls in decision making about prevention of unplanned pregnancies |  | • Low self-esteem and lack of autonomy  
• Lack of dialogue and parental guidance |
| 3.4.1.3 **Prescriptive social norms** for adolescent decision-making about prevention of unplanned pregnancies |  | • Religious norms  
• Community norms |
| 3.4.1.4 Limited **flexibility of environment** for adolescent decision making about the prevention of unplanned pregnancies |  | • Negative nursing staff attitudes  
• Acceptable and unacceptable health service delivery  
• Inaccessibility of health services in emergencies |
| 3.4.1.5 Adolescent girls’ **lack of reflection** about decision making to prevent unplanned pregnancies |  | • Critical thinking and recognition of oppression  
• Change |
| 3.4.2 Socio-economic factors influencing adolescent girls’ decision making in the prevention of unplanned pregnancies | 3.4.2.1 Poverty  
3.4.2.2 Substance abuse |  | • Financial dependence on partners  
• Alcohol consumption |
3.4 THEMES, CATEGORIES AND SUB-CATEGORIES

Three themes, namely, emancipated decision making factors, socio-economic factors and the existing sources of information about pregnancy prevention emerged during data analysis. Categories and sub-categories of themes which emerged from data are also tabled in Table 3.2 above.

3.4.1 Theme 1: Emancipated decision making factors

Under this theme, adolescent girls alluded to the fact that they experience challenges in decision making when seeking pregnancy prevention methods from health care services. The socio-cultural context where decision making about the prevention of unplanned pregnancies takes place does not permit them to make free choices in the prevention of unplanned pregnancies. These emancipated decision-making factors were categorised according to the Wittmann-Price theoretical framework (Wittmann-Price, 2004:440) in this study as lack of personal knowledge, lack of empowerment, prescriptive social norms, lack of reflection and lack of flexible environment, as tabled in Table 3.2.

Emancipated decision making is a theoretical concept indicating a process of reaching a more positive state of being, a state of freedom of choice by first acknowledging the affective experience of oppression (Wittmann-Price, 2006:378). Emancipation means to free from restraints, control or power over another, to release from paternal care, and to free from any controlling influence (Wittmann-Price, 2004:439). This situation was alluded to by adolescent girls who described their being controlled by societal norms on
the prevention of unplanned pregnancies. Adolescent girls reported that most decisions about prevention of pregnancy were made by their male partners.

One 21-year-old participant said:

“Decisions about sex are mostly taken by my boyfriend because even the condom he sometimes refuses to use it. He uses it when he is happy but if not in a good mood he refuses and I am afraid of insisting because he will say I am out of control.” [Participant H]

3.4.1.1 Category 1: Adolescent girls’ lack of ‘personal knowledge’ about pregnancy prevention

The category of adolescent girls’ personal knowledge about decision making in the prevention of unplanned pregnancy in this context reflects the state of knowledge of adolescent participants in the study. Table 3.3 below illustrates a summary of the sub-categories of the category of personal knowledge as described by participants.

Table 3.3: Adolescent girls’ lack of ‘personal knowledge’

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
</tr>
</thead>
</table>
| 3.4.1.1 Adolescent girls’ lack of personal knowledge about pregnancy prevention | • Intuitive knowledge  
• Lack of knowledge and experience  
• Myths and negative attitudes |

According to Wittmann-Price (2004:441), personal knowledge influences everything one does because it is being aware of one’s own feelings. It is objective because it makes a person aware of how knowledge affects any one situation. Personal knowledge is a form of knowledge gained through experience and shaped by the unique perspective of the individual (Bonis, 2009:1332).

Participants’ personal knowledge emerged as intuitive knowledge, lack of knowledge and experience, myths and negative attitude about contraceptives and pregnancy prevention.
• **Intuitive knowledge**

Intuition is defined by Sweeney (1994:919) as knowledge without formal reasoning, a non-rational aspect of the pattern of knowledge. Rational knowledge is needed for the recognition of new patterns subsumed in personal knowledge. Intuitive knowledge is regarded as immediate knowledge, independent of the linear reasoning process of facts as a whole, knowledge without formal reasoning (Sweeney, 1994:917).

Participants in the study had intuitive knowledge, knowledge without formal reasoning, about contraceptives and the prevention of unplanned pregnancies. They thus described their personal knowledge as no knowledge or very little knowledge about contraceptives and pregnancy prevention.

A 17-year-old participant had this to say about personal knowledge:

“I don’t know much about prevention of pregnancy because I have never used contraceptives. It was the first time that I have sex. I hear people talking about prevention of pregnancy.” [*Participant C*]

A 21-year-old had this to say:

“I did not have information about getting pregnant and sex until after I had my baby when I take my child to the clinic I hear nurses talking about pregnancy and prevention. All what I knew about pregnancy was that if you sleep with a man, you are going to fall pregnant and the man will leave you with that child.” [*Participant H*]

In support of adolescent participants’ personal knowledge, the study by Richter and Mlambo (2005:5) on perceptions of rural teenagers on teenage pregnancy indicates that teenage pregnancy is often a result of lack of knowledge about contraception, poor knowledge about human physiology and lack of quality sex education.

• **Lack of knowledge and experience about sex and contraceptives**

Experience is used in the context of situations or activities in which individuals interact with the environment. It refers to experiences of others; experiences in practice (Bonis,
2009:1333). Adolescent girls in this study who did not have experience in decision making about sex and pregnancy prevention found themselves falling pregnant as they did not have experience with using contraceptives, as expressed by inappropriate and inconsistent use of contraceptives, especially condoms. This led to condoms bursting or slipping out during sexual intercourse.

This is a quote from a 17-year-old participant:

“I have never used contraceptives. It was the first time that I had sex. I hear people talking about prevention of pregnancy.” [Participant C]

A 15-year-old participant had this to say:

“I was not using contraceptives because it was the first time that I slept with a man (had sex). We used a condom once and thereafter had unprotected sex. I did not know that I was going to fall pregnant.” [Participant K]

An 18-year-old participant said:

“I did not care about what people say, all I wanted to do was to feel what other people feel when talking about sex so that I can also share my experiences. I must not be left behind and be a fool. I did not know much about sex.” [Participant F]

In support of lack of experience of adolescent girls regarding sex in this study, a study by Juarez (2003:171) on adolescent reproductive health in Latin America among low income groups states that sex in adolescents is more occasional and opportunistic, occurs at an age where the phase of development has not been completed, and the logistics of finding a setting for sexual activity are complicated and opportunistic. In a study on adolescent decision making, Halpern-Felsher (2009:6) reiterates this by stating that adolescents have less experience and knowledge about making sexual decisions than adults.
• **Myths and negative attitude**

Volume two (Barnhart, 1995b:1377) defines a myth as a belief, opinion or story that is not based on facts or reality. Adolescent girls expressed myths they lived with regarding the use of contraceptives which prevented them from using contraceptives and thus led to them falling pregnant. Adolescent participants expressed that they believed that contraceptives, especially the injection, would make them fat and that sexual intercourse would be too wet. They also believed that contraceptives would condemn them and make them infertile. They believed their partners when they told them that contraceptives cause vaginal infections and that amenorrhoea due to injectables make the blood get into the men and make them sick.

These are some of the quotes:

A 21-year-old participant said:

“My husband does not believe in using contraceptives as he says they cause infections. He believes that the condoms are injuring me so we should not use them.” [Participant D]

An 18-year-old adolescent participant said:

“When using an injection because sometimes you do not menstruate my boyfriend says the menses will get into him and make him sick.” [Participant J]

A 20-year-old participant said:

“Some of my friends are using contraceptives; some say they make you fat, I also realised that my friend is fat. I did not go to the clinic to ask about them or try to use them because I am afraid I will get fat.” [Participant L]

An 18-year-old participant said:

“At the clinic they tell me that ‘Depo’ (injectable contraceptive) is going to condemn me and I believe them and they also tell me that if they give me oral contraceptives I will forget to take them.” [Participant M]
In support of the myths, the study conducted by Lebese et al. (2010:33) with adolescent girls revealed that society’s reluctance to confront issues of sexuality forms a barrier between parents and teenagers, thus promoting the presence of misconceptions about sexual health, sexual risks and its consequences. Wood and Jewkes (2006:110) found that teenagers believed that contraceptive injections could cause infertility, if menstruation was irregular they called it a blood ‘blockage’ and would stop using contraception until the bleeding started again. They complained that contraceptives made them sick, made them have waist pains after sex, weight loss, diminished sexual feelings because of vaginal wetness and fear of being condemned (i.e. made infertile). Some teenagers believed that they could prevent pregnancy by only taking contraceptive pills on the days their boyfriends visited them (Wood & Jewkes, 2006:112).

Attitude is defined by the World Book dictionary, volume one (Barnhart, 1995a:132) as the behaviour of a person towards a situation. Negative attitudes therefore imply negative behaviour towards a situation. Adolescent girls in the study expressed negative attitudes towards the use of contraceptives to prevent unplanned pregnancies through not using contraceptives, or stopping the use of contraceptives due to the negative attitudes and myths they had about contraceptives.

A 20-year-old participant said:

“To be honest I knew about other contraceptives but I thought that if I used the injectable method I will get fat as my friends told me that injection makes the person fat.” [Participant G]

A quote from a 21-year-old participant:

“I was not on any contraceptive method because the oral methods I was afraid that I will forget to take the pill and the injection I am afraid of the injection as I once went to the clinic and after being injected I took a long time to heal.” [Participant H]
A 19-year-old adolescent had this to say:

“I was preventing using the injectable method so I realised that it was making me fat I decided to stop using it and that was the time when I started having sex.” [Participant M]

In support of the negative attitudes of adolescent girls to contraceptive use in this study, the study conducted by Oindo (2002:35) on contraception and sexuality among the youth in Kenya revealed that the negative attitudes towards youth contraception were attributed to the perceived health risks and the notion that the practice promotes promiscuity. On the contrary, Richter and Mlambo (2005:5) in a study conducted about teenage pregnancy in South Africa state that, despite the positive attitude teenagers have on contraceptive use, they shy away from the responsibility of using contraceptives.

3.4.1.2 Category 2: Empowerment of adolescent girls in decision making about the prevention of unplanned pregnancies

Adolescent girls in the study lacked empowerment to be able to make emancipated decisions about the prevention of unplanned pregnancies. Table 3.4 indicates the category empowerment, sub-categorised as expressed by participants.

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
</tr>
</thead>
</table>
| 3.4.1.2 Lack of empowerment of adolescent girls in decision making about prevention of unplanned pregnancies | • Low self-esteem and lack of autonomy  
• Lack of dialogue and parental guidance |

Wittmann-Price (2004:440) defines empowerment as a positive process that promotes autonomy and independence and implies that, through knowledge, some type of power is shared or transmitted. According to Wittmann-Price (2004:442), empowerment is a component of the emancipation process where knowledge is seen as power needed to challenge, engage in dialogue, act and disagree to be able to make healthy choices.
However; in this study, empowerment emerged as empowerment of adolescent girls for decision making to prevent unplanned pregnancies. The lack of empowerment of adolescent girls in this study was expressed by adolescent girls’ **low self-esteem and lack of autonomy in decision making** and **lack of dialogue and parental guidance**.

- **Low self-esteem and lack of autonomy in decision making**

Self-esteem is regarded by Commendador (2007:616) as an evaluation the individual makes and maintains with regard to him- or herself which is expressed as an attitude of approval or disapproval. It is the sense of pride in oneself, an individual’s positive or negative attitude towards the self.

Adolescents in this study expressed that they suffered self-doubts and fear of their partners’ approbation in decision making about pregnancy prevention. They needed the approval of their male partners for decisions about the contraceptive methods to be used. This situation of low-self-esteem and self-deprecation by adolescent girls illustrates Freire’s (1972, in Fulton, 1997:533) analysis that people’s perception of themselves is impaired by their submersion in the reality of oppression.

These are some of the quotes which illustrate low self-esteem:

An 18-year-old participant said:

“*Right now I do not have anything, I do not have matric, I am nothing, and I am just living, relying on a man.*” [*Participant N*]

The 20-year-old participants had this to say:

“I agree with everything my boyfriend tells me. I am afraid that he also will leave me like the father of my first child did. I don’t know what I can change because I always listen to what my boyfriend says if he allows me to use contraceptives for prevention I will do so but if he refuses I will not use them.” [*Participant I*]

“I realised that my boyfriend was unhappy so I felt pity for him and thought that if we had sex he will feel better and I must not bother him with condoms.” [*Participant H*]
Adolescent girls’ low self-esteem resulted in fear of challenging their sexual partners in decision making about preventing pregnancy. Self-deprecation and low self-esteem are characteristics of the oppressed (the adolescent girls), which originate in their internalisation of the opinions the oppressors (their sexual partners) hold of them (Fulton, 1997:533).

Autonomy is described by Wittmann-Price (2004:442) as an outcome of empowerment because it has the ability to produce independent thinking and action. Fulton (1997:533), on the other hand, describes autonomy as making and being responsible for one’s own decisions. Fotso, Ezeh and Essendi (2009:3) regard women’s autonomy as including women’s freedom of movement, decision making related to economic matters, freedom from violence from husbands and decision making related to health care. Adolescent girls in the study could not make their own decisions about pregnancy prevention but needed the approval of their male sex partners.

This is a quote from an 18-year-old participant:

“About the methods of prevention I must ask my boyfriend that between the injection and the oral contraceptives what works better for him because sometimes they say contraceptives makes them weak (laughs...). Injection because sometimes you do not menstruate he says the menses will get into him and make him sick, while I will get fat so it is better if I use oral contraceptives, which is why I was using oral contraceptives.”

[Participant J]

A 21-year-old participant said:

“Sometimes we agree on decisions about pregnancy and sex, but because in Black culture the man is the head of the family most decisions are made by my husband.”

[Participant D]

According to Acharya, Bell, Simkhada, Teijlingen and Regmi (2010:1), who concur with these findings on autonomy, women’s autonomy in health care decision making is extremely important for better maternal and child health outcomes and as an indicator of women empowerment. Adolescent girls’ low self-esteem and lack of autonomy in this
study indicated that their choices about pregnancy prevention methods depended on the approval of their male sexual partners. In support of lack of adolescent sexual autonomy in this study, in their study on the attitudes of Kenyan in-school adolescents towards sexual autonomy, Adaji, Warenius, Faxelid and Ong’any (2010:34) indicate that sexual autonomy for women and girls, especially premarital sex and prevention of unwanted pregnancies, remains a highly contentious issue in Kenya.

- **Lack of dialogue and parental guidance**

Adolescent girls in the study reported not engaging in dialogue with their parents on issues of sex and pregnancy prevention as it is culturally not acceptable. They indicated that there is a need that parents should start talking to their daughters and guide them about issues of sex and prevention of pregnancy. Participants expressed that information from parents is more important and has longer-lasting effects than that from friends. They indicated that not engaging in dialogue with their parents denied them the information, knowledge and guidance about sex and prevention of pregnancy which they needed from their parents to be able to make informed decisions.

This is a quote from a 17-year-old participant:

“My mother is old fashioned has these cultural things that we should not know about prevention, she is never open with me about prevention and relationship and sex, she believes that I am still young, I just overhear her talking to my sister asking her if she is preventing but me, No.. (Shake head…) she never talks to me. Even with my sister she is not so open. I never know whether she wants me to prevent or not. Maybe if there was an older person who spoke to me about preventing unplanned pregnancies…. or...Maybe I should call it teenage pregnancy but no adult has ever talked to me about such. When we talk about this with my friends we take it as a joke we laugh about it and do not take it serious. We do not take it as educational that can help us. If I could have heard it from my mother or sister maybe it could have had a message to me.”

[Participant O]
An 18-year-old participant had this to say:

“I think if at home they can be open with me about boyfriend issues I would have listened to them, but now at home they are afraid of talking to us about such things. I can only talk to my friends and my boyfriend about boyfriend stuff and prevention of pregnancy and I take it that advices from home are always the best, but at home they do not talk to us.” [Participant M]

The findings of this study about lack of dialogue and parental guidance is supported by Lederman and Mian (2003:34), who allude that family involvement, parental values, parental monitoring and parent-child communication are important factors influencing critical life choices and are a crucial part of adolescent pregnancy prevention. Lebese et al. (2010:33) reiterate, stating that societies are reluctant to openly confront issues of sexuality, and the reluctance forms a barrier of communication between parents and teenagers and even between sexual partners. Poor dialogue about sexual health between parents and teenagers is one of the contributory factors of high teenage pregnancy.

In a study conducted about Botswana, Mookodi et al. (2012:6) also concur with lack of dialogue with parents, stating that there exist among the Batswana people a tradition of reticence on sexual matters between parents and young people where adolescent girls are comfortable discussing sexuality with their friends than they are with their parents. According to Were (2007:322), one of the determinants of teenage pregnancy is lack of parental guidance on issues of sexuality and counselling which is reinforced by cultural taboos which inhibits such discussions.

3.4.1.3 Category 3: Prescriptive social norms for adolescents’ decision making about the prevention of unplanned

Adolescent girls indicated that their decisions and behaviour regarding sex and pregnancy prevention are influenced by social norms. Table 3.5 indicates the category prescriptive social norms, sub-categorised as described by adolescent girls who participated in the study.
Norms are regarded as standards established by society to tell its members what types of behaviour are typical or expected (Baumeister & Bushman, 2009:256). Wittmann-Price (2006:381) describes awareness of social norms as women’s awareness that the external environment promotes one of the possible alternatives in their reproductive health choices as more acceptable than the other.

Participants in this study indicated that the religious and community norms are prescriptive for adolescent girls and make it difficult for them to freely seek pregnancy prevention. They indicated that men play a dominant role in decision making about pregnancy prevention; this is valued by the community and thus regarded as a norm.

- **Religions norms**

Religious norms such as ‘no sex before marriage’ and the prohibition of the use of contraceptives in some churches were given as examples of what participants regarded as prescriptive norms. They felt that they lack the freedom of consulting the clinics for contraceptive advice for fear of church members who might see them. This led them to having unprotected sex which ended in unplanned pregnancies.

The following quote from a 21-year-old participant was testimony:

*“The church does not agree with prevention of pregnancy. They give us tea which cleans us. They say women must have children but not young girls who are still at school.”* [Participant D]

An 18-year-old participant had this to say:
“The church does not believe in young girls falling pregnant and having unplanned pregnancies, worse of all that the church does not believe in having an abortion. When I came here to seek advice about this pregnancy I prayed and said: ‘God I am not perfect I know what I want to do is wrong.’” [Participant N]

A 19-year-old participant had this to say:

“The church does not allow girls to use prevention because they do not allow sex before marriage. They do not talk much about sex and prevention in church but we as church members know that it is not allowed in church for girls to have sex before marriage. I agree with the church that ‘it’s a sin’ to have a baby before marriage but most of the times people have children before marriage, or... should I say it’s a mistake (shake shoulders...) I don’t know. I agree with them that marriage before one can have babies. This pregnancy of mine was a mistake because this happened because of the love for worldly things.” [Participant L]

Akitunde and Ayantayo (2005:4) assert that sex is considered sacred according to the African Traditional Religion; its sacredness is exemplified by the fact that, among others, it must be performed mainly by husband and wife, therefore leaving no room for pre-marital sex support the findings of this study about church norms.

In support of the church norms in this study, the Christian religious organisations also do not close their eyes to the situations associated with sex in the contemporary times. Christians’ circles, for example through the Sunday school teachings, advise followers to desist from sexual immorality. Christian filmmakers like Mount Zion among others teach against sexual immorality (Akitunde & Ayantayo, 2005:7). Part of religion as a social control is that it provides consequences for deviance, such as guilt, shame, public embarrassment and expectation of divine punishment (Hardy & Raffaelli, 2003:732).

Oppression in decision making is a phenomenon identified in adolescent girls’ health care when they feel obliged to choose the most socially accepted option (Wittmann-Price & Bhattacharya, 2008:225), which is abstaining from sex until they are married, rather than the option that best suits their personalities, which is seeking the prevention
of unplanned pregnancies. The church norms forbid adolescent girls from engaging in sex before marriage, yet the current environment in which these young girls grow is said to be that of permissiveness, with the media providing a host of sexual messages both implicit and explicit (Siebold, 2011:125). Therefore, young girls find themselves caught between the church norms and the current environment in which they grow, with the resultant growing rate of unplanned pregnancies.

- **Community norms**

  Community norms were said by adolescent girls during the interviews to influence their decision making about the prevention of unplanned pregnancies, making it difficult for them to freely seek pregnancy prevention. They indicated that their community is patriarchal, with males making most of the decisions about issues of sex and contraceptives; decisions such as condom use and having sex. They also indicated that they are afraid of seeking contraceptives in the community where they are known, as contraceptive use is associated with ‘sleeping around’ and this is not acceptable according to the norms of the community as it will spoil their chances of getting married in the local community.

This is a quote from a 21-year-old participant:

“Sometimes we agree on decisions about pregnancy and sex, but because in Black culture the man is the head of the family most decisions are made by him.” [Participant D]

Another 21-year-old participant said:

‘I do not have any say in decisions about sex, I listen to what my boyfriend tell me to do as I am afraid that he will beat me up if I do not do as he wishes. When he says do this I do that, and when he tells me not to do something I just follow the rules. Otherwise he will say I am not a good woman.’ [Participant I]
A 17-year-old had this to say:

“At the clinic there is that thing that the community like to know more about other people’s affairs, so that is why people use clinics far from where they stay. The community like to check other people’s affairs and if you are a young girl they will say why do you use prevention methods it means you are ‘sleeping around’ and nobody will marry you.”

“My friends believe that we should go to the family planning clinic but they are afraid of what will people in the community say when they see us going to the clinic. The community members when they see a young girl going for family planning clinic they say you are ‘sleeping around’.” [Participant P]

The study conducted in Botswana by Mookodi et al. (2012:6) support the findings about community norms influencing adolescent decision making in the prevention of unplanned pregnancies by stating that, in Botswana, a patriarchal sex/gender system relegates males to positions of power and women to subordinate positions within the context of cultural beliefs and practices. Sexual behaviour and relationships of adolescent girls should be seen within rapid socio-economic change, gender identity and unequal power relations between men and women. Men are traditionally expected to initiate and control sexual activity. This places women in a subordinate position with regard to the negotiation of safe sex, particularly with regard to the use of condoms (Mookodi, et al, 2012:6).

In their study on the attitudes of Kenyan in-school adolescents towards sexual autonomy, Adaji et al. (2010:34) indicate that, although adolescent boys have knowledge about condom use and the protection it offers against unwanted pregnancies, male norms favouring sexual experiences without condoms often prevent them from using the condom correctly and consistently. The study further alludes that prevalent societal norms limit young women’s access to and use of contraceptives, thus emphasising sexual submissiveness and weakening young women’s ability to negotiate the use of contraceptives.
Cardoza et al. (2011:1) concur, stating that adolescent sexual health is affected by the social contexts in which individuals live. Social norms set standards and establish paradigms that are sometimes difficult to change and, because knowledge development always occurs in a social context, society influences individual perception (Wittmann-Price, 2004:442) about pregnancy prevention. Adolescent girls in this study thus found themselves influenced by prescriptive social norms in making decisions about preventing unplanned pregnancies.

3.4.1.4 Category 4: Limited flexibility of environment for adolescent decision-making about the prevention of unplanned pregnancies

Adolescent girls in this study shared their experiences of the environment where they get pregnancy prevention methods. They described the environment as not adolescent-friendly, making it difficult for them to seek pregnancy prevention methods as summarised in Table 3.6 below.

Table 3.6: Limited flexibility of environment

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.1.4</td>
<td>Limited flexibility of environment for adolescent decision-making about the prevention of unplanned pregnancies</td>
</tr>
<tr>
<td></td>
<td>• Negative nursing staff attitude</td>
</tr>
<tr>
<td></td>
<td>• Acceptable and unacceptable health service delivery</td>
</tr>
<tr>
<td></td>
<td>• Inaccessible health service delivery in emergencies</td>
</tr>
</tbody>
</table>

Flexibility refers to the ability to be adapted to fit various conditions, easily managed, all of the surrounding things, conditions, and influences affecting the growth and development of living things (Barnhart, 1995a:816).

Wittmann-Price (2006:378) describes a flexible environment as an internal and external environment which is responsive and resilient to increased choices, thus enhancing self-esteem and satisfaction.

Participants in the study affirmed that the availability of a flexible environment for the prevention of unplanned pregnancies would facilitate emancipated decision making.
They expressed the following challenges experienced in seeking pregnancy prevention methods: **negative staff attitude, acceptable and unacceptable health service delivery** and **inaccessible health service delivery in emergencies**

- **Negative staff attitude**

Attitudes are defined by Griffin and Moorhead (2007:69) as complexes of beliefs and feelings about specific persons, objects, events or situations. They can be positive or negative affective responses formed by a variety of forces, including personal values, experiences and personality.

Negative staff attitude towards adolescents seeking pregnancy prevention in the reproductive health services was expressed by adolescent participants and this is regarded as creating fear of the clinics. They alluded that health care professionals are rude, especially to adolescent girls seeking pregnancy prevention, saying they are too young to be sexually active; they refuse to change methods when requested by adolescents and only make the injectable method available with the reason that adolescents will forget the ‘Pill’. They indicated that clinic staff say they are ‘sleeping around’ when they should be concentrating on their school work. Adolescent stated that this therefore makes them buy contraceptives from either general practitioners or pharmacies, with both of these having financial implications.

The following quote came from a 17-year-old participant:

“The clinic staff from what I hear, are rude, I have never been there because I am afraid of them, I use a private doctor, if you are pregnant they say ‘don't you know how to use the condom?’ They are harsh and do not make a person feel comfortable. They are worse for teenagers I hear they will tell you that you are not ready for the child so why must you have sex, they blame you for everything. I never go to the clinic for getting prevention pills (oral contraceptives) I only go to the clinic when I am sick. I am afraid that the nurses will be rude to me. There is a place where I buy the prevention pills.” [Participant O]

An 18-year-old participant had this to say:
“Nurses are rude to young girls who go for family planning saying that they sleep around. They usually ask what you are coming to the clinic for. And then they would say: what are you doing with sex because you are still young? Because I am still at school they will say: ‘what are you doing with sex when you are still at school?’ (Anger on the face)” [*Participant J*]

Ehlers (2003a:21) supports these findings on negative attitudes of nurses, stating that adolescents indicated that some of the advice they got from the family planning clinic was that they were too young to use contraceptives. In addition, Wood and Jewkes (2006:113) state that nurses’ attitudes are a major barrier to teenagers getting hold of contraception. The nurses are uncomfortable about providing teenagers with contraception as they feel that they should not be having sex, and they are judgemental and unhelpful when responding to contraception requests, which the adolescents described as ‘harassment’. The study by Mothiba and Maputle (2012:6) reiterates, indicating that negative staff attitude was found to be a barrier to adolescent access to contraceptives.

- **Acceptable and unacceptable health service delivery**

Although there was a feeling among 19% (n=3) adolescent participants that the clinic staff were helpful, 81% (n=13) participants regarded service delivery as unacceptable as they indicated the following challenges encountered when seeking pregnancy prevention methods at the clinics as illustrated in Table 3.7.

**Table 3.7: Challenges experienced by participants in the clinics**

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long queues, sometimes the queues are cut and patients are sent home</td>
<td>6</td>
<td>37</td>
</tr>
<tr>
<td>Staff go for tea and lunch for a long time while patients wait</td>
<td>5</td>
<td>31</td>
</tr>
<tr>
<td>Staff start with meetings before attending to patients</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Clinics run short of needles for injectable method of contraceptives</td>
<td>4</td>
<td>25</td>
</tr>
</tbody>
</table>
Challenges expressed were such that one participant expressed more than one challenge. Adolescent participants referred to service delivery as unacceptable as queues are long, sometimes they are turned back because of the long queues, nursing staff go for tea and lunch for a long time while patients wait, clinics run short of equipment such as needles for injectable methods, sending patients away, and lack of privacy and confidentiality as all patients follow the same queue.

The following is a quote from an 18-year-old participant:

“I was using the injectable method of contraception (Depo-Provera). One day when I went to the clinic when I was due for my injection, the clinic sister told me that the needles are finished for the day and that I should come the following day.” [Participant B]

A quote from a 21-year-old participant:

“I did not go to the clinic because at the clinic we wait for a long time. The queues are long and the nurses go for tea for more than an hour and the nurses are sometimes rude to us especially the young girls they say we sleep around.”

“(Anger in tone of voice..) the clinic staff are slow, they go for tea for hours while we wait and when they come back from tea they are irritable and start shouting at us. They sometimes turn us back because we are too many they cannot attend to all of us and ask that we come back the following day.” [Participant E]

An 18-year-old participant had this to say:

“The nurses do not have a problem with us the only problem is that they go for lunch for a long time and we have to wait for them. They take an hour and we have to wait’. “

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethical issues such as lack of privacy and confidentiality, all patients using the same queue</td>
<td>4</td>
<td>25</td>
</tr>
</tbody>
</table>
sometimes say they ran out of stock for needles and tell us to come back sometimes the following week.” [Participant F]

A quote from a 21-year-old participant:

“The clinic start at 08H00 and closes at 16H00 and the nurses start by praying and they take their time, sometimes they start by having a meeting and will only start working around 10H00. Patients are many and sometimes they cut the queue and tell patients to come back the following day. I think the clinic sometimes contribute to people not using contraceptives because all patients follow the same queue, those coming for injectable contraceptives, the Pill, babies coming for immunisations, as well as the sick. If there was a queue for family planning, a queue for immunisations as well as queue for the sick it would be better if there is a queue for everything as some people take a long time in consultation. We do not want people to know why we came to the clinic.” [Participant H]

WHO (2009:8) confirms the findings of this study on unacceptability of health care delivery, indicating that some of the reasons given by adolescents for not using health care services for contraceptive counselling include fear that health workers will ask them difficult questions or scold them; or that health workers will not maintain confidentiality and privacy.

The assertion by Maholo et al. (2009:56) that the socio-cultural environment of teenagers in South Africa must receive attention to prepare future registered nurses to deal with teenagers, also supports the health service delivery findings of this study. Richter and Mlambo (2005:12) in agreement state that teenagers are reluctant to visit clinics for contraceptives because their anonymity is not guaranteed. A common concern among adolescents is that they may come across relatives in the clinic who may tell their parents that they are using contraceptives (Richter & Mlambo, 2005:12).

In their study on contraceptive options for the youth, Aradhya, Finger and Scholl (2007:5) align themselves with the findings on unacceptable service delivery, indicating that misconceptions about the side effects of contraceptives and fears that the service
will not be confidential are common among adolescents. The study further indicates that young people sometimes avoid going to the clinic because they are afraid of being seen by someone they know.

- **Unavailability of services**

The services were regarded by adolescent girls as not always available in emergencies as summarised below in Table 3.8. However, 13% (n=2) participants did not comment about availability of services in emergencies.

**Table 3.8: Unavailability of services**

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The unavailability of emergency contraceptives in the clinics</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Condoms not available in emergencies like after party when they want to have sex as most communities in Hammanskraal are rural</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Health service delivery not available after 16H00 and during weekends in some clinics</td>
<td>7</td>
<td>43</td>
</tr>
</tbody>
</table>

All participants interviewed described the services as accessible in terms of operation times as some clinics operate from 08H00-16H00 while others render a 24-hour service. The problems encountered by adolescents were adolescents who are staying next to the clinics operating between 08H00 -16H00 and do not offer a service after 16H00 or over weekends. They also expressed that condoms are not available in emergencies such as when they come from parties with their male sexual partners. They indicated that areas where they buy condoms close early as most of Hammanskraal is rural. They expressed that condoms should be made available in entertainment areas where adolescents party until late.

A 17-year-old participant said:

“I told my boyfriend to buy me the Morning after Pill (Emergency contraceptives) as they are not available at the clinics and I am afraid to go to the clinic.” [Participant O]
Another 17-year-old participant said:

“I have never used any other contraceptives. I was afraid of getting fat, so I was only using the condoms and because these are rural areas condoms are not always available. When we come from partying we cannot get condoms as the areas where we buy them are closed. Maybe the areas where we party should sell condoms.”

[Participant P]

While adolescents are benefiting from provision of the increased availability and accessibility of emergency contraceptives in the United Kingdom, they face a series of challenges such as their ability in the law to access the service in terms of their autonomy, the main difficulty being those adolescents under the age of 16 (Fallon, 2009:123). Sexual activity of adolescents under the age of 16 is regulated in part by the Sexual Offences Act (2007), which states that it is a crime for a man to have sexual intercourse with a girl less than 16 years of age (Fallon, 2009:123).

According to Chapter 3, section 35 of the Sexual Offences Act (2007), any male who engages in sex with the girl under the age of 16 years shall be guilty of an offence. The Sexual Offences Act (2007) in South Africa, however, does not prevent the provision of any family planning method to adolescents. Mahery, Proudlock and Jamieson's (2010:27) Guide to the Children’s Act for health professionals states that contraceptives may be provided to a child on request from a child and without the consent of the parent or caregiver of the child if the child is at least 12 years of age. The study conducted by Sheeder et al. (2009:296) on the reasons for ineffective adolescent contraceptive use indicate that some of the reasons adolescents give for using contraceptives ineffectively are the ways in which family planning services fail to meet their individual and collective reproductive health care needs.

The rights approach to sexual and reproductive health care goes beyond provision of family planning, reproductive and sexual health; it implies incorporating the principle of human rights to sexual and reproductive health. The exercising of sexual and reproductive rights depends on the individual's freedom to make genuinely free
decisions regarding his or her health and body in a healthy environment regarding the social determinants of sexual and reproductive health services (Goicolea, 2010:2).

**3.4.1.5 Category 5: Adolescent girls’ lack of reflection about decision-making to prevent unplanned pregnancies**

Reflections on the experiences of having unplanned pregnancies were made by adolescent girls in the study, sub-categorised in Table 3.9 as described by participants.

Table 3.9: Adolescent girls’ reflection

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
</tr>
</thead>
</table>
| 3.4.1.5 Adolescent girls’ lack of reflection about decision making to prevent unplanned pregnancies. | • Critical thinking and recognition of oppression  
• Change |

Reflection, which involves looking both inwards and outwards to develop an understanding and create meaning (Bonis, 2009:1333), emerged as a category in this study where adolescent girls reflected on their decision making to prevent unplanned pregnancies. Wittmann-Price (2004:441) defines reflection as a consciousness or a learned method of perceiving society and its oppressive influence. It is viewed as a form of critical thinking, a necessary tool for understanding groups, not only individuals, a method that can be used to change society for the better (Wittmann-Price, 2004:441).

The following were forms of reflections expressed by participants about their unplanned pregnancy: **critical thinking and recognition of oppression, and change.**

- **Critical thinking and recognition of oppression**

  Critical thinking is regarded by Alligood (2010:518) as a disciplined process in which one actively and skilfully uses reasons and logic as a guide to belief and action in decision making. Jasper (1999:457) concurs, indicating that critical thinking makes one think more deeply about one’s knowledge base and question what one knows.

  Participants alluded that having unplanned pregnancies made them to start thinking critically about themselves and their future.
This is a quote from an 18-year-old participant:

“Adolescents must not make sexual decisions based on what other people say, they should know what they want in life as people always have something to say and complain all the time. They must know that their future depends on their decisions not decisions of other people like their boyfriends or people in the community.” [Participant B]

A quote from a 21-year-old participant:

“I need to be careful about relationships and making choices about partners. I realised that most boyfriends only want you for sex and then they leave you. I need to be serious about going for family planning.” [Participant E]

A 20-year-old participant had this to say:

“I will tell other young girls that ‘never say never’ because everybody can fall pregnant. They must go to the clinic to get contraceptives if they have boyfriends otherwise they will fall pregnant. I am one of the people who thought will never fall pregnant, but here am I with an unplanned pregnancy.” [Participant G]

Freire (in Green, 2002:7) supports the findings of this study about critical thinking, stating that it is valuable to consider the importance of reflection as a learning tool to foster critical thinking and awareness. According to Freire, education should be designed to maintain and integrate the younger generation into the existing system, providing them with the means to deal critically and creatively with reality and discover how to participate (Green, 2002:7).

Mooney and Nolan (2005:241) indicate that oppression occurs when constraints and restrictions diminish, immobilise and fashion people into subordination resulting in an imbalance of power. The situation of restriction by social norms has been identified in this study where adolescent girls are restricted by the community as a patriarchal society which put males in superior positions in decision making about pregnancy prevention and issues of sex and the church.
Participants expressed that, through reflection, they realised that the community, which includes their sexual partners and religion, is a form of restriction which makes it difficult for them to make free choices about preventing unplanned pregnancies. They expressed that having an unplanned pregnancy made them realise that their male partners are taking an advantage over them because they are females. They further indicated that the occurrence of unplanned pregnancy, and also engaging in the interview dialogue helped them realise that they can engage in discussions with their partners and make their own decisions about sex and pregnancy prevention.

They indicated that they needed to start thinking about their future and making it a priority rather than listening to what community members have to say about the prevention of unplanned pregnancies.

A quote from the 21-year-old participant:

“I will tell other young girls like me that they must be careful in relationships. They must not believe anybody who says he loves them. If at school they must not rush into relationships but should concentrate on school and getting education. If sexually active they must go for family planning and use condoms.” [Participant D]

A 21-year-old participant had this to say:

“Young girls must not look at what other people are doing nor listen to what people in the community are saying or doing as they will lead them astray, they must go to the clinic if they have boyfriends and are sexually active.” [Participant H]

A quote from a 19-year-old participant:

“Young girls must not allow people telling them not to prevent promising to use the condom only at the end they are the once who will fall pregnant. They must be careful about men they will lead you astray.” [Participant L]

In recognition of the oppressive laws of the country on women, South African women were involved in a campaign which led to the adoption of the Women's Charter for Effective Equality. Two of the preamble statements of the Charter state that women's
subordination and oppression has taken many forms under patriarchy, custom and 
tradition, coalition and apartheid; and women have come together in a coalition of 
organisations to engage in a campaign that enables women to draw their diverse 
experiences and define what changes are required within new political, legal and social 
system (Women’s National Coalition, 1994). The Women’s Charter for Effective Equality 
supports the findings of this study on recognition of oppression and the need for 
change. Hutson (2007:3) reiterates about the oppression of women, indicating that 
despite the change in government and the writing of the Constitution in post-Apartheid 
South Africa, oppression of women is still rampant – women are not allowed to make 
important decisions, they remain subservient and do not feel the oppression.

- Change

Participants reflected that they needed to start putting themselves first in relationships 
as their futures depend on the decisions they make. Adolescent participants expressed 
that the experience of having an unplanned pregnancy made them realise that they 
needed to change their sexual behaviour and focus more on education; they could start 
thinking about having children when they have completed their education. They 
explained that they needed to be careful in relationships as men only need them to have 
sex and when they fall pregnant they leave them. They indicated that, given a chance, 
they would share their experiences with peers about the experience of having an 
unplanned pregnancy. They alluded that they would warn their peers and colleagues at 
school and in the community to take decisions based on what they want, not what the 
community, including their sex partners, or the church wants.

This is a quote from a 19-year-old participant:

“I will tell other young girls that when their parents talk to them they must listen. If they 
do not have anybody to guide them, teachers at school are there for them or even the 
clinic staff. They must be careful of friends they are not always honest when you have 
problems like me they laugh at you.” [Participant L]
A 21-year-old participant said:

“They must go to school and not engage in early sex. If they do not have parents like me they can go to the social workers they will help them. They will help them get a better home and a better education.”

“I want to go to adult school and do courses that will help me be able to get a job and work for me and my child and stop relying on the other person. Right now I do not have anything, I do not have matric, I am nothing, and I am just living, relying on a man. That is going to stop.” [Participant N]

A 15-year-old participant had this to say:

“Adolescent girls must stay away from men and go to school so that when they are grown up they must not be like our parents who are struggling because they did not go to school. I will tell them that the school is important more than men because you will get pregnant and have to stay home while guys continue with school. I do not want to have a boyfriend again until I finish school.” [Participant K]

Freire (in Mooney and Nolan, 2005:241) regards the education process as an instrument for liberation and promotes an education based on liberation, whereby individuals are empowered through critical examination of their reality.

In support of change, the South African News Agency reports that the government of South Africa proposed the Women Empowerment and Gender Equality Bill to enforce gender parity across all sectors of society. This move demonstrates commitment by government to act decisively and enforce change and speed up the process of gender transformation (Williams, 2013).

3.4.2 Theme 2: Socio-economic factors influencing adolescent decision making in the prevention of unplanned pregnancies

Adolescent participants in this study indicated that some socio-economic factors influenced their decision making in the prevention of unplanned pregnancies as summarised in Table 3.10.
Table 3.10: Socio-economic factors influencing adolescent decision making in the prevention of unplanned pregnancies

<table>
<thead>
<tr>
<th>THEMES</th>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.2</td>
<td>Socio-economic factors influencing adolescent decision making in the prevention of unplanned pregnancies</td>
<td>3.4.2.1 Poverty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.4.2.2 Substance abuse</td>
</tr>
</tbody>
</table>

Socio-economic factors were the second theme that emerged from data analysis which influences the occurrence of unplanned pregnancies in adolescent girls. Poverty and substance abuse were the two categories which emerged under the theme socio-economic factors.

3.4.2.1 Category 1: Poverty

“Gender Equality is more than a goal in itself. It is a precondition for meeting the challenge of reducing poverty, promoting sustainable development and building good governance” (Kofi Annan, quoted in BrainyQuote, 2014a)

Poverty was expressed by participants as the root cause of the occurrence of unplanned pregnancy; especially in adolescents who were unemployed or did not have parents and depended on their partners for financial support.

Poverty is defined by Bellù and Liberati (2005:20) as the lack of or inability to achieve a socially acceptable standard of living. Chambers (2006:3) indicates that people are said to be in poverty when they are deprived of income and other resources needed to obtain the conditions of life – the diet, material goods, amenities, standards and services that enable them to play their roles, meet their obligations and participate in the relationships and customs of their society. Poverty is a multidimensional phenomenon with various manifestations, including lack of income and productive resources sufficient to ensure sustainable livelihood, hunger, malnutrition, ill-health, and limited or lack of access to education and other basic services, characterised by a lack of participation in decision making and civil, social and cultural life (Anger, 2010:138). Adolescent girls in
this study alluded that they lacked the power of decision making in the prevention of unplanned pregnancy due to poverty, they therefore relied on decisions made by their sexual partners.

This is a quote from a 20-year-old participant:

“I was staying with the father of my first child who was taking care of both of us at home because there was no other way as my mother died and my father does not care about me. The other important thing which I think make me fall pregnant is poverty because when I tell my boyfriend to use the condom and he refuses there is nothing I can do about it because he will tell me that I am having sex with other men and who will support me?” [Participant N]

A 21-year-old participant had this to say:

“My boyfriend controls me on issues of sex and condom use. When I tell him about condom use he sometimes threatens to beat me up, so I am afraid of him and so I agrees with everything he tells me. I am afraid that he also will leave me like the father of my first child did and who will take care of us?” [Participant I]

The study conducted by Macleod and Tracey (2010:25) on consequences and contributory factors of teenage pregnancy corroborates that poverty is a factor influencing adolescent decision making in the prevention of unplanned pregnancy, indicating that poverty is related to a weak parent-child relationship, which in turn is related to vulnerable personalities and behaviour attributes, usually ending in unplanned adolescent pregnancy.

In support of adolescent poverty in this study, Were (2007:322) indicates that overall lack of access to education, sex education and information regarding contraceptives, as well as widespread poverty, predispose girls to teenage pregnancy. In support, the National Campaign to prevent Teen and Unplanned Pregnancy (2010:1) indicate that poverty is a cause and consequence of early unplanned pregnancy.
Many disadvantages of poverty, such as lack of education, lack of information, insecurities and poor access to services, have been documented by Chambers (2006:3) in support of the findings of this study on poverty. The recommendations of the programme (Chambers, 2006:3) suggest that policies and strategies to eradicate poverty require not only economic growth and redistribution but also direct intervention in many areas such as expanding education and removing discrimination and social injustices. The South African government, in an effort to reduce poverty by half by 2015 in line with its commitments to the Millennium Development Goals (MDGs) through the Social Assistance Amendment Act (2010), gives effect to social security grants that directly benefit children, who include adolescent girls. The Act also deals with matters pertaining to cash grants e.g. disability grants, foster care grants and care dependency grants, all of which affect children and the youth who are eligible for obtaining it. Children also have a right to social security, hence the provision of cash grants. South Africa has developed poverty alleviation/reduction strategies in line with the Social Assistance Amendment Act (2010).

The following poverty alleviation is available for South African citizens who meet the criteria according to the Social Assistance Amendment Act (2010):

_Aged persons grant:_ An amount of R1 140 paid to women over 60 years and men over 65 years who are South African citizens and qualify for such a grant.

_Child support grants:_ The amount of R280 paid to the primary care-giver of the child.

_Foster care grant:_ An amount of R1 140 paid to the foster parents. These amounts are reviewed annually.

_Enabling the poor to access basic education:_ To enable poor adults to send their children to school the South African government has, in their commitment to provide free and compulsory education for ten years, designed its education policy in such a way that school fees are decided upon on at annual School Governing Body (SGB) meetings. At the SGB meetings, parents vote for the amount to be paid for school fees.
Parents who cannot afford these fees, or can afford a lesser amount, are granted an exemption or a reduction in fees (South African Schools Act, 1996).

_School nutrition programme_: The school nutrition programme was initiated for young primary school children who are food-deprived to enable them to participate fully in their educational development and achievement.

_Social relief of distress programme_: A temporary provision for families who are in such dire material need that they are unable to provide for their or their families’ most basic needs. This social relief is provided for a period of three months. However, it can be extended for a further three months in special circumstances.

_Special programme for food security_: Provincial social development departments in collaboration with development agencies and other social relief organisations provide food parcels to the most vulnerable and needy households in the community.

_Providing adequate shelter for the poor_: Providing adequate shelter in South Africa lies with the Department of Housing. The mechanism for achieving this has been the Housing Subsidy Scheme that was started in 1994. The Government Capital Housing Subsidy is available to South African citizens who are over twenty-one years old, married or living with long-term partners, have dependants, and have not owned property before, whose income is below R3 500 per month (Mhlanga, 2012:1)

_Unemployment insurance fund (UIF):_ The UIF strives to contribute to the alleviation of poverty in South Africa through provision of short-term income relief when they become unable to work due to illness, maternity leave or adoption of a small child. This fund also provides relief to dependants of deceased contributors (Department of Labour, 2012:1)

**3.4.2.2 Category 2: Substance abuse**

The use of alcohol during partying was alluded to by adolescent participants as another contributory factor to the occurrence of unplanned pregnancy. According to the Department of Health (2012a:9), substances of abuse mean chemical, psychoactive substances such as alcohol, tobacco, over-the-counter drugs and prescription drugs or
substances. Substance abuse means the sustained or sporadic excessive use of substances of abuse.

Adolescent girls who participated in the study alluded to using substances, especially alcohol and inappropriately or inconsistently using pregnancy prevention methods, and therefore ending up having unprotected sex.

A quote from a 17-year-old participant:

“We were at the party and my boyfriend decided that we must have sex after the party. I agreed because I knew him before the party. We decided to have fun after party by having sex and then the condom burst as we were having sex.” [Participant C]

A 21-year-old participant had this to say:

“One time I and my partner went out partying with his friends, we had alcoholic drinks, and we relaxed and had a nice time. When we came back my boyfriend and I decided to have sex without a condom, but before we had sex I told him about the condom and he refused, I took it was because he was drunk.” [Participant I]

In their study on adolescent pregnancy desire and pregnancy incidence, Sipsma et al. (2011:112) align themselves with the findings of this study about substance abuse and unplanned adolescent pregnancies by stating that participants reported alcohol and drug use.

The study conducted by the Annie E Casey Foundation (2009:6) supports the findings of this study on substance abuse, indicating that substance abuse is a key concern as teens who drink or use drugs are more likely to have sex, to begin having sex at a younger age, to have more sexual partners and to have unplanned pregnancies. Feldstein and Miller (2006:634) in support indicate that, although substance-related problems naturally remit for most adolescents, beginning regular or binge drinking at a younger age, drinking larger amounts per occasion and progressively escalating their alcohol use appear to increase adult dependence. The same authors further contend that substance abuse during adolescence is normative and is associated with sexual
experimentation which occurs while drinking alcohol, leading to adverse sexual consequences including unplanned pregnancy.

3.4.3 Theme 3: The existing sources of information for adolescent decision making about pregnancy prevention

Sources of information were described by adolescent girls as important for knowledge about contraceptives and pregnancy prevention. The sources of information about decision making in the prevention of unplanned pregnancy in this study are summarised in Table 3.11.

**Table 3.11: The existing sources of information about pregnancy prevention**

<table>
<thead>
<tr>
<th>THEMES</th>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.3 The existing sources of information for decision making about pregnancy prevention in adolescent girls</td>
<td>3.4.3.1 Formal sources of information</td>
<td><em>The school</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>The clinic</em></td>
</tr>
<tr>
<td></td>
<td>3.4.3.2 Informal sources of information</td>
<td><em>Family</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Friends, peers</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>The community</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>The media</em></td>
</tr>
</tbody>
</table>

Participants in this study expressed the use of a variety of sources to get information for decision making about pregnancy prevention. Two categories of information sources emerged from data analysis: **formal** and **informal sources** of information about pregnancy prevention. The formal sources of information in this study were regarded as the school and clinic. Family, friends, peers, the community and the media were regarded by adolescent girls as informal sources of information on the prevention of unplanned pregnancies.

3.4.3.1 Category 1: Formal sources of information

The adolescent girls indicated using the **school** and **clinic** as the formal sources where they got information on the different methods for decision making on pregnancy prevention. Table 3.12 reflects the category of formal sources of information for
adolescent girls’ decision making on pregnancy prevention and sub-categories summarised as described by participants.

Table 3.12: Formal sources of information

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.3.1 Formal sources of information</td>
<td>• The school</td>
</tr>
<tr>
<td></td>
<td>• The clinic</td>
</tr>
</tbody>
</table>

- The school

The school was said to be the main source of information about pregnancy prevention during adolescence, during life orientation (LO) and natural science lessons. The school health nurses who sometimes visit the schools for health promotion and health assessment and the social workers looking after orphans at school were also said to be sources of information about pregnancy prevention. Participants also indicated that the school also provided learners with extra-curricular reading materials such as pamphlets and brochures with information about pregnancy prevention.

This is a quote from a 15-year-old participant about the school as a formal source of information about pregnancy prevention:

“At school sometimes they bring people to come and tell us about HIV and teenage pregnancy and the social workers sometimes come to school to come and check on the orphans at school. Even people from the clinic do come to school and talk to us. Teachers also teach us during the Life Orientation (LO) and Natural Science period.”

[Participant K]

This was the testimony from a 21-year-old participant:

“At school during the Life orientation periods, we were taught. At school it was taught in the lower grades I think Grade 7 but I still remember vividly the information.”

[Participant D]

An 18-year-old participant said:
“I got all the information at school. Teachers used to give us pamphlets sometimes to read. It was the lower grades so sometimes we did not understand. We were afraid to ask as the colleagues would say you sleep around if you ask many questions.”

[Participant J]

Sexual education refers to a planned process of education that fosters the acquisition of factual information, formation of positive attitudes, beliefs and values, as well as the development of skills to cope with the biological, psychological, socio-cultural and spiritual aspects of human sexuality (Iyoke, Onah & Onwasigwe, 2006:82). While sexual education has been part of the curriculum in the US in public schools for many years (Darroch, Landry & Singh, 2000:205), in Italy, sex education was not officially in the schools’ curricula until the year 2000 although many drafts laws had been submitted and supported by Parliament (Donati, Medda, Spinelli & Grandolfo, 2000:303).

The curriculum of the LO learning area in the South African Basic Education Curriculum of 2005 (Prinsloo, 2007) forms an excellent basis for equipping learners to respond positively to social demands, assume responsibility and optimise their life chances, and teaches learners, among other things, about sexual education and sexually transmitted infections, which include HIV and Aids. LO is central to the holistic development of learners and addresses skills, knowledge and values regarding the personal, social, intellectual, emotional and physical growth of learners. The focus of the study of LO is on the foundation phase (grades 4, 5 and 6) and the senior phase (grades 7, 8, 9, 10, 11 and 12). LO in the South African curriculum contains the following five topics: development of the self in society, social and environmental responsibility, constitutional rights and responsibilities, physical education, and the world of work (Department of Basic Education, 2012:6).

According to Anasi and Nwalo (2012:19), the school can be a hub for the provision of accurate and appropriate reproductive health information. The study indicates that adolescents who have received sexual education in school have more accurate information than the other students. School-based reproductive health information provision is important for girls for whom school constitutes the major source of
information. School libraries are a means of not only obtaining access to required information but also providing the users with independent access to all kinds of information. Libraries are also open to the general community and generally safe; therefore, they constitute a major source of information for decision making in pregnancy prevention if appropriately used (Anasi & Nwalo, 2012:19).

The study conducted by Biddlecom, Hessburg, Singh, Bankole and Darabi (2007:38) support the school as a source of information by stating that school is an effective place to offer adolescents sexual and reproductive health-related information and skills. The study further indicates that some of the reasons for the school’s excellence as an information source are that the school provides an excellent forum for reaching a large number of adolescents in a structured setting. The daily, ongoing format of classroom instruction provides an opportunity for adolescents to practice skills, raise questions and concerns, and obtain comprehensive education on sexual and reproductive health issues over an extended period of time (Biddlecom et al., 2007:24). In South Africa, the study by Ehlers (2010:21) concurs with the findings of this study on sources of information about adolescent pregnancy prevention, where teachers were ranked first, followed by friends, and nurses and doctors were ranked last.

- **The clinic**

Participants who used the clinic as a source of information indicated starting to use the clinic as a source of information for pregnancy prevention after they had their first baby. The information was received during the visit to the clinic for immunisations of their babies.

A 21-year-old participant had this to say:

“At the clinic they used to tell us about prevention. I started going to the clinic after I had my child.” [Participant H]
Chapter 3
Findings and literature control

A quote from a 20-year-old participant:

“Information about family planning was given at the clinic but that was only after I had a baby.” [Participant A]

Health care professionals in public health clinics have a profound impact on adolescent girls’ sexual health and decision making about pregnancy prevention. When quality health care services are provided by skilled professionals without judgement and with respect for confidentiality, adolescent girls are more likely to use the services. Services which are convenient in respect of opening times, not involving long queues and are offered free of charge are more likely to attract adolescent girls (Panday, Makiwane, Ranchod & Letsoalo, 2009:68).

WHO (2009:8) contends that adolescents are, however, often unable to obtain the health services they need. In many places, health services, such as emergency contraception, are not available to anyone – neither to adolescent girls nor to adults. In other places, where these health services are available, adolescents may be unable to use them because of restrictive laws and policies, e.g. laws that forbid the provision of contraceptives to unmarried adolescent girls (WHO, 2009:8). However, Mahery et al. (2010:27) indicate that, in South Africa, contraceptives may be provided to a child on request from the child and without the consent of the parent or guardian of the child if the child is at least 12 years of age. Common reasons for adolescent girls not using reproductive health services for contraceptive counselling as asserted by WHO (2009:8) and confirmed by adolescent girls in this study include fear that health workers will ask them difficult questions or scold them; or that health workers will not maintain confidentiality.

Strengthening the health care system to better serve adolescents has great potential to increase adolescent utilisation of health care services (Biddlecom et al., 2007:29) and enhance emancipated decision making in preventing unplanned pregnancies.
3.4.3.2 Category 2: Informal sources of information

Adolescent participants described informal sources of information as having helped them to get information and knowledge about sex, contraceptives and pregnancy prevention for decision making. Table 3.13 indicates the category informal sources of information for adolescent girls’ decision making in unplanned pregnancy prevention.

**Table 3.13: Informal sources of information**

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.3.2 Informal sources of information</td>
<td>• Family (mother, sister, aunt)</td>
</tr>
<tr>
<td></td>
<td>• Friends, peers and sexual partners</td>
</tr>
<tr>
<td></td>
<td>• The community</td>
</tr>
<tr>
<td></td>
<td>• The media</td>
</tr>
</tbody>
</table>

The informal sources of information emerged as the family (mother, sister, aunt), the community, friends, peers, sexual partners and the media who would discuss sex issues, pregnancy and pregnancy prevention on an informal basis.

- **The family**

Within the family, the mother was the least used as an information source about pregnancy prevention. Other family members used for information were sisters and aunts.

This is a quote from a 15-year-old participant:

“At home my mother usually tells us that we must be careful and not have sex, even if we have male friends we should not have sex. They do not talk about preventing pregnancy.” [Participant K]

A 21-year-old had this to say:

“My sister used to advise me that if I have a boyfriend I must go to the clinic otherwise I will fall pregnant but I did not take her serious that is why I fell pregnant. She started advising me again seriously after I had my first child.” [Participant E]
In their study on a parent-adolescent relationship programme, Lederman and Mian (2003:34) in support of the findings on the family as a source of information contend that family involvement, family structure, parental values, parental monitoring and parent-child communication are important factors influencing critical life choices and are a crucial part of teen pregnancy prevention. The capacity of families to nurture adolescent girls and help them set goals for their lives may contribute to decision making about pregnancy prevention and lower rates of adolescent pregnancies (Lederman & Mian, 2003:34).

In support, Pedlow and Carey (2004:176) assert that parents continue to be important and that parent-adolescent discussions about sex can protect adolescents from other influences that might encourage risky sex. Their study further indicates that adolescents who talk with their parents about sex are also more likely to discuss sexual risks with their partners. Parents play an important role in shaping the sexual and reproductive health behaviour of their adolescent girls by keeping abreast of where the adolescents are and what they are doing, advising them, providing them with money for health care and talking with them about sex-related matters. A number of studies in Sub-Saharan Africa have found that adolescents who live with a parent or talk with a parent about sex-related matters have a lower likelihood of being sexually active at an early age because they delay first sex (Biddlecom et al., 2007:37).

In support of the findings, Lebese et al. (2010:34) assert that encouraging parent-teen communication and assisting parents in monitoring adolescent girls' behaviour may be especially important for decision-making to prevent unplanned pregnancy. Parents act as role models for their adolescent girls; therefore, there is a need for them to positively influence their daughters to make sexual choices to prevent unplanned pregnancies. Parents’ and guardians’ acceptance and support of adolescent girls are crucial to the success of adolescent pregnancy prevention programmes (Lebese et al., 2010:34).
• **Friends, peers and sexual partners**

Friends, peers and sexual partners were also regarded as informal sources of information, as alluded to by participants in the study for decision making about the prevention of unplanned pregnancies.

A quote from an 18-year-old participant:

“I got the information from my friends about pregnancy prevention. Sex nobody told me about it because I do not have parents so I experienced it myself when I started dating.”  
*Participant N*

In support of these findings, Panday et al. (2009:29) contend that studies have shown that adolescents are more likely to have sex when they believe that their friends are having sex. Evidence from the study by Pedlow and Carey (2004:176) proves that peers influence adolescents’ attitudes, values and sexual risk behaviour. Peers who engage in risky sexual behaviour are associated with initiating sexual intercourse and other risky behaviours such as early alcohol and substance use (Pedlow & Carey, 2004:176). Their study further indicates that deciding to postpone sexual activity is also influenced by peers.

Panday et al. (2009:29) further argue that gender power inequalities play a significant role in adolescent girls’ decision making, vulnerability to unprotected sex and unplanned pregnancies. Pressure from sexual partners and changing sexual partners increase the risk of early pregnancy as indicated by Jones (2010:91) in the study titled “Pregnant adolescents identify drivers for sexual risk-taking”.

• **The community**

Although the community is not a preferred method of information source about pregnancy prevention, adolescent girls in the sampled group indicated getting information about pregnancy prevention from the community.

This is a quote from a 15-year-old participant:
“I got information from people in the community talking that women fall pregnant and they must go to the clinic to get prevention methods.” [Participant K]

Biddlecom et al. (2007:38) align themselves with these findings on the community as a source of information, indicating that the community supports adolescent girls and their families in decision making about the prevention of unplanned pregnancies. The environment that children grow up in has an important influence on their risk of adolescent pregnancy. Traditionally, grandparents, other family members, community leaders and other adults have played a role in talking about sex-related matters with the younger generation. Although this is no longer the case, adults can still help to address the sexual and reproductive health needs of adolescent girls by promoting community support for relevant pregnancy prevention programmes (Biddlecom et al., 2007:38).

Social disorganisation, high levels of disadvantage and poor achievement of a community increase the likelihood of adolescent girls engaging in sex earlier and having unplanned pregnancies, as corroborated by Panday et al. (2009:67). The same authors further indicate that the socio-economic conditions of individuals and communities have to be addressed in an effort to enhance emancipated decision making to prevent unplanned pregnancies in adolescent girls.

- The media

The media was also regarded as a source of information for decision making about unplanned pregnancy prevention by the sampled group of adolescent girls in this study.

The following is a quote from a 17-year-old participant:

“I knew about pregnancy and prevention, I got the information from the pamphlets, from books and magazines by reading and I also watch TV when they talk about sex stuff.” [Participant C]

In support of these findings, Bankole, Biddlecom, Guiella, Singh and Zulu (2007:34) indicate that adolescents are the key target of the media for reproductive health information on pregnancy prevention. According to Biddlecom et al. (2007:37), mass
media (radio, television and newspapers) are among adolescents’ most preferred and commonly used sources of information for sexual and reproductive health. Reasons why the radio, in particular, is one of their preferred sources of information are that radio is a reliable source, it reaches a wide audience, it gets information to young people quickly, listeners do not need to go somewhere for the information, and parents can listen to it and teach their children what they learn (Biddlecom et al., 2007:37).

Donahue, Haskins and Nightingale (2008:1), however, express concern about the extent of the influence of mass media use on decision making about pregnancy prevention by adolescents. Their study indicates that adolescents’ mass media use has exploded; parents are worried that teens are drowning in messages about sex, drinking of alcohol and a host of other behaviour and products that threaten their health and wellbeing. Jewkes and Christofides (2008:9) support the media as a source of information, stressing that access to information is crucial for teenagers who want to prevent pregnancy. The study indicates that, while concerns that providing information will ‘encourage’ teenagers feature prominently in discourse around teenage sexuality, international experience over several decades has shown that the country in Europe with the most extensive and open approach to sexual education, the Netherlands, has the best record in terms of teenage pregnancy.

3.5 CONCLUSION

The findings of the study in this chapter indicated the factors which influence the occurrence of unplanned pregnancies in adolescent girls and the existing sources of information about pregnancy prevention. Themes, emancipated decision making factors, socio-economic factors and the existing sources of information about pregnancy prevention and categories which emerged during data analysis were discussed. Based on the findings of the study, the requirements for construction of a programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making can be summarised as the need for:

- Empowerment
- Personal knowledge
• Flexible environment
• Reflection
• Awareness of social norms by adolescent girls to be able to make
• Emancipated decisions in the prevention of unplanned pregnancies.

These core concepts, which form the framework for the programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decisions are analysed for their finer descriptive meanings in Chapter 5, which is phase two of programme construction.

In Chapter 4, models and theories used in decision making for the prevention of unplanned pregnancies in adolescent girls are discussed.
CHAPTER 4
MODELS AND THEORIES USED IN DECISION MAKING FOR THE PREVENTION OF UNPLANNED PREGNANCIES IN ADOLESCENT GIRLS

4.1 INTRODUCTION

In Chapter 3, the findings of the study were discussed. The literature control provided a framework as well as a benchmark for comparing and contrasting the findings (themes and categories) of this study with findings of other studies which dealt with similar problems. In this chapter, theories and models applicable to adolescent decision making about the prevention of unplanned pregnancies are discussed. The chapter addresses objective four of the study, which is to describe applicable models and theories for decision making in the prevention of unplanned pregnancies in adolescent girls and is part of phase one of the study, namely, situational analysis.

The purpose of the study was to construct a programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making. Both the findings of the study and models and theories used in decision making for the prevention of unplanned pregnancies in adolescent girls were used as building blocks for the programme construction in this study.

4.2 DESCRIPTION OF THEORIES AND MODELS

There are many theories and models applicable to adolescent decision making in the prevention of unplanned pregnancies. Chinn and Kramer (2011:257) view a theory as a creative and rigorous structuring of ideas that projects a tentative, purposeful and systematic view of phenomena. A theory is made up of a collection of ideas called concepts. Alligood (2010:520) describes a theory as a set of statements that tentatively describes, explains or predicts relationships among concepts that have been systematically selected and organised as abstract representations of some phenomena. These systematic organised perspectives serve as guides for nursing action. Walker and Avant (2011:61) support this view of a theory, describing a theory as an internally consistent group of relational statements that presents a systematic view of
phenomena, which is useful for description, explanation and/or control. By virtue of its predictive and prescriptive potential, the theory is regarded by Walker and Avant (2011:61) as the primary means of meeting the goals of the nursing profession concerned with a clearly defined body of knowledge, a vital component in human decision making process.

According to Chinn and Kramer (2011:156), a model refers to a symbolic presentation of empirical experience in the form of numbers, letters or graphic diagrams. Models provide a sense of understanding regarding the development of theoretical relationships. Models are also useful in illustrating various forms of theoretical relationships, can be presented as a theory, or can be constructed to show links between related theories.

The use of theories and models in adolescent girls' decision making for pregnancy prevention in this study is in line with Brindis, Sattley and Mamo’s (2005:16) assertion that no one theory can provide the ‘best’ solution for designing, delivering, and/or evaluating effective adolescent pregnancy prevention programmes. Adolescent pregnancy prevention programmes often and appropriately rely on several theoretical assumptions (Brindis et al., 2005:16).

4.3 THEORIES AND MODELS APPLIED IN THE STUDY

For the purpose of this study, construction of a programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making, the following theories and models are discussed:

- Wittmann-Price Theory of Emancipated Decision Making in women’s health issues
- Dual process models
- Developmental theories
- The ecological systems model


4.3.1 The Wittmann-Price Theory of Emancipated Decision Making in women’s health issues

The Wittmann-Price Theory, which has its theoretical basis guided by critical social theory and feminist theory (Wittmann-Price, 2004:437), forms the basis for this study. Critical elements of the Wittmann-Price Theory that form the basis for emancipation in decision making are: personal knowledge, empowerment, awareness of social norms, flexible environment and reflection (Wittmann-Price, 2004, 2006; Wittmann-Price & Bhattacharya, 2008). These concepts are used as the framework for the programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making in this study.

For women (adolescent girls) to reach a state of emancipated decision making, Wittmann-Price and Bhattacharya (2008:225) propose that the five sub-concepts of the theory, namely, personal knowledge, empowerment, flexible environment, awareness of social norms and reflection, need to be present.

Adolescent girls need to have personal knowledge, which is a combination of explicit knowledge and tacit knowledge (Reinders, 2010:28; Siefring, 2012:4). Explicit knowledge is information well-stored, and well-documented knowledge of the facts and information about unplanned pregnancy prevention in this study. Tacit knowledge, on the other hand, is regarded as experiential knowledge which cannot be directly observed, but must be inferred from observing performance or behaviour (Hunt, 2003:100) of adolescent girls. Such personal knowledge will enable adolescent girls to conceptualise goals, to anticipate and perceive events, and to respond in accordance with changing individual and environmental needs (Hunt, 2003:101) when making decisions.

Empowerment is regarded as a component of the process of emancipation but it alone cannot ensure freedom of choice without the presence of other components of emancipation (the five sub-concepts of the theory) (Mooney, 2013:4). Empowerment occurs between two or more people (Wittmann-Price, 2004:441), that is, adolescent girls who are empowered and professionals who make it possible for or enable
adolescent girls to become capable of setting and reaching goals within a flexible environment.

A **flexible environment**, which is a psychosocial non-judgemental environment, based on openness, shared vision, and willingness to change (WHO, 2012:39) is needed for adolescent girls in decision making. Adolescent girls have to make use of their personal knowledge and empowerment within a flexible environment (Wittmann-Price & Bhattacharya, 2008:226) to make decisions in preventing unplanned pregnancies.

**Awareness of social norms** indicates awareness by adolescent girls that behaviour is the outcome of institutional structures and development which occurs in a social context. It is awareness by adolescent girls that **social norms** are inevitable and allows them to appraise those norms appropriately in relation to personal knowledge through reflection within a flexible environment (Wittmann-Price, 2004:442).

**Reflection** is regarded as a cognitive and interactive process (MOSEP, 2009:1) in which adolescent girls consciously engage when considering alternatives in decision making. Adolescent girls have to engage in reflection on action (generalised descriptions and evaluations of events that occurred and decisions made) as well as reflection in action (tied to the context in which an event occurs) (MOSEP, 2009:1; Wittmann-Price, 2004:441) when making decisions about the prevention of unplanned pregnancies.

**Emancipated decision making** is described as the process through which adolescent girls reach a more positive state of being, a state of freedom in choice, by first acknowledging the effective experience of oppression (Wittmann-Price, 2006:378). Adolescent girls will be able to reach a state of making emancipated decisions in the prevention of unplanned pregnancies through the use of personal knowledge, empowerment, reflection and awareness of social norms in a flexible environment.

Models identified as applicable to adolescent girls’ decision making in pregnancy prevention in this study are discussed next.
4.3.2 Dual-process models

Halpern-Felsher (2009:3) identifies dual-process models which incorporate the normative models commonly used in decision making. Dual-process models used to address social, emotional and reactive process are most often used by adolescents in decision making (Halpern-Felsher, 2009:3). Research indicates that people are not risk-neutral; they interpret and respond to potential losses and gains differently (Wolff, 2012:12). People do not always make decisions normatively but tend to violate assumptions of rationality by making different choices. Choices made by individuals depend on whether the problem is worded in terms of gain or losses. Another explanation for decision making was thus necessary to explain decision making other than the normative process. Dual-process models were developed as an alternative to normative models of decision making (Wolff, 2012:12).

The basic tenet of dual-process models is that there are two processes of decision making, namely, the deliberate/analytical process and the intuitive/experiential process (Halpern-Felsher, 2009:4; Wolff, 2012:12).

The deliberate/analytical process: This path uses normative processes of decision making which involve slower, more effortful, analytical, rational processing in decision making. In this path, decision making includes deliberate, cognitive processing such as consideration of consequences and perceptions of risks and benefits, attitudes about the behaviour and related outcomes. This path also considers social norms such as what one believes others expects them to do. For this system to be activated, an individual needs to be motivated and have a feeling that the decision is important and deserves one’s attention (Halpern-Felsher, 2009:4; Wolff, 2012:12).

Other criteria included in the deliberate/analytical process path are factors such as:

- The willingness to make a decision;
- The capacity to make an autonomous decision;
- Searching for, recognising and incorporating new information relevant to the decision;
The ability to judge the value of advice from other sources;
The ability to implement and carry out one’s decisions;
The ability to evaluate and learn from one’s decisions;
The ability to reach decisions with which one is satisfied;
The ability to make decisions that are consistent with one’s goals (Halpern-Felsher, 2009:4).

This path of decision making is less likely to be used by adolescents (Halpern-Felsher, 2009:4). This would imply the willingness and capacity of adolescent girls to make autonomous decisions, which are compromised by social norms and their stage of development. Adolescent girls’ personal knowledge about the prevention of unplanned pregnancies (Chapter 3) indicate that they still have to search for, recognise and incorporate new, relevant information. They need to be able to judge the value of advice from other sources and implement their decisions when engaging in sex to prevent unplanned pregnancies. In making decisions, adolescent girls have to reach decisions that satisfy them, that is, decisions which are consistent with their goals.

The intuitive/experiential process represents the less planned and more experience-based, reactive, and affective path often employed by adolescents. This process operates in the periphery of awareness and is typically fast, automatic, effortless, sometimes emotionally charged and highly contextualised. The intuitive/experiential process includes descriptive social norms such as personal perception and misperceptions about the extent to which peers and other important groups are engaging in behaviour (Halpern-Felsher, 2009:4; Wolff, 2012:12). The intuitive/experiential path also includes variations in adolescents’ psychosocial maturity to make decisions, including:

- Acknowledgement that adolescents’ decisions are often impulsive rather than planned;
- The ability to recognise and acknowledge when advice is needed;
- Social perspective taking, or the ability to recognise that other people may have a different point of view or set of knowledge from one’s own;
• Future perspective taking or the ability to project into the future, to consider possible outcomes associated with various choices, and to plan for the future (Halpern-Felsher, 2009:4; Wolff, 2012:12).

Adolescence is a time when important decisions are made which may have lifelong consequences. Nevertheless, adolescents may lack the psychosocial trait (Halpern-Felsher, 2009:4; Scott, 2012:8) and cognitive maturity (Piaget in McLeod, 2012:1) required to consistently make and act upon mature decisions. It is therefore important to determine interventions to enhance emancipated decision making abilities (Halpern-Felsher, 2009:4; McLeod, 2012:1; Scott, 2012:8) in adolescent girls which may lead to positive outcomes in their lives. The stance of enhancing emancipated decision making in adolescent girls is shared by the purpose of this study, which is to construct a programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.

Most adolescent (girls’) sexual decisions are experience-based, reactive, and context-based (Halpern-Felsher, 2009:4), resulting in unplanned pregnancies. It is at this stage of adolescence that the role of the family, friends, the community and health care professionals become important to protect and guide adolescent girls in decision making for the prevention of unplanned pregnancies (Halpern-Felsher, 2009:4; Wittmann-Price & Bhattacharya, 2008:225). These categories of individuals also emerged in the collected data of this study as sources of information in adolescent girls’ decision making.

The developmental theories also identified as applicable in adolescent girls decision making are discussed next.

4.3.3 Developmental theories

Developmental theories add insight into decision making in adolescent girls. Piaget (Shaffer & Kipp, 2010:55) proposes four major stages of cognitive development: the sensorimotor stage (birth to age 2), the preoperational stage (ages 2 to 7), the concrete-operational stage (ages 7 to 11-12) and the formal-operational stage (ages 11 to 12 and
According to Piaget’s cognitive-developmental theory (Fantasia, 2008:85), adolescence is marked by transition of thinking in which the individual moves from the stage of concrete cognition of late childhood, to the formal operational thinking of adulthood. It is during the period of formal operation that adolescents develop the ability to think abstractly and theoretically, draw conclusions from available information, predict possible outcomes and understand more abstract concepts such as love and values. The advance in cognition implicit in this model (the cognitive-developmental model) enables the individual to act in a more thoughtful, mature manner and be able to make own decisions (Fantasia, 2008:85; Shaffer & Kipp, 2010:55).

Piaget (Fantasia, 2008:85) admits that adolescents may not be able to reason as adults until the age of fifteen, and may never fully operationalise all components of thinking in decision making; therefore, many adolescents continue to utilise a more concrete process throughout their lives (Fantasia, 2008:85). Parents have been utilised for concrete maturity for children and adolescents’ cognitive abilities. Adolescents, however, need guidance and support to make decisions with which they are satisfied.

According to Slater and Bremner (2003:401), adolescents’ ability to become autonomous and fully operational appears to be related to the kind of family environment that was present in their home. Some parents are demanding while offering less support to adolescents, while other parents are responsive to adolescents’ needs. Relationships with responsive and supportive family were viewed by Slowinski (2001:7) as significant in adolescents’ decision making. According to Slowinski (2001:7), lack of attentive and nurturing parents is linked to early sexual activity while a stable family environment is associated with delay in initiation of sexual intercourse, both of which are significant in adolescent pregnancy prevention. Parents play an important role as in a formal operational process for influencing adolescents’ decision making (Piaget in McLeod, 2012:1), can thus be applied to the use of contraceptives to prevent unplanned pregnancies.
Piaget’s assertion that adolescents’ inability to reason as adults until the age of fifteen (Fantasia, 2008:85) concurs with section 35 of the Sexual Offences Act (2007). The Act states that children only from the age of sixteen are regarded as capable of consenting to sex, which makes them capable of making their own sexual decisions. However, the act states that children can make their own decisions about contraceptive use from the age of twelve (Mahery, Jamieson & Scott, 2011:20).

Decision making ability is an essential aspect of optimal adolescent development. Cognitive skill attainment alone does not guarantee that adolescents will transfer such skills to real-life situations. Decision making skills are also dependent on factors such as age, gender, intelligence, social class, family structure and dynamics, religiosity and socio-cultural environment (Scott, 2012:8). Such demographic factors were taken into consideration in this study.

Freud’s psychosexual theory of development proposes that the three components of personality, namely, the id, ego and superego, develop gradually and become integrated in a series of five developmental psychosexual stages, namely, the oral stage, the anal stage, the phallic stage, latency and genital stage (Shaffer & Kipp, 2010:45). During the phallic stage (3-6 years), pleasure is described as derived from genital stimulation where children are described as developing an incestuous desire for opposite sex parent – called the Oedipus complex (Shaffer & Kipp, 2010:45). The oedipal phase re-appears during adolescence during the phases of identity versus role confusion and intimacy versus isolation when adolescents develop true feelings for the opposite sex (Erikson, cited in Fleming, 2004:11). Freud (Slater & Bremner, 2003:399) describes adolescence as a time of ‘libidinal invasion’ which is attributed to the fact that, as libidinal forces surge, instinctual pulls become stronger and the integrity of the ego is threatened – a disharmony between the adolescent and developmental lines which can make adolescence a time of opposition and paradox. The disharmony which occurs during this phase of development may have consequences for adolescent decision making about preventing unplanned pregnancies.
Critique of the Freud’s theory by feminist scholars is that the theory is sexist and based on the biases of male-dominated culture. According to the feminist critiques, the Oedipal and Electra complexes posit children’s sexual fantasies as a cover-up for rampant incest and child abuse. Freudan theorists are seen by feminists critics as tending to ignore women’s experience (Crandell, Crandell & Vander Zanden, 2009:38).

In contrast to Freud’s theory, Erikson places less emphasis on sexual urges and more emphasis on social and cultural influences. Freud’s theory is labelled as psychosexual and Erikson’s theory as psychosocial (Shaffer & Kipp, 2010:45). Erikson’s theory partitions the life span into eight stages, each of which brings a psychosocial crisis involving transitions in important social relationships (Weiten, Lloyd, Dunn & Hammer, 2009:341). Erikson believes that the crises of the ego present challenges to one’s individual identity. Successful development of the personality (psychosocial development) depends on meeting and overcoming the crises (Fleming, 2004:4).

Adolescence and early adulthood are times when, according to Erikson (Weiten et al., 2009:341), a developing sense of identity is opposed by doubts about sexual and social roles in life (adolescence) and when the capacity for intimate relationships alternates with feelings of isolation (early adulthood). According to Erikson (Weiten et al., 2009:341), identity refers to having a relatively clear and stable sense of ‘who’ one is in the larger society. Developing identity involves wrestling with important issues such as ‘Who am I?’ and ‘What do I stand for?’ Gender, ethnicity and sexual orientation are also important aspects of identity development. Development of the individual identity achievement is important in determining feelings about self, personal beliefs and levels of achievement (Weiten et al., 2009:341), which are important developments for adolescent girls’ ability to make decisions.

To achieve independence, the basic task of adolescents according to Erikson (Fleming, 2004:12) is to separate themselves from parents, especially same-sex parents, and assume identity of their own. Adolescents thus rebel against parents and society (Freud’s oedipal conflicts returns), but the adolescents, who are no longer children, must display their sexual feelings toward the opposite-sex parent onto others: their
sexual partners. The rebellious feelings suggested by Freud (Fleming, 2004:12; Shaffer & Kipp, 2010:43) reawaken sexual urges and childhood fears of being unloved, rejected and inferior. Adolescents thus need support from their social network, which includes parents, peers, the community and the school, to develop into mature adults (Shaffer & Kipp, 2010:43) to be able to make rational emancipated decisions in preventing unplanned pregnancies.

The ecological systems model, also identified as applicable to adolescents’ decision making in the prevention of unplanned pregnancies, is discussed below.

**4.3.4 The ecological systems model**

The ecological systems model recognises the multiple spheres of influence on health behaviour within the families, communities and societies within which they are nested. Table 4.1 indicates the ecological model: levels of influence.

**Table 4.1: The ecological systems model**

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community level</strong></td>
<td></td>
</tr>
<tr>
<td>Intrapersonal factors</td>
<td>Individual characteristics such as knowledge, attitudes and beliefs about contraceptives and contraceptive use.</td>
</tr>
<tr>
<td>Interpersonal factors</td>
<td>Interpersonal processes and primary groups, including family, friends, sexual partners, that provide social identity, support and role definition.</td>
</tr>
<tr>
<td>Institutional/organisational/ community factors</td>
<td>The school, community norms, rules, regulations, media and informal structures which influence decision making in unplanned adolescent pregnancy prevention.</td>
</tr>
<tr>
<td><strong>National level</strong></td>
<td></td>
</tr>
<tr>
<td>Structural factors</td>
<td>Socio-economic conditions and the cultural context of the society that may either enable or serve as a barrier to healthy behaviour.</td>
</tr>
<tr>
<td>Public policies</td>
<td>Local and national laws that regulate or support healthy actions and practices for prevention</td>
</tr>
</tbody>
</table>

Source: Adapted from Winch (2012:3) and Panday et al. (2009:29)
Chapter 4
Models and theories

The ecological model recognises that behaviour takes place in a dynamic social context. Termed reciprocal causation, individuals, according to the ecological model, are not passive recipients of external influence but the social environment is as much shaped by individual behaviour as individual behaviour is shaped by the social environment (Panday et al., 2009:29; Winch, 2012).

The ecological systems model provides a useful way to organise factors associated with complex social problems such as adolescent decision making in pregnancy prevention. The model adopts a multi-level approach to account for the complex web of personal, social, economic and cultural forces that influence the life trajectory of adolescents and subsequent decision making in pregnancy prevention. The model considers levels of influence and the related factors in each level which have an influence in adolescent sexual behaviour and consequently influence decision making in unplanned pregnancy prevention (Panday et al., 2009:29; Winch, 2012). The community level and the national level are identified in this study as having an influence on adolescent girls’ decision making in the prevention of unplanned pregnancies.

The ecological systems model provides a useful way to organise factors associated with complex social problems such as adolescent pregnancy. The model adopts a multi-level approach to account for the complex web of personal, social, economic and cultural forces that influence the life trajectory of adolescents and subsequent adolescent pregnancy (Winch, 2012:3; Panday et al., 2009:29). In this study, data revealed a multi-factorial and multi-level influence of adolescent girls’ decision making about pregnancy prevention. The programme for enhancing adolescent girls’ pregnancy prevention through emancipated decision making in this study therefore considered the multilevel, multifactorial factors influencing decision making in adolescent girls about the prevention of unplanned pregnancies.

The ecological systems model considers levels of influence and the related factors in each level which have an influence in adolescent sexual behaviour and consequently influence decision making in unplanned pregnancy prevention (Panday et al., 2009:29). Two levels of influence for the programme for prevention of adolescent girls’ unplanned
pregnancies are considered: the macro/national level and the micro/community level (see Table 4.1)

- **The community level of influence**

  The community level represents the level where primary health care clinics, used by adolescent girls for pregnancy prevention methods, are situated. Direct influences such as intrapersonal/individual, interpersonal and institutional/organisational factors influencing adolescents’ decision making in unplanned pregnancy prevention at this level are discussed.

  *Intrapersonal/Individual factors:* Panday et al. (2009:29) contend that adolescents may have incomplete knowledge about the contraceptives and how to use them, as well as negative attitudes and beliefs about contraceptives which will influence their decisions on pregnancy prevention. Sexual experience, sexual partnership, sexual frequency, age, mixing of sexual partners (that is, having young and older sexual partners), as well as contraceptive use are other factors at intrapersonal level identified as influencing decision making in unplanned adolescent pregnancy in South Africa (Panday et al., 2009:29).

  In support of adolescents’ incomplete knowledge about contraceptives, Bankole et al. (2007:36) indicate in their study in Sub-Saharan countries, Malawi, Ghana, Uganda and Burkino Faso that, although awareness of condoms as a method of contraception is high across these countries, there is a large knowledge gap in the use of the male condom. Puri, Ingham and Matthews (2007:535) concur with the knowledge gap of adolescents, indicating that, despite knowledge of modern contraceptive methods, their use among young women aged between 15-19 years was regarded as slow in South Asian countries. Incorrect contraceptive use, cognitive deficits, and misunderstandings about the efficacy of natural methods by adolescents have been identified by Sheeder et al. (2009:295) as some factors influencing decision making in adolescent pregnancy prevention.
Interpersonal factors: On the interpersonal level, Panday et al. (2009:29) indicate that the adolescents’ partners may refuse to use contraceptives, labelling their use as trust issues, the peers may not believe that it is important to use contraceptives and parents may not have discussions with them about contraceptives due to restrictive social norms. As the key sources of sexual and reproductive health information for adolescents, friends and parents are regarded by Bankole et al. (2007:37) as having an influence on adolescent decision making about pregnancy prevention. WHO (2012:4) indicates that key factors in adolescents decision making about health seeking behaviour, including unplanned pregnancy prevention, are support of parents, friends and siblings.

Institutional/organisational factors: Panday et al. (2009:29) indicate that, at institutional level, adolescents’ decisions about pregnancy prevention may be influenced by difficulty in accessing contraceptives due to judgemental attitudes of health care professionals. According to the South African Human Rights Commission (2009:45), staff attitudes and beliefs towards various vulnerable groups (including adolescents) have been widely identified as a problem for the South African health care system which denies adolescents quality of care. WHO (2012:7) provides the quality care framework for adolescent decision making in preventing unplanned pregnancies and indicate that, to be considered adolescent friendly, health services, including the Primary Health Care clinics, should be accessible, acceptable, equitable, appropriate and effective.

In Argentina, decisions on sexual behaviour and pregnancy prevention in adolescents have been reported by Reina, Ciaravino, Llovera and Castelo-Branco (2010:479) as being influenced by insufficient sexual education, changes in the scale of values and difficulty in accessing health services. The school and mass media, identified by Bankole et al. (2007:37) as the most commonly used source of information in Sub-Saharan countries, have an influence on decision making about pregnancy prevention. Adaji et al. (2010:34) add information on the influence at the institutional level on adolescent decision making about pregnancy prevention, stating that prevalent societal norms limit young women’s (adolescent girls’) access to and use of contraceptives. The
study further indicates that such norms also emphasise sexual submissiveness and weaken young women’s (adolescent girls’) ability to negotiate the use of contraceptives.

- **The national level of influence**

At national level, the indirect influencing factors such as public policies and socio-economic conditions influencing adolescent girls’ decision making in the prevention of unplanned pregnancies are considered.

The South African Constitution (1996) as amended specifically recognises the right of access to health care. In line with the Constitution, the Patient’s Rights Charter (Health Professions Council of South Africa, 2008:1) further stresses the rights of access to health care, indicating that patients have the right to access and to participate in decision making within the health care services, including sexual and reproductive health services for pregnancy prevention.

In South Africa, poor policy implementation on adolescent-friendly and adolescent reproductive health services may affect adolescents’ ability to access contraception and contraception information (McCawley, 2013:4; Panday et al., 2009:29). Indirect policy benefits accrued through increased access to educational and economic opportunities for young people and the availability of social grants such as old age pension and the Child Support Grant in South Africa have enabled parents to keep their children at school (Panday et al., 2009:40).

Fletcher (2007:374) adds insight to the importance of public policies, indicating that the effect of public policies depends on the type of social effects present in the environment. Fletcher (2007:374) further proposes that public policies addressing issues such as teenage sexuality and unplanned pregnancies should involve parents, educators and policy makers to help teenagers in making decisions about sexuality and subsequent unplanned pregnancy prevention.

In South Africa, according to Panday et al. (2009:29), the conditions of adolescent girls may be that they may come from a poor socio-economic background where educational and financial aspirations are stunted and the only opportunity for upward mobility is
through relationships. These conditions negatively influence their decision making about pregnancy prevention. Harner (2005:20) reiterates the influence of poor socio-economic conditions on adolescent decision making about pregnancy prevention, arguing that, for some adolescent girls, relationships with older men may be viewed as more advantageous than relationship with male peers when daily needs such as food, shelter, clothing and money are not met by care givers. Adolescent girls may feel forced to seek out others to provide for these resources and adult men may be perceived by adolescent girls as better able to provide those resources (Harner, 2005:22). Substance abuse, which includes alcohol and drugs, is one of the factors within the socio-economic context identified by Siebold (2011:130) as having a negative influence on adolescent decision making in sexual and reproductive health which may lead to unplanned pregnancy.

Policies and legislation which are within the national level have an indirect influence on adolescent decision making as well as health care programmes.

4.4 CONCLUSION

In this chapter, theories and models applicable to adolescent decision making in the prevention of unplanned pregnancies were discussed. The influence and interrelationship of these theories and models is indicated through:

- **The dual process models** sheds light on the fact that decision making in adolescents does not always follow the normative processes. Therefore, dual process models, usually followed by adolescents in decision making about sexuality and pregnancy prevention, were developed as an alternative to normative models of decision making.
- **Developmental theories** indicate the value of adolescents’ cognitive and psychosocial development and maturity in decision making about pregnancy prevention.
- **The ecological systems model** recognises the multiple spheres of influence on health behaviour within the families, communities and societies. Decision making
in adolescents is regarded as influenced by the intrapersonal, interpersonal and institutional/community factors for preventing of unplanned pregnancies.

- The **Wittmann-Price Theory** of Emancipated Decision Making in women’s health on which the study is based has attributes of emancipated decision making, namely, **personal knowledge, empowerment, flexible environment, awareness of social norms and reflection**. These attributes are needed by adolescent girls to be able to make emancipated decisions in preventing unplanned pregnancies in this study. For adolescents to reach a stage of emancipation, characterised by the noted attributes consideration has to be taken of the developmental stage of adolescent girls, the environment where the decision is taken (ecological system’s models) and the process (dual process models) of decision making, commonly used by adolescents.

These theories are therefore important in programme construction for the prevention of unplanned pregnancy in this study. Phase one of the study, comprising of the findings of the study and theories and models, form the building blocks for the programme.

In the next chapter, which takes the study to the next level, phase two, key concepts are analysed.
CHAPTER 5
CONCEPT ANALYSIS

5.1 INTRODUCTION

In Chapter 4, models and theories applicable to unplanned adolescent pregnancy prevention were discussed. This chapter, which describes phase two of the study, focuses on identifying, defining and clarifying the main concepts of this study according to Walker and Avant (2011). The theoretical concepts of the Wittmann-Price theoretical framework (Wittmann-Price, 2004:440), upon which the study is based and which were identified in the findings are the main concepts. These concepts are personal knowledge, empowerment, awareness of social norms, flexible environment, reflection and emancipated decision making.

5.2 THE PROCEDURE OF CONCEPT ANALYSIS

According to Walker and Avant (2011:157), concept analysis is a strategy that allows the inquirer to examine the attributes and characteristics of a concept. It is an attempt to capture the critical elements of the chosen concepts in order to encourage communication and promote understanding. Conceptual meaning conveys thoughts, feelings, ideas, values and attitudes that reflect the human experience.

Walker and Avant (2011:159) modified and simplified Wilson’s (1963) classic concept analysis procedure to eight instead of eleven steps. In this study, the following steps of analysis were followed:

- Select a concept
- Determine the purposes of the analysis
- Identify all uses of the concept
- Determine the defining attributes
- Identify antecedents and consequences
- Identify a model case

These steps of concept analysis followed in this study are discussed below.
5.2.1 Selecting the concept

A concept is regarded by Chinn and Kramer (2011:158) as a complex mental formulation of experience consisting of perception of the world, including people, visual images, behaviour and interaction. Concepts are further regarded as complex mental formulations of experience which form a major component of the theory (Chinn & Kramer, 2011:158). A concept is defined by Walker and Avant (2011:59) as the basic building block of a theory, a mental image of phenomena, an idea, or a construct in the mind about a thing or an action. Concepts help in categorising or organising environmental stimuli, identifying how experiences are similar or equivalent by categorising all the things that are alike about them.

According to Chinn and Kramer (2011:163), concept selection is guided by the purpose and expresses the values related to the purpose. Walker and Avant (2011:160) further indicate that the concept selection should reflect the topic or area of great concern, a concept that is useful to the research programme or to further theoretical development in the area of interest. The concept selection in this study was guided by both the purpose of the study and the findings. The purpose of this study was to construct a programme and implementation guidelines for the prevention of unplanned pregnancy in adolescent girls through emancipated decision making. The Wittmann-Price theoretical framework (Wittmann-Price, 2004:440) concepts upon which the study is based were therefore selected for analysis.

5.2.2 Determining the purposes of analysis

Concept analysis in this study is seen as necessary as it refines ambiguous concepts of the Wittmann-Price Theory (Wittmann-Price, 2004:440) so that everyone who subsequently uses the concepts will be speaking the same language. The analysis of these concepts provided the finer descriptive concepts for the outcomes of the programme. The findings of concept analysis were used as building blocks for construction of the emancipatory education programme. Analysis of the concepts assisted in guiding the programme structure, and was used as a criterion for evaluating the programme and to determine if the programme achieved its outcome, which is
emancipated decision making in the prevention of unplanned pregnancies in adolescent girls.

5.2.3 Identifying all uses of the concept

Dictionaries, thesauri, colleagues and available literature were used to identify as many uses as possible of the concepts in this study. Identifying the uses of the concepts was not limited to nursing dictionaries; available literature, including legal, physical and psychosocial literature was also used to describe the concepts of the Wittmann-Price Theory (Wittmann-Price, 2004:441), used as a framework for this study. Literature was also used to identify and define antecedents, defining attributes and consequences of the concepts used in this study.

5.2.4 Determining the defining attributes

According to Walker and Avant (2011:162), determining and defining attributes of a concept is the heart of concept analysis. The purpose of defining attributes of a concept is to give a broader insight into the concept and to differentiate the concept from others. Determination of defining attributes is the primary accomplishment of concept analysis. Defining attributes in this study helped the researcher to name the occurrence of a specific phenomenon about the concepts of the Wittmann-Price Theory (Wittmann-Price, 2004:440) as differentiated from other similar or related ones (Walker & Avant, 2011:162).

Dictionaries, thesauri, colleagues and available literature, which were invaluable to support and validate the ultimate choices of the defining attributes of the concepts of the Wittmann-Price Theory and provide the evidence base for the concept analysis (Walker & Avant, 2011:161), were used in this study.

5.2.5 Identifying antecedents and consequences

Walker and Avant (2011:167) describe antecedents as those events that must occur or be in place prior to the occurrence of the concept. In this study, antecedents are conditions that are necessary to enhance the process of emancipated decision making in the programme for the prevention of unplanned pregnancies in adolescent girls.
Consequences of the concept, that is, the situation that follows the occurrence of the concept, events or incidents that occur as a result of the occurrence of the concept, or the outcomes of the concept (Bonis, 2009:1334; Walker & Avant, 2011:167) have been described in this study. The consequences or outcomes are the criteria that will be used to measure the achievement of the concepts, which in this study will be used as criteria for continuous assessment during the process of programme implementation and to evaluate the success of the programme at the end of programme implementation.

5.2.6 Identifying a model case

The model case has been described as an example of the use of the concept that demonstrates the defining concept, and may be an example from real life or found in literature (Walker & Avant, 2011:163). The model case used in this study is an example from a real-life setting derived from the study.

The process of concept analysis followed in this study as described above is discussed below:

5.3 IDENTIFYING THE MAIN CONCEPTS

The programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making in this study was based on the Wittmann-Price theoretical framework. Wittmann-Price (2004, 2006) and Wittmann-Price and Bhattacharya (2008:226) indicate that, for emancipated decision making in women’s (adolescent girls’) health to occur, the concepts personal knowledge, empowerment, flexible environment, reflection and awareness of social norms are pre-requisites. These concepts are the main concepts in this study and are therefore analysed.

Figure 5.1 below indicates the emancipated decision making concepts in adolescent girls for the prevention of unplanned pregnancies.
5.4 DEFINITION OF THE MAIN CONCEPTS

Each of the main concepts identified is defined with reference to the dictionary definition, subject definition, defining attributes, antecedents, and consequences or outcomes of the concept (Chinn & Kramer, 2011:188). Finally, the operational definitions, as building blocks for the model case and criteria for assessment of the outcomes, are formulated.

It should, however, be mentioned that some old literature was used in analysing the Wittmann-Price concepts as recent literature giving an analysis of these concepts could not be found.

5.4.1 Defining the concept ‘PERSONAL KNOWLEDGE’

5.4.1.1 Dictionary definition of the concept ‘PERSONAL KNOWLEDGE’

BusinessDictionary.com (2013) defines personal knowledge as “cognizance of a circumstance or fact gained directly through firsthand experience or observation”, while
The Law Dictionary (2013) defines it as “the knowledge possessed by any individual, usually accumulated through observation or personal experiences”. Personal knowledge is also described as tacit knowledge, which is an unspoken, unwritten and hidden store of knowledge held by every human being, based on experiences, emotions, intuitions, insights and observations. According to USLegal (2013), personal knowledge means “knowledge of circumstances or facts gained through first-hand observation or experience”.

Other dictionaries consulted give a definition of knowledge, which has a direct link to personal knowledge. These are described below.

The World Book Dictionary, Volume One (Barnhart, 1995a:1162) defines knowledge as “what one knows, a range of information, all that is known or can be learned or the sum of what is known, the act of knowing or familiarizing, clear and certain mental perception, understanding”. The Concise Oxford Dictionary (Allen, Fowler & Fowler, 1992:656) defines knowledge as “awareness or familiarity, gained by experience, a person’s range of information, theoretical or practical understanding of a subject or language, the sum of what is known, understood as true, justified belief, certain understanding”.

Knowledge is defined in the Oxford South African Pocket Dictionary (Balfour, Shaw & Jarosek, 2002:500) as “awareness of familiarity gained by experience, a person’s range of information, theoretical or practical understanding of a subject, the sum of what is known, true, justified”. The Longman Dictionary of Contemporary English (Alexander, 1992:581) defines knowledge as “what a person knows, the facts, information, skill, understanding that one gained, especially through learning or experience”. The Oxford Dictionary of Philosophy (Blackburn, 2008:18) on the other hand defines knowledge as epistemology (Greek), meaning “the place of experience in generating knowledge, the place of reason in doing so, the relationship between knowledge and certainty and between knowledge and impossibility for error, the possibility of universal scepticism, and the changing forms of knowledge that arise from new conceptualisations of the world”.

165
5.4.1.2 Subject definition of the concept ‘PERSONAL KNOWLEDGE’

Personal knowledge is defined by Hunt (2003:100) as the capacity to act, with a distinction made between behavioural potential, which cannot be directly observed, and observable performance or behaviour.

Reinders (2010:28) and Siefring (2012:4) describe personal knowledge as a combination of tacit knowledge and explicit knowledge. Explicit knowledge is regarded as well-stored and well-documented information, that is, knowledge that has already been articulated. Explicit knowledge is recorded, is externalised, can be audibly or visibly expressed through a medium, is searchable and retrievable, and is easy to transmit. According to Siefring (2012:4), tacit knowledge on the contrary is unarticulated and entangled with contexts, objects and situations. Etymology would imply that tacit knowledge is ‘silent knowledge’, that is, it remains unspoken, unvoiced or unwritten. Tacit knowledge is regarded as experiential knowledge, which is entangled with objects, contexts, processes and situations. Tacit knowledge is contextually embedded, normally unspoken, internalised, informal, experiential, not easily transferable, complicated, difficult to explain, and can be demonstrated but remains intangible and hard to codify. Reinders (2010:28) further contends that professional expertise involves the ‘tacit’ dimension of practical knowledge, which is a dimension of personal knowledge. Hunt (2003:100) defines personal knowledge in the context of tacit knowledge found in the heads, experiences and memories of people. Since knowledge cannot be directly observed, it must be inferred from observing performance or behaviour (Hunt, 2003:102).

Wittmann-Price (2004:441) describes personal knowledge as the ability to understand oneself and to make a person aware of how knowledge affects situations and influences everything one does. It also has a component of self-awareness, self-reflection and the ability to understand oneself; in the context of women’s health care, it is awareness by a woman that she has thought about alternatives in health care in relation to herself (Wittmann-Price, 2004:441). Personal knowledge is regarded by Sweeney (1994:919) as the recognition of a new pattern through processing by the human being. This processing may consist of any combination of human and environmental interaction.
(experience), rational intuition, appraisal, active comprehension and personal judgement. The personal knowledge may be new only to the individual or to all humanity (Sweeney, 1994:919).

Personal knowledge stems from reflection on personal experience of scientific knowledge and the personal application of that knowledge. It is this personal type of knowledge which is the most essential component of knowing. Only personal knowledge can answer the question of ‘What is it like?’ for the individual (Bonis, 2009:1330). Personal knowledge is also described through the concept of personal knowing as an overlapping of experiential learning, interpersonal knowing, intuitive knowing and knowledge gained through personal experience, which depends upon awareness of the experience as well as on the reflection and synthesis of old knowledge with the new (Bonis, 2009:1330). The person's behaviour and performance both depend on the knowledge acquired through learning, practice and experience (Hunt, 2003:101).

Sweeney (1994:920) states that the person acquiring personal knowledge tolerates ambiguity and internal contradictions while establishing contact with hidden reality. In this way, heightened consciousness and new pattern recognition occurs, contributing to personal knowledge.

According to Sweeney (1994:919), personal knowledge is supported and improved by an interactive process which should occur in learning through dialogue between the educator and the educated even as they diverge from different truths. Training programmes and schools are important in our society as they provide formal opportunities to acquire personal knowledge (Hunt, 2003:101). The multidisciplinary health team members and school educators, in collaboration with the parents and the community (Naravage, Vichit-Vadakan, Sakulbumrungsil & Van der Putten, 2005:777), engage in constant dialogue with adolescents to build on personal knowledge.

Sweeney (1994:920) indicates that, for a person to acquire personal knowledge, the necessary antecedents must be present. Antecedents of personal knowledge have been identified as the involvement of human beings who are conscious and rational,
interaction with the environment, family members sharing their experiences, awareness
to being open to an experience, and the person’s need and drive for knowledge (Bonis,

Defining attributes of the concept personal knowledge described by Bonis (2009:1334);
Hunt (2003:100) and Sweeney (1994:920) have been summarised as intentional,
passionate investment of energy in interpreting information, active comprehension,
rational intuition, appraisal and personal judgement.

The outcomes or consequences of personal knowledge are identified as feeling
energised and passionate about the knowledge, having conviction, intellectual
satisfaction, a vision of global application of the new knowledge and a sense of
responsibility, including the need to communicate the new knowledge and persuade
others of its validity, find meaning and be able to undergo transformation (Bonis,
2009:1334; Sweeney, 1994:919). The outcomes of personal knowledge are further
described by Hunt (2003:101) as providing orderliness to individuals’ lives, which allows
them to conceptualise goals, anticipate and perceive events, and respond in
accordance with changing needs, purpose and desires. According to Hunt (2003:101),
the knowledge of people greatly affects their safety, effectiveness and comfort, as well
as the satisfaction with which the goal of an individual is formulated and attained.

Table 5.1 lists the essential attributes for the concept ‘personal knowledge’ identified
from the definitions.

Table 5.1: Essential attributes of the concept ‘personal knowledge’

<table>
<thead>
<tr>
<th>ESSENTIAL CRITERIA</th>
<th>RELATED CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range of information</td>
<td>• Facts (theoretical)</td>
</tr>
<tr>
<td></td>
<td>• Skills (practical)</td>
</tr>
<tr>
<td></td>
<td>• True and justified</td>
</tr>
<tr>
<td></td>
<td>• Familiarisation</td>
</tr>
<tr>
<td></td>
<td>• Mental perception</td>
</tr>
<tr>
<td></td>
<td>• Reflection and synthesis of old knowledge with new</td>
</tr>
<tr>
<td></td>
<td>• Active comprehension</td>
</tr>
</tbody>
</table>
## ESSENTIAL CRITERIA | RELATED CRITERIA
--- | ---
Process of acquisition | - Interactive process  
- Overlapping of learning, practice and experience  
- Dialogue between the educator and the educated  
- Collaboration between school educators, multidisciplinary team members, parents and the community  
- Training programmes and schools provide formal opportunities to acquire personal knowledge

Characteristics of the person acquiring personal knowledge | - Tolerance of ambiguity and internal contradictions for new pattern recognition to occur  
- Possession of heightened consciousness  
- Establishing contact with reality within the surrounding social environment

Antecedents of personal knowledge | - Involvement of human beings who are conscious of reality and rational  
- Interaction with the environment; family members sharing their experiences  
- Awareness of being open to an experience  
- Need and drive for knowledge

Defining attributes of personal knowledge | - Intentional, passionate investment of energy in interpreting information  
- Rational intuition  
- Appraisal  
- Personal judgement  
- A component of self-awareness  
- Understanding oneself  
- Self-reflection  
- Recognition/awareness of new pattern of knowledge/behaviour
5.4.1.3 Operational definition of the concept ‘PERSONAL KNOWLEDGE’

Personal knowledge has been operationally defined in this study as:

- The recognition of new patterns of knowledge and behaviour;
- The ability to understand oneself;
- A component of self-awareness;
- Self-reflection acquired through overlapping of learning, practice and personal experience.

Personal knowledge is also acquired through a dialogical, interactive process of collaboration between adolescent girls, health care professionals, parents, friends, peers, sexual partners, the school and the community. Improved personal knowledge of adolescent girls induces a feeling of energy, passion about the knowledge, a sense of responsibility and finding meaning to undergo transformation in their endeavour to make emancipated decisions in preventing unplanned pregnancies.
For adolescent girls to acquire personal knowledge, they should have heightened consciousness and establish contact with reality within the surrounding social environment in making emancipated decisions for the prevention of unplanned pregnancies.

5.4.2 Defining the concept ‘EMPOWERMENT’

5.4.2.1 Dictionary definition of the concept ‘EMPOWERMENT’

The Collins English Dictionary and Thesaurus (Sinclair, 2000:198) defines to empower as “to enable or to authorise”. The Oxford South African Pocket Dictionary (Balfour et al., 2002:384) regards to empower as to “authorise, give licence, make able or give power”. The World Book Dictionary, Volume One (Barnhart, 1995a:692) defines to empower as “to give power or authority, to enable or permit, to authorise, commission or give licence”.

The Longman Dictionary of Contemporary English (Alexander, 1992:333) regards to empower as to “give the power or legal rights” to do something. The Concise Oxford Dictionary (Allen et al., 1992:394) on the other hand defines to empower as to “authorise, licence, give power, make able”.

Empowerment as defined by Churchill Livingstone’s Dictionary of Nursing (Brooker, 2006) as the “enabling process by which individuals gain power and control over decisions” that affect their lives.

5.4.2.2 Subject definition of the concept ‘EMPOWERMENT’

Empowerment is regarded by Rodwell (1996:307) as a process aimed at changing the nature and distribution of power in a particular cultural context. It includes enabling people to recognise their strengths, abilities and personal power-sharing, as well as respect for self and others as part of the process. According to Rodwell (1996:307), power originates from self-esteem developed from love, responsibility, opportunities for choice, perceived meaning and hope. Empowerment is further seen as a process of transferring power and includes the development of positive self-esteem and recognition of the worth of self and others.
Gibson (1991:359) regards empowerment as a social process of recognising, promoting and enhancing people’s abilities to meet their own needs, solve their own problems and mobilise the necessary resources in order to feel in control of their own lives; a process of helping people to assert control over factors which affect their health. Empowerment is a process, a dynamic two-pronged construction of identity, both individually and collectively (Commission on Women and Development, 2007:9).

Empowerment is regarded by Hawks (1992:610) as an interpersonal process of providing the tools, resources and environment to develop, build and increase the ability and effectiveness of others to set and reach goals for individual and social ends. Empowerment occurs between two or more people: the person who empowers, that is, the teacher who makes possible or enables, and the person who is empowered, who becomes capable of setting and reaching goals.

Wittmann-Price (2004:442) also regards empowerment as the process that provides the resources, tools and environment to develop and build, as well as to set and reach goals, for individual and social needs. According to Hawks (1992:609), the concept of empowerment indicates that both the empowerer and the empowered are active in the learning process. Learning is lifelong, but the appropriate environment, tools and resources must be available. The person empowering should allow choices among available tools and resources and allow participation in decision making and goal setting (Hawks, 1992:612). The empowerer must possess and use professional skills in order to empower the empowered.

Empowerment is a component of the process of emancipation, but it alone cannot ensure freedom of choice without the presence of other components of emancipation (Wittmann-Price, 2004:432). Freire (in Mooney, 2013:4) regards emancipatory education and learning through listening, dialogue, active involvement and action by learners (adolescent girls) as empowerment methods for emancipation. Education, leading, mentoring/support, providing, structuring and actualising are identified by Hawks (1992:610) as methods used in empowerment.
According to Gibson (1991:359) and Hawks (1992:612), antecedents of empowerment include the person empowering, the person empowered and the environment for empowerment. The person empowering should possess and use professional knowledge and skills and act as a facilitator, supporter, counsellor, educator, resource consultant, resource mobiliser, facilitator, enabler and advocate. The empowerer should further act as a leader who involves others in setting goals and the decision making process, and should motivate, energise, excite and liberate others. There must be willingness by the person who empowers to allow choices among available tools and resources, and facilitate participation in decision making.

For empowerment to occur, the persons empowered (adolescent girls) must be willing to assume responsibility, commit, motivate, participate in goal setting and decision making and accept change and behaviours that encourage empowerment (Drosselmeyer, Power & Sloan, 2010:11; Hawks, 1992:612). According to Hawks (1992:612), a nurturing and caring environment is necessary for empowerment to occur. According to Hawks (1992:612), an environment conducive to empowerment consists of openness, honesty, genuineness, communication and interpersonal skills, acceptance of people as they are, mutual trust and respect, value of others, courtesy, and shared vision.

The defining attributes of empowerment (Drosselmeyer et al., 2010:11; Gibson, 1991:359; Hawks, 1992:612; Rodwell, 1996:309) further elaborate on the concept of empowerment. From the above literature, the defining attributes of empowerment have been identified as a helping process, partnership with values of self and others, mutual decision making, using resources, opportunities and authority, freedom to make choices, and acceptance of responsibility.

The outcomes or consequences of empowerment include increased problem solving ability, better communication, satisfaction, improved self-esteem, autonomy and responsibility, the ability to set and reach goals, a sense of control over life and the change process, positive self-concept, personal satisfaction, self-efficacy, a sense of mastery, a sense of connectedness, self-development, a feeling of hope and social
justice. The empowered person is intellectually reflective, independent, caring and ethical, and can act in public interest both locally and globally (Drosselmeyer et al., 2010:12; Gibson, 1991:359; Hawks, 1992:612; Rodwell, 1996:310; Wittmann-Price, 2004:441).

Table 5.2 lists the essential attributes for the concept ‘empowerment’

**Table 5.2: Essential attributes of the concept ‘empowerment’**

<table>
<thead>
<tr>
<th>ESSENTIAL CRITERIA</th>
<th>RELATED CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enabling process</td>
<td>• Authorise</td>
</tr>
<tr>
<td></td>
<td>• Commission</td>
</tr>
<tr>
<td></td>
<td>• Give power</td>
</tr>
<tr>
<td></td>
<td>• Give legal rights</td>
</tr>
<tr>
<td></td>
<td>• A process of emancipation</td>
</tr>
<tr>
<td>Requirements/antecedents of</td>
<td>• Interactive, interpersonal process</td>
</tr>
<tr>
<td>empowerment</td>
<td>• Partnership</td>
</tr>
<tr>
<td></td>
<td>• The person empowering</td>
</tr>
<tr>
<td></td>
<td>• The person empowered</td>
</tr>
<tr>
<td></td>
<td>• Empowerment environment</td>
</tr>
<tr>
<td></td>
<td>• Empowerment methods</td>
</tr>
<tr>
<td>The person empowering</td>
<td>• Possesses and uses professional and knowledge and skills</td>
</tr>
<tr>
<td></td>
<td>• Helper, supporter, counsellor, educator resource consultant, mobilise resource</td>
</tr>
<tr>
<td></td>
<td>facilitator, enabler and advocate</td>
</tr>
<tr>
<td></td>
<td>• A leader who involves others in setting goals in decision making process</td>
</tr>
<tr>
<td></td>
<td>• Motivates, energises, excites and liberates others</td>
</tr>
<tr>
<td></td>
<td>• Willingness to allow choices among available tools and resources</td>
</tr>
<tr>
<td></td>
<td>• Facilitate participation in decision making</td>
</tr>
<tr>
<td>The person empowered</td>
<td>• Willing to assume responsibility</td>
</tr>
<tr>
<td></td>
<td>• Commitment, motivation</td>
</tr>
<tr>
<td></td>
<td>• Participate in goal setting and decision making</td>
</tr>
<tr>
<td></td>
<td>• Interpersonal skills</td>
</tr>
<tr>
<td></td>
<td>• Accepting change and behaviours that encourage empowerment</td>
</tr>
<tr>
<td>ESSENTIAL CRITERIA</td>
<td>RELATED CRITERIA</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| The empowerment environment            | - Nurturing and caring  
- Openness, honesty, genuiness  
- Open communication  
- Acceptance of people as they are  
- Mutual trust and respect  
- Value of others  
- Courtesy and shared vision        |
| Empowerment method                     | - Education and training  
- Leading, mentoring/support, providing structuring, actualising  
- Emancipatory education and learning involving dialogue, active involvement |
| Attributes of empowerment              | - A helping, social process  
- Partnership  
- Values of self and others  
- Mutual decision making  
- Using resources  
- Opportunities and authority, freedom to make choice and accept responsibility |
| Outcomes/consequences of empowerment   | - Increased problem solving ability  
- Better communication  
- Satisfaction  
- Improved self-esteem  
- Autonomy and responsibility  
- Ability to set and reach goals  
- Sense of control over life and change process  
- Positive self-concept  
- Personal satisfaction, self-efficacy  
- A sense of mastery  
- A sense of connectedness  
- Self-development  
- Feeling of hope, social justice  
- Being intellectually reflective  
- Caring and ethical  
- Ability to act in public interest both locally and globally |
5.4.2.3 Operational definition of the concept ‘EMPOWERMENT’

In this study, ‘empowerment’ refers to an enabling social, interactive and collaborative process by the empowerer who possesses and uses professional knowledge and skills. The empowerer acts as a facilitator and guides adolescent girls within a nurturing and caring environment. Empowerment requires open communication, honesty, mutual trust, mutual decision making and respect, using resources and tools to enable adolescent girls to realise their strengths and abilities, and to develop positive self-esteem, autonomy and responsibility. Resources and tools such as leading, mentoring, support, emancipatory education and learning, which involve dialogue and active involvement, are empowerment methods used to enable adolescent girls to set and reach goals to be able to make emancipated decisions in the prevention of unplanned pregnancies. For empowerment to occur, adolescent girls must have commitment, motivation and good interpersonal skills in order to make emancipated decisions in preventing unplanned pregnancies.

5.4.3 Defining the concept ‘FLEXIBLE ENVIRONMENT’

5.4.3.1 Dictionary definition of the concept ‘flexible environment’

The Oxford South African Pocket Dictionary (Balfour et al., 2002:338) defines flexible as “able to bend without breaking, manageable, and adaptable”. Flexible is regarded by World Book Dictionary, Volume One (Barnhart, 1995a:816) as “capable of being bent without breaking, easily bent in all directions, adaptable and able to turn easily from situation or subject to another”.

Longman Dictionary of Contemporary English (Alexander, 1992:391) defines flexible as being “bent easily, change, and be changed to be suitable for new needs”. Collins Dictionary and Thesaurus (Gilmour, McKeown & Summers, 2008:106) defines flexible as “adaptable, easily bent”. Flexible is regarded by Blackwell’s Nursing Dictionary (Freshwater & Maslin-Prothero, 2005:233) as the ability to “change, bend or conform”.

Environment is defined by The Concise Oxford South African Pocket Dictionary (Balfour et al., 2002:295) as the “physical surroundings especially as affecting people’s lives,
conditions or circumstances of living”. The World Book Dictionary, Volume One (Barnhart, 1995a:706) regards environment as all of the “surrounding things, conditions and influences affecting the growth or development of living things”. The Longman Dictionary of Contemporary English (Alexander, 1992:340) defines environment as the “physical and social conditions in which people live, which influence their feelings and development, the natural conditions such as water, air, and land in which people, animals and plants live”.

Collins English Dictionary and Thesaurus (Gilmour et al., 2008:92) defines environment as “external conditions and surroundings in which people, animals or plants live”. Blackwell’s Nursing Dictionary (Freshwater & Maslin-Prothero, 2005:211) regards the environment as the “external surroundings, the total of all the conditions and forces that surround and act upon an organism or any of its parts”. Mosby’s Allied Medical, Nursing and Allied Health Dictionary (Anderson, Anderson & Glanze, 1998:569) regards environment as “all of the many factors, such as physical and psychological, that influence or affect the life and survival of a person”.

5.4.3.2 Subject definition of the concept ‘FLEXIBLE ENVIRONMENT’

According to Lenz and Engledow (1986:329), environment means the surroundings of an organisation, that is, the ‘climate’ in which the organisation functions. August-Brady (2000:7) defines flexibility as the capacity for ready adaptation to various purposes or conditions and for free, rapid and varied execution. The process of flexibility is described as the ability to adapt or respond to the changing environment, to look at a total picture, to see multiple perspectives and not a narrow perspective. The process of creating flexible environments has to be planned and managed (August-Brady, 2000:7). A flexible environment has been described as a non-judgemental environment that supports freedom of choice, is responsive to change and leads to personal benefits for individuals and society. A flexible environment allows women unopposed enactment of a chosen alternative (Wittmann-Price, 2004:441).

Critical attributes of flexibility in environment have been described by August-Brady (2000:8) as being resilient (being able to respond or adapt to change while performing
efficiently and effectively, to absorb various disturbances yet incorporate new changes and to deal with everyday events without becoming overwhelmed), responsive (being responsive to change and being able to act differently yet appropriately in different situations), evolutionary (developing and adapting healthily) and integrating (integrating the whole picture and seeing multiple perspectives simultaneously). For the environment to be regarded as flexible, conditions such as honesty, trust, genuineness, communication, interpersonal skills, courtesy and shared vision are necessary (Gibson, 1991:359; Hawks, 1992:612). Attributes of a flexible environment have been described by WHO (2012:39) as one in which health providers are non-judgemental, treat adolescent girls with respect and provide information and education through a variety of channels; health services are either free or affordable, accessible, available, acceptable and guarantee adolescents’ confidentiality and privacy; policies, protocols and guidelines are in place to guide health care professionals; and adolescents are actively involved in designing and assessing health services.

Antecedents of flexibility in environments have been described as the need for or threat of change (linked to a better outcome in terms of performance, thinking or behaviour), openness (to change), vision (to recognise that change is needed), predisposition to change (willingness and motivation) and uncertainty (flexibility is valued in an environment of uncertainty) (August-Brady, 2000:9).

The consequences of flexible environments are regarded as increased choices leading to the outcomes, effectiveness and efficiency, personal benefits of enhanced self-esteem, understanding and improved thinking, and allowing women to make free choices. A flexible, nurturing and caring environment allows choices among available tools and resources and facilitates participation in decision making, which is necessary for empowerment (August-Brady, 2000:9; Wittmann-Price, 2004:441). Wittmann-Price and Bhattacharya (2008:226) regard a flexible environment which recognises that sources of power or social norms are inevitable and allow the person to appraise those norms appropriately in relation to personal knowledge through reflection as emancipating.
The essential attributes for the concept ‘flexible environment’ are summarised in Table 5.3.

**Table 5.3: Essential attributes of the concept ‘flexible environment’**

<table>
<thead>
<tr>
<th>ESSENTIAL CRITERIA</th>
<th>RELATED CRITERIA</th>
</tr>
</thead>
</table>
| Surrounding or climate                      | • Physical, social and psychological  
  • Can bend, non-judgemental, integrative evolving, resilient response, responsive to change, manageable, suits different needs  
  • Affects growth or development |
| Process of creating a flexible environment  | • Ability to adapt or respond to change  
  • Ability to look at the whole picture and see multiple perspectives  
  • Planning and management of the environment |
| Antecedents of creating a flexible environment | • The need for or threat of change  
  • Openness  
  • Predisposition to change  
  • Uncertainty in physical, social and psychological environment |
| Critical attributes of a flexible environment | • Resilient, responsive  
  • Evolutionary, integrative  
  • Honesty, trust, genuineness, communication, interpersonal skills, courtesy and shared vision  
  • Policies, protocols and guidelines are in place  
  • Adolescents’ active involvement in designing and assessing health care |
| Consequences/outcomes of a flexible environment | • Effectiveness and efficiency, increased choice  
  • Enhanced self-esteem  
  • Better understanding and thinking  
  • Participation in decision making  
  • Emancipation |

**5.4.3.3 Operational definition of the concept ‘FLEXIBLE ENVIRONMENT’**

A ‘flexible environment’ is described in this study as a physical, social and psychological environment which is non-judgemental, integrative and evolving. Such an environment
is characterised by resilient responses to change and uncertainty based on openness, shared vision and willingness to change. A flexible environment results in greater diversity of choice, effectiveness, efficiency, empowerment, reflection, personal knowledge and emancipation of adolescent girls in making emancipated decisions about the prevention of unplanned pregnancies. A flexible environment enhances self-esteem, broader thinking, better understanding and participation in decision making for adolescent girls’ emancipated decision making in the prevention of unplanned pregnancies.

5.4.4 Defining the concept: ‘AWARENESS OF SOCIAL NORMS’

5.4.4.1 Dictionary definition of the concept ‘AWARENESS OF SOCIAL NORMS’


The Oxford South African Pocket Dictionary (Balfour et al., 2002:609) defines a norm as a “standard that is required or acceptable, a standard of customary behaviour”. The World Book Dictionary, Volume Two (Barnhart, 1995b:1418) defines norm as “standard, pattern for a group”. Encyclopaedia Britannica (2012) defines a social norm as “rule or behaviour shared by members of the social group”. A norm is defined by the Concise Oxford Dictionary (Allen et al., 1992:808) as “standard or pattern or type, customary behaviour, a standard quantity to be produced”. Longman Dictionary of Contemporary English (Alexander, 1992:333) regards a norm as a “standard or pattern or type, customary behaviour, a standard quantity to be produced”. According to the Oxford Dictionary of Philosophy (Blackburn, 2008:254), a norm is regarded as a “rule for behaviour, or a definite pattern of behaviour, departure from which renders a person liable to some kind of censure”.

180
Awareness of social norms thus implies having knowledge of and being well-informed, cognisant and conscious about standard, pattern or customary behaviour or a definite pattern of behaviour, departure from which renders a person liable to some kind of censure.

### 5.4.4.2 Subject definition of the concept ‘AWARENESS OF SOCIAL NORMS’

Awareness is regarded by Stanton, Chambers and Piggott (2001:2) as the perception and comprehension of the meaning of, and projection of the future of a situation. Awareness is further regarded as the conscious, dynamic orientation of a situation; a reflection about the past, present, future and the potential features of the situation. Awareness generates momentary knowledge and behaviour required to attain the goals specified for a situation (Stanton et al., 2001:3). Awareness is regarded by Rettie (2003:2) as an understanding of the activities of others, which provides the context for one’s own activity. Phipps-Morgan and Lobo (2009:1) regard a nurse who is aware as one who is sensitive to, engaged with, and cognisant of others’ needs.

Social norms are regarded as group members jointly accepting a rule of behaviour by agreeing to conform to the rule. The group enter into joint commitment to accept the rule together as a body. Social behaviour is viewed as a sum total of the person’s habits and intentions which are affected by norms, values and social actions. Behaviour is the outcome of institutional structures and development which occurs in a social context (Brett, 2001:12, Detel, 2008:470; Maville & Huerta, 2008:45). According to Mooney and Nolan (2005: 241), society is structured by rules, habits, convictions and meanings to which human beings adhere.

Social norms in a group imply that there is a pattern of behaviour to which members regularly conform. Members regard social norms as standards by which behaviour of members may be judged as correct or incorrect. Members believe that they ought to conform; they are justified to, in forcing one another to conform and threaten deviance by way of sanctions. Social norms are regarded as community norms, based on explicit or implicit agreement created by an authority or body of agents representing the group (Detel, 2008:470).
Awareness of social norms implies conscious and dynamic reflection about the past, present, future and the potential features of social norms as standards by which behaviour of members may be judged as correct or incorrect (Detel, 2008:470; Rettie, 2003:2; Stanton et al., 2001:3). According to Wittmann-Price (2004:442, 2006:178), awareness of social norms is awareness that the social context exerts influence over information transfer, influencing individual perception where knowledge development occurs. It is an awareness of how society places more value on one or more of the alternatives being considered. According to Wittmann-Price and Bhattacharya (2008:226), a person can never be completely separated from the environment and its social and cultural context.

Awareness of social norms indicates an awareness that social norms are inevitable and allows the person to appraise those norms appropriately in relation to personal knowledge through reflection within a flexible environment. An awareness of social norms refers to the realisation that social norms set standards that are sometimes difficult to change, and refers to awareness that social norms have sanctioned one of the possible alternatives as more acceptable than others (Wittmann-Price, 2004:442).

Emancipation allows innately free people to use resources, acquired through reflection based on personal and professional knowledge or empowerment, to make appropriate health care decisions regardless of the popularity of the decisions in the social climate. Adolescent girls are supposed be aware of social norms that influence adolescent pregnancy prevention within their social context and appraise these norms to be able to make emancipated decision in preventing unplanned pregnancies.

The antecedents of awareness of social norms have been summarised as indifference, frustration, helplessness and despair about standards of behaviour (Phipps-Morgan & Lobo, 2009:1; Wittmann-Price, 2004:442). The defining attributes of awareness of social norms have been identified as attention, heightened perception, focus, serenity, alertness, clarity, expansion and connectedness to social and cultural contexts and standards of behaviour. The consequences of the concept awareness have been described by Phipps-Morgan and Lobo (2009:1) as creativity, compassion, coherency,
heightened sensitivity, increased understanding, a humanistic approach and potential for making meaningful choices and connections.

The antecedents of awareness of social norms imply being frustrated, helpless and in despair regarding customary rules of behaviour (Phipps-Morgan & Lobo, 2009:1; Wittmann-Price, 2004:442). The defining attributes of awareness of social norms have been identified as attention, heightened perception, focus, serenity, alertness, clarity, expansion and connectedness with customary rules of behaviour within the social context (Phipps-Morgan & Lobo, 2009:1; Wittmann-Price & Bhattacharya, 2008:226). The consequences/outcomes of awareness of social norms include creativity, compassion, coherency, heightened sensitivity, increased understanding, a humanistic approach and the potential for making meaningful choices and connections with social norms as standards of customary behaviour within the social context (Phipps-Morgan & Lobo, 2009:1; Wittmann-Price, 2004:442).

Table 5.4 lists the essential attributes of the concept ‘awareness of social norms’

**Table 5.4: Essential attributes for the concept ‘awareness of social norms’**

<table>
<thead>
<tr>
<th>ESSENTIAL CRITERIA</th>
<th>RELATED CRITERIA</th>
</tr>
</thead>
</table>
| Conscious, dynamic perception and comprehension of standards of behaviour | • Rules  
• Customary  
• Required  
• Generally acceptable  
• Shared by members of the social group  
• Behaviour of members may be judged as correct or incorrect |
| Knowledge and understanding of social behaviour | • Sum total of the person’s habits and intentions  
• Affected by norms, values  
• Outcome of institutional structures |
## ESSENTIAL CRITERIA | RELATED CRITERIA
--- | ---
Process of developing awareness of social norms | • Development in social context  
• The person can never be completely separated from the environment and its social and cultural context  
• Social norms are inevitable, allows the person to appraise those norms appropriately in relation to personal knowledge and empowerment through reflection within a flexible environment.

Antecedents of awareness of social norms | • Indifference, apathy, anger, ignorance, frustration, helplessness and despair about customary rules of behaviour

Defining attributes | • Attention, heightened perception, focus, serenity, alertness, clarity, expansion and connectedness with customary rules of behaviour within the social context

Consequences/outcomes | • Creativity, compassion, coherency, heightened sensitivity, increased understanding, a humanistic approach, potential for making meaningful choices and connections with customary rules of behaviour

### 5.4.4.3 Operational definition of the concept ‘AWARENESS OF SOCIAL NORMS’

Awareness of social norms in this study denotes conscious and dynamic knowledge, perception and comprehension by adolescent girls of social norms as standards of customary behaviour that are required or acceptable through which their behaviour may be judged as correct or incorrect. Awareness of social norms by adolescent girls have to result in creativity, compassion, coherency, heightened sensitivity, increased understanding, a humanistic approach, and the potential for making meaningful choices and connections with norms as customary rules of behaviour. Awareness of social norms entails adolescent girls being aware that social norms imply an interaction between the person, the environment and its social and cultural context and that social norms are inevitable, and allows them to appraise these norms in relation to personal
knowledge and empowerment through reflection in a flexible environment in order to make emancipated decisions in the prevention of unplanned pregnancies.

5.4.5 Defining the concept ‘REFLECTION’

5.4.5.1 Dictionary definition of the concept ‘REFLECTION’

The Concise Oxford South African Pocket Dictionary (Balfour et al., 2002:295) defines reflection as “throwing back, showing an image, showing a realistic or appropriate way”. The World Book Dictionary, Volume Two (Barnhart, 1995b:1755) defines to reflect as “to throw back, to think carefully”.

To reflect is defined by the Longman Dictionary of Contemporary English (Alexander, 1992:874) as “to throw back, to express, to make clear, be a sign of, to think carefully”. The Collins English Dictionary and Thesaurus (Gilmour et al., 2008:229) defines to reflect as to “throw back, form an image, to show, consider at length, and bring credit or discredit”.

5.4.5.2 Subject definition of the concept ‘REFLECTION’

Reflection is viewed by Duffy and Scott (1998:185) as a central concept in critical social theory, where the image of ‘the self’ flexes back towards a person, so that one can see one’s self in new ways. MOSEP (2009:1) defines reflection as a process of thought that is active and careful, an activity in which people ‘recapture experience’ and evaluate it. According to MOSEP (2009:1), reflection involves returning to an experience, connecting with the feelings and evaluating the experience. Gazi University, (2000:1) defines reflection as thinking for an extended period by linking recent experiences to earlier ones in order to promote a more complex and interrelated mental scheme, the thinking involves looking for commonalities, differences and interrelations with the aim of developing higher-order thinking skills.

Reflection is regarded by Wittmann-Price (2004:441) as a consciousness or a learned method of perceiving society and its oppressive influence, a form of critical thinking or cognitive awareness and the development of a perception of questioning practices that are based solely on tradition or authority. Reflection, which involves stepping out of
oneself and freeze-framing the moment to understand it better, is considered a valid method of knowledge acquisition. Emancipatory reflection enables individuals and groups to examine rules, habits and traditions that are accepted unquestioned (Wittmann-Price, 2004:441). From self-awareness comes knowledge through reflection, which is viewed as liberating because, as one becomes knowledgeable of oneself as a member of social system, one can choose to be different (Duffy & Scott, 1998:185).

Wittmann-Price (2004:441) refers to reflection as a cognitive or interactive process in which a woman consciously engages when considering alternatives in health care. Dialogue and journaling have been referred to as some methods that promote reflection (Wittmann-Price, 2004:441). Reflection is regarded as a conscious or learned method of perceiving society and its oppressive influences, a form of critical thinking, developing a perception of practices based on tradition or authority, and a necessary tool for understanding groups (Wittmann-Price, 2004:441).

Rogers (2001:41) defines reflection as a cognitive and affective process or activity that requires active engagement on the part of the individual, triggered by an unusual or perplexing situation or experience. Reflection involves examining one’s responses, beliefs and premises in light of the situation at hand; and results in integration of the new understanding into one’s experience.

MOSEP (2009:1) describes two types of reflection: reflection on action and reflection in action. Reflection on action is described as reflection at a distance from the actual event that requires reflection. Reflection on action can be generalised and involves descriptions and an evaluation of the occurred events and decisions made. Reflection on action gives the reflective individual an opportunity to become wiser. Reflection in action is tied to the context in which an event occurs. The reflection is often tangible and has a tendency to appear as implicit/tacit knowledge (MOSEP, 2009:1). Wittmann-Price (2004:441) describes ‘reflection in action’ as a true way to desirable behaviour or action, to stop and think about what we are doing and to truly reflect.

Antecedents or requirements of reflective process are identified by Rogers (2001:42) as the presence of a triggering event described in terms of the response of the individual
event, that is, a state of doubt, hesitation, perplexity or mental difficulty. Other antecedents identified in literature (Rogers, 2001:42) include readiness and willingness to engage in reflective process, open-mindedness, wholeheartedness, responsibility on the part of the learner, conscious awareness and deliberate choice. Antecedents are echoed by Lucas (2012), who adds that reflection requires a willingness to question, self-motivation, proactivity, a critique of the way of behaving and thinking as one engages.

Techniques that foster reflection are explained by Rogers (2001:46) as education, physical activity, use of language, using principles of andragogy in education, reflective practice, combining the teaching of applied science with coaching in teaching reflection-in-action, the use of role modelling as a way of demonstrating reflection, the use of structured experience. Gazi University (2000:1) adds the use of reflective journals or group discussions as other techniques fostering reflection.

Outcomes of reflection are identified by Rogers (2001:47) and Lucas (2012) as learning, changes in habits and expectations, development of accurate perceptions, avoiding premature cognitive commitment, achieving greater flexibility and creativity, enhancing overall effectiveness, critical thinking, increased capacity for change, increased control of the context, greater freedom of action, increased flexibility and innovation, effective coping with divergent situations and acquisition of knowledge. Table 5.5 lists the essential attributes of the concept reflection.

Table 5.5: Essential attributes of the concept ‘reflection’

<table>
<thead>
<tr>
<th>ESSENTIAL CRITERIA</th>
<th>RELATED CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Throwing back</td>
<td>• Showing an image</td>
</tr>
<tr>
<td></td>
<td>• Showing a realistic or appropriate way</td>
</tr>
<tr>
<td></td>
<td>• Thinking carefully</td>
</tr>
<tr>
<td></td>
<td>• Bringing credit or discredit</td>
</tr>
<tr>
<td></td>
<td>• Image of ‘the self’ flexing back towards a person</td>
</tr>
<tr>
<td>ESSENTIAL CRITERIA</td>
<td>RELATED CRITERIA</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------</td>
</tr>
</tbody>
</table>
| Thinking for an extended period | • Linking recent experiences to earlier ones  
• Recapturing and evaluating experience  
• Looking for commonalities, differences and interrelations |
| Cognitive and affective process | • Activity that requires active engagement  
• Triggered by an unusual or perplexing situation or experience  
• Involves examining one’s responses, beliefs and premises  
• Consciousness or a learned method of perceiving society and its oppressive influence  
• Cognitive awareness, a form of critical thinking  
• Developing a perception of questioning practices that are based solely on tradition or authority  
• Reflection-on-action and reflection-in-action  
• Emancipatory reflection  
• Enables individuals and groups to examine rules, habits and traditions that are accepted unquestioned  
• Developing higher order thinking skills |
| Antecedents/requirements of reflection | • Presence of a triggering event  
• A state of doubt, hesitation, perplexity or mental difficulty  
• Readiness and willingness to engage in reflective process  
• Open-mindedness, wholeheartedness  
• Responsibility on the part of the learner  
• Conscious awareness and deliberate choice  
• A willingness to question  
• Self-motivation, proactivity, critique of the way of behaving, thinking while engaging |
### Table

<table>
<thead>
<tr>
<th>ESSENTIAL CRITERIA</th>
<th>RELATED CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Processes and techniques/methods that foster reflection</td>
<td>- Education</td>
</tr>
<tr>
<td></td>
<td>- Physical activity, use of language using principles of andragogy in education</td>
</tr>
<tr>
<td></td>
<td>- Reflective practice, combining the teaching of applied science with coaching in teaching reflection-in-action</td>
</tr>
<tr>
<td></td>
<td>- Use of role modelling to demonstrate reflection</td>
</tr>
<tr>
<td></td>
<td>- Use of structured experience</td>
</tr>
<tr>
<td></td>
<td>- Use of journals or group discussions following practical experience</td>
</tr>
<tr>
<td>Outcomes/consequences of reflection</td>
<td>- Learning, changes in habits and expectations</td>
</tr>
<tr>
<td></td>
<td>- Developing accurate perceptions</td>
</tr>
<tr>
<td></td>
<td>- Avoiding premature cognitive commitment</td>
</tr>
<tr>
<td></td>
<td>- Achieving greater flexibility and creativity</td>
</tr>
<tr>
<td></td>
<td>- Enhancing overall effectiveness</td>
</tr>
<tr>
<td></td>
<td>- Increased capacity for change</td>
</tr>
<tr>
<td></td>
<td>- Increased control of the context</td>
</tr>
<tr>
<td></td>
<td>- Freedom of action, increased flexibility and innovation</td>
</tr>
<tr>
<td></td>
<td>- Effective coping with divergent situations</td>
</tr>
<tr>
<td></td>
<td>- Critical thinking, acquisition of personal knowledge, empowerment</td>
</tr>
</tbody>
</table>

### 5.4.5.3 Operational definition of the concept ‘REFLECTION’

In this study, reflection implies an activity of thinking for an extended period, a consciousness, a learned method of perceiving society and its oppressive influence, a form of critical thinking and the development of a perception of questioning practices that are based solely on tradition or authority, which requires the presence of a triggering event, open-mindedness, conscious awareness, deliberate choice and responsibility by adolescent girls in making emancipated decisions in the prevention of unplanned pregnancies.

Reflection is described in the light of reflection-on-action and reflection-in-action, the outcomes of which include freedom of choice, acquisition of personal knowledge, and
empowerment of adolescent girls for making emancipated decisions in the prevention of unplanned pregnancies. The processes and techniques that foster reflection include physical activity, use of language, using principles of andragogy in education, reflective practice, coaching, role modelling, the use of structured experience and the use of reflective journals or group discussions.

5.4.6 Defining the concept ‘EMANCIPATION’

5.4.6.1 Dictionary definition of the concept ‘EMANCIPATION’

The World Book Dictionary, Volume One (Barnhart, 1995b:666) defines emancipation as a “process of setting free from slavery of any kind, release, enfranchisement”. Emancipation is defined by the Oxford South Africa Pocket Dictionary (Balfour et al., 2002:286) as “freeing from legal, social, or political restrictions, freeing from slavery”. The Collins English Dictionary and Thesaurus (Collins, 2005:90) defines emancipate as “discharge from, release, set free from social, political or legal restraints”. The Longman Dictionary of Contemporary English (Alexander, 1992:331) defines to emancipate as “to make free socially, politically or legally”.

Emancipation is defined by Wikipedia (2014) as “any form of various efforts to procuring political rights or equality”. Merriam-Webster (2013) defines to emancipate as “to free from restraints, control or power of another, to free from bondage, to release from paternal care and responsibility, to free from any controlling influence (such as traditional mores or beliefs)”.

5.4.6.2 Subject definition of the concept ‘EMANCIPATION’

Emancipation is described by Brett (2001:12) as the destruction or reconstruction of old institutions in societies because of their inability to satisfy legitimate social needs in order to understand and manage change, not to sustain and maintain the status quo of the present system. Emancipation is further regarded as a process of reaching a more positive state of being, a state of relative freedom of choice by acknowledging an experience of oppression, cognitively reflecting upon the experience with or without dialogue (Wittmann-Price, 2004:441).
Emancipation means freedom from restraint, control or power of another, being released from paternal care and freedom from any controlling influence, the outcome of which is to equalise power between the dominant and oppressed groups (Wittmann-Price, 2004:439). Emancipation involves equalising the external and internal demand, which means women in general (adolescent girls in particular) choosing what is best for them even if this is not the popular alternative sanctioned by societal norms (Wittmann-Price, 2004:442).

Galloway (2012:164) and Thompson (2000:2) argue that emancipation develops through a process of conscientisation, within which the oppressed identify the contradictions that exist socially, politically and economically, and in doing so, take action against the oppressive elements that perpetuate their subordinate position. Conscientisation as an act of understanding allows the oppressed to identify the unequal power and resource distribution that exists and to devise means by which to transform an oppressive reality. The struggle for transformation and emancipation must be controlled by the oppressed themselves in order for them to resolve the contradictions which are part of their own understanding and experiences of the world.

According to Freire (1972, in Mooney, 2013:6), emancipatory praxis operates from the basis that there is no ‘neutral’ education. Accordingly, the process of emancipation is one which is transformative, through which the oppressed group operate to free themselves from the imposition of dominant ideologies. Paulo Freire (in Wittmann-Price and Bhattacharya, 2008:228) proposes that the institutions of education are the starting point of emancipated societies.

The process of emancipation involves creation of a flexible environment, awareness of social norms and appraisal of those norms, personal knowledge, reflection and empowerment (Wittmann-Price, 2004:442). In order for emancipation to be realised (antecedents) when making health care decisions, individuals or groups must realise that oppression exists (Wittmann-Price, 2004:441). Critical attributes of emancipation have been identified by Wittmann-Price (2004:441) as reflection, personal knowledge, empowerment, awareness of social norms and a flexible environment. Concepts such
as autonomy, intentional action and active participation are regarded by Wittmann-Price (2004:442) as related to emancipation.

The consequence of emancipation is described by Wittmann-Price (2004:442) as free choice. Table 5.6 lists the essential attributes of the concept reflection

**Table 5.6: Essential attributes of the concept ‘emancipation’**

<table>
<thead>
<tr>
<th>ESSENTIAL CRITERIA</th>
<th>RELATED CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting free from</td>
<td>• Slavery</td>
</tr>
<tr>
<td></td>
<td>• Legal, social, or political restrictions</td>
</tr>
<tr>
<td></td>
<td>• restraints, control or power</td>
</tr>
<tr>
<td></td>
<td>• Bondage</td>
</tr>
<tr>
<td></td>
<td>• Paternal care and responsibility</td>
</tr>
<tr>
<td></td>
<td>• Any controlling influence</td>
</tr>
<tr>
<td>Equalising power</td>
<td>• Between the dominant and oppressed group</td>
</tr>
<tr>
<td></td>
<td>• Destruction or reconstruction of old institutions</td>
</tr>
<tr>
<td></td>
<td>• Equalising external and the internal demands in order to satisfy legitimate social needs</td>
</tr>
<tr>
<td>The process of emancipation</td>
<td>• Creation of a flexible environment, awareness of social norms and appraising those norms, personal knowledge, reflection and empowerment</td>
</tr>
<tr>
<td></td>
<td>• Process of conscientisation</td>
</tr>
<tr>
<td>Antecedents of emancipation</td>
<td>• Conscientisation and the realisation that oppression exists</td>
</tr>
<tr>
<td>Critical attributes of emancipation</td>
<td>• Reflection</td>
</tr>
<tr>
<td></td>
<td>• Personal knowledge</td>
</tr>
<tr>
<td></td>
<td>• Empowerment</td>
</tr>
<tr>
<td></td>
<td>• Awareness of social norms</td>
</tr>
<tr>
<td></td>
<td>• A flexible environment</td>
</tr>
<tr>
<td>Related concepts</td>
<td>• Autonomy, intentional action, active participation</td>
</tr>
<tr>
<td>Consequence of emancipation</td>
<td>• Free choice</td>
</tr>
</tbody>
</table>

192
5.4.6.3 Operational definition of the concept ‘EMANCIPATION’

In this study, emancipation is described as the process of setting adolescent girls free from social restrictions, and releasing them from paternalistic care and responsibility as well as from any form of controlling influence, by first acknowledging an affective experience of oppression, using the process of conscientisation as well as dialogue to enable adolescent girls to make emancipated decisions in preventing unplanned pregnancies. The process of emancipation occurs through emancipatory education and learning, using personal knowledge, empowerment and reflection, making adolescent girls aware of social norms and the creation of a flexible environment by professionals to enable adolescent girls to reach a positive state of being, a state of freedom of choice in preventing unplanned pregnancies.

5.4.7 Definition of the concept ‘DECISION MAKING’

5.4.7.1 Dictionary definition of the concept ‘DECISION MAKING’

The Oxford South African Pocket Dictionary (Balfour et al., 2002:230) defines a decision as “ conclusion reached after consideration”. The Collins English Dictionary and Thesaurus (2005:149) defines a decision as “a conclusion, judgement, resolution or reaching a settlement, act of making one’s mind, firmness of purpose”. A decision is described by The World Book Dictionary, Volume One (Barnhart, 1995a:178) as “the act of making one’s mind, a resolution”. The Longman Dictionary of Contemporary English (Alexander, 1992:265) defines a decision as “a choice or judgement, the quality of being able to make choices or judgement and to act on them with firmness”.

Blackwell’s Nursing Dictionary (Freshwater & Maslin-Prothero, 2005:169) regards decision making as “the process of choosing courses of action or reaching conclusions regarding important matters”. Decision making is regarded by Mosby’s Medical, Nursing and Allied Health Dictionary (Anderson et al., 1998:449) as “the process of evaluating available information and reaching a judgement or conclusion based on that information”. Merriam-Webster (2013) defines a decision as “a determination or conclusion that is arrived at after consideration, to arrive at a solution that ends in uncertainty or dispute, to make a choice or judgement, to bring to a definite end".
5.4.7.2 Subject definition of the concept ‘DECISION MAKING’

Decision making is regarded by Commendador (2003:28) as a process of making choices among possible alternatives or making choices among competing courses of action. According to Commendador (2003:28), the Normative Model of Decision Making states that decision making first recognises that one must determine that a decision is to be made, understand the goals to be attained, list options, determine consequences, and integrate the information. The Conflict Model of Decision Making (Fantasia, 2008:85) describes decision making as a stressful process that involves potential risks, the assessment of possible successes, and consideration of the time it takes to arrive at the decision. Classical Decision Theory (Fantasia, 2008:85) regards making a decision as involving choosing a course of action among a fixed set of alternatives to work towards a specific goal.

According to Halpern-Felsher (2009:3), competent decision making is not determined by the actual behaviour or the outcomes, but the ability of the decision maker to demonstrate that all the possible options of the decision have been considered and weighed, and that the risks, benefits and all possible components of decision making have been considered. Competent decision making is regarded by Halpern-Felsher, (2009:3) as a process, not the ultimate decision making. In decision making, one does not only consider engaging in a particular action but one also considers the consequences associated with not engaging in the behaviour. This is important in adolescent girls, for whom the choice is often between engaging and not engaging in risky behaviour, both of which have positive and negative outcomes for the youth. The path in which decision making includes deliberate, cognitive processing such as consideration of consequences, perceptions of risks and benefits, attitude about the behaviour and related outcomes, and injunctive social norms, is usually less likely to be followed by adolescents in decision making. Adolescents usually follow the less planned, more experience-based, reactive and affective path (Halpern-Felsher, 2009:4).

Emancipated decision making is described by Wittmann-Price (2006:378) as a theoretical concept indicating the process of reaching a more positive state of being, a state of freedom in choice, by first acknowledging the effective experience of
oppression. Oppression is recognisable when it produces a dilemma in decision making by socially sanctioning one alternative as superior to the other. To arrive at an emancipated decision, women (adolescent girls) must cognitively reflect upon the choices, with this reflection accomplished with or without dialogue. Wittmann-Price and Bhattacharya (2008:225) propose that the five sub-concepts of the Wittmann-Price Theory, namely, personal knowledge, empowerment, awareness of social norms, flexible environment and reflection need to be present in order for women to reach a state of emancipated decision making.

Terms such as critical thinking, reflective judgement and problem solving are regarded as surrogate terms of decision making. While there is a subtle difference in the surrogate terms, they are all the components of the decision making process in which an end result is reached (Commendador, 2003:28; Fantasia, 2008:85).

Table 5.7 lists the essential attributes of the concept ‘decision making’.

**Table 5.7: Essential attributes of the concept ‘decision making’**

<table>
<thead>
<tr>
<th>ESSENTIAL CRITERIA</th>
<th>RELATED CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Act of making up one’s mind</td>
<td>• Reaching a conclusion based on information</td>
</tr>
<tr>
<td></td>
<td>• Evaluating available information and reaching a judgement resolution</td>
</tr>
<tr>
<td></td>
<td>• Reaching a settlement</td>
</tr>
<tr>
<td></td>
<td>• Making choices among possible fixed set of alternatives</td>
</tr>
<tr>
<td></td>
<td>• Making choices among competing courses of action</td>
</tr>
<tr>
<td>Competent decision making</td>
<td>• Considering and weighing all possible; considering risks, benefits and all possible components</td>
</tr>
<tr>
<td>Emancipated decision making</td>
<td>• Reaching a more positive state of being, a state of freedom in choice</td>
</tr>
<tr>
<td></td>
<td>• First acknowledging the effective experience of oppression</td>
</tr>
<tr>
<td></td>
<td>• Cognitively reflecting upon the choices with or without dialogue</td>
</tr>
</tbody>
</table>
## Table

<table>
<thead>
<tr>
<th>ESSENTIAL CRITERIA</th>
<th>RELATED CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Components of emancipated decision making</td>
<td>Personal knowledge</td>
</tr>
<tr>
<td></td>
<td>Empowerment</td>
</tr>
<tr>
<td></td>
<td>Awareness of social norms</td>
</tr>
<tr>
<td></td>
<td>Flexible environment</td>
</tr>
<tr>
<td></td>
<td>Reflection</td>
</tr>
<tr>
<td>Surrogate terms</td>
<td>Critical thinking</td>
</tr>
<tr>
<td></td>
<td>Reflective judgement</td>
</tr>
<tr>
<td></td>
<td>Problem solving</td>
</tr>
</tbody>
</table>

### 5.4.7.3 Operational definition of the concept ‘DECISION MAKING’

Decision making is regarded in this study as a process used by adolescent girls in the following:

- Evaluating available information;
- Making their mind;
- Drawing a conclusion or reaching a judgement;
- Making choices among a possible fixed set of alternatives based on information in the prevention of unplanned pregnancies.

Emancipated decision making is described as the process through which adolescent girls reach a more positive state of being, a state of freedom in choice, by first acknowledging the effective experience of oppression. Emancipated decision making is arrived at through conscientisation, dialogue and cognitively reflecting upon the choices. Attributes of emancipated decision are: personal knowledge, empowerment, awareness of social norms, flexible environment and reflection for adolescent girls' prevention of unplanned pregnancies. Concepts such as critical thinking, reflective judgement, problem solving, autonomy, intentional action and active participation are regarded as related to the outcomes of emancipated decision making in adolescent girls’ prevention of unplanned pregnancies.
5.5 COMPREHENSIVE DEFINITION OF THE CONCEPTS

The prevention of unplanned pregnancies in adolescent girls through emancipated decision making is an act of enabling adolescent girls to reach a more positive state of being, a state of freedom in choice, by first acknowledging the effective experience of oppression in decision making about pregnancy prevention. To reach a state of emancipated decision making in the prevention of unplanned pregnancies, adolescent girls need to have personal knowledge, empowerment, awareness of social norms, availability of a flexible environment and the ability to reflect about the prevention of unplanned pregnancies.

5.6 DISCUSSION OF THE EXEMPLAR CASE

In order to provide the real description of preventing unplanned pregnancies in adolescent girls through emancipated decision making, a model or exemplar case (Walker & Avant, 2011:163) has been described. In this study, the model case utilised is that of adolescent girls, the participants in this study. One-to-one interviews with participants revealed that adolescent girls lack and need:

- **Personal knowledge**, described by intuitive knowledge as well as myths and negative attitudes about pregnancy prevention;
- **Empowerment** to address their low self-esteem, lack of autonomy, lack of dialogue and encourage parental guidance in decision making about pregnancy prevention;
- **Awareness of social norms**, which emerged in data as restrictive community norms and religious norms and the appraisal of these norms;
- **A flexible environment** to improve the negative staff attitude as well as the unacceptable and inaccessible health service delivery in emergencies for decision making in the prevention of unplanned pregnancies.
- **Reflection** to enhance critical thinking, dialogue, active participation and change in order to make emancipated decisions in the prevention of unplanned pregnancies.
Lack of **personal knowledge** was described by participants as intuitive knowledge, lack of experience about sex and contraceptives, and myths and negative attitudes about pregnancy prevention.

These are some of the quotes from participants:

“I did not have information about getting pregnant and sex until after I had my baby when I took my child to the clinic I heard nurses talking about pregnancy and prevention. All what I knew about pregnancy was that if you sleep with a man, you are going to fall pregnant and the man will leave you with that child.” [*Participant H*]

“When using an injection because sometimes you do not menstruate my boyfriend says the menses will get into him and make him sick.” [*Participant J*]

“I have never used contraceptives. It was the first time that I have sex. I hear people talking about prevention of pregnancy.” [*Participant C*]

The need for **empowerment** was expressed by adolescent girls as low self-esteem, lack of autonomy, lack of dialogue and parental guidance, which emerged as sub-categories.

These are the quotes from participants:

“Right now I do not have anything. I do not have matric, I am nothing, and I am just living, relying on a man.” [*Participant N*]

“About the methods of prevention I must ask my boyfriend that between the injection and the oral contraceptives what works better for him because sometimes they say contraceptives makes them weak. Injection because sometimes you do not menstruate he says the menses will get into him and make him sick, while I will get fat so it is better if I use oral contraceptives, which is why I was using oral contraceptives.” [*Participant J*]

“I think if at home they can be open with me about boyfriend issues I would have listened to them, but now at home they are afraid of talking to us about such things. I
can only talk to my friends and my boyfriend about boyfriend stuff and prevention of pregnancy and I take it that advices from home are always the best, but at home they do not talk to us.” [Participant M]

Awareness of social norms emerged in the data as restrictive community norms and religious norms as well as appraisal of these norms by adolescent girls.

These are the quotes from participants:

“The church does not allow girls to use prevention because they do not allow sex before marriage. They do not talk much about sex and prevention in church but we as church members know that it is not allowed in church for girls to have sex before marriage’. I agree with the church that ‘it's a sin’ to have a baby before marriage but most of the times people have children before marriage, or... should I say it’s a mistake (shake shoulders...) I don’t know. I agree with them that marriage before one can have babies. This pregnancy of mine was a mistake because this happened because of the love for worldly things.” [Participant L]

“At the clinic there is that thing that the community like to know more about other people’s affairs, so that is why people use clinics far from where they stay. The community like to check other people’s affairs and if you are a young girl they will say why do you use prevention methods it means you are ‘sleeping around’ and nobody will marry you.” [Participant O]

Limited flexibility of environment was described as negative staff attitude, unacceptable and inaccessible health service delivery in emergencies for decision making in the prevention of unplanned pregnancies.

These are the quotes from participants:

“Nurses are rude to young girls who go for family planning saying that they sleep around’. They usually ask what you are coming to the clinic for. And then they would say: what are you doing with sex because you are still young? Because I am still at
school they will say: ‘what are you doing with sex when you are still at school?’” (Anger on the face) [Participant J]

“I did not go to the clinic because at the clinic we wait for a long time. The queues are long and the nurses go for tea for more than an hour and the nurses are sometimes rude to us especially the young girls they say we sleep around’. (Anger in tone of voice.) the clinic staff are slow, they go for tea for hours while we wait and when they come back from tea they are irritable and start shouting at us. They sometimes turn us back because we are too many they cannot attend to all of us and ask that we come back the following day.” [Participant E]

“I have never used any other contraceptives. I was afraid of getting fat, so I was only using the condoms and because these are rural areas condoms are not always available. When we come from partying we cannot get condoms as the areas where we buy them are closed. Maybe the areas where we party should sell condoms.” [Participant P]

Reflection emerged as critical thinking, dialogue, active participation and change to in order to make emancipated decisions in the prevention of unplanned pregnancies.

These are the quotes:

“Young girls like me must be careful in relationships. They must not believe anybody who says he loves them. If at school they must not rush into relationships but should concentrate on school and getting education. If sexually active they must go for family planning and use condoms.” [Participant D]

“I want to go to adult school and do courses that will help me be able to get a job and work for me and my child and stop relying on the other person.” [Participant N]

The lack of these core concepts of emancipated decision making in women’s (adolescent girls’) health care issues (Wittmann-Price, 2004, 2006; Wittmann-Price & Bhattacharya, 2008) indicates the limited capacity for adolescent girls’ choices in
making health care decisions. Adolescent girls are thus limited in making emancipated decisions in preventing unplanned pregnancies.

5.7 CORE QUALITIES OF AN EMANCIPATION PROGRAMME

Based on the definitions of the concepts above, which are common requirements for facilitating the process of emancipated decision making in the prevention of unplanned pregnancies in adolescent girls, the requirements of such a programme would include:

- An interactive process with an overlapping of learning, practice and experience which involves dialogue with between educator and the educated. The process of emancipation involves improving personal knowledge, reflection and empowerment, creation of a flexible environment, and awareness of social norms.
- The person facilitating emancipation should possess and use professional knowledge and skills, be a facilitator, supporter, counsellor, educator, resource consultant, mobilise resource, enabler and advocate, and should also be a leader who involves others in setting goals in the decision making process, motivates and liberate others, and facilitates participation in decision.
- The person being emancipated should be willing to assume responsibility, be committed, be motivated, participate in goal setting and decision making, have good interpersonal skills and accept change and behaviours that encourage emancipation.
- Methods used for emancipation include emancipatory education, which involves conscientisation, dialogue, active involvement, using principles of andragogy, reflection and a variety of facilitation and assessment methods which include, but are not limited to, reflective journals and group discussions.

5.8 CONCLUSION

In this chapter, the process and purposes of concept analysis were described. The main concepts were identified and described, as well as operationally defined. The exemplar case was also highlighted. The core qualities of the emancipatory education programme were described, which leads to the next chapter. In the next chapter, the conceptual
framework for the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls is discussed.
CHAPTER 6
THE CONCEPTUAL FRAMEWORK FOR THE EMANCIPATORY EDUCATION PROGRAMME FOR ADOLESCENT GIRLS TO PREVENT UNPLANNED PREGNANCIES

6.1 INTRODUCTION

In Chapter 5, the concept analyses of the main concepts were discussed. This chapter continues with phase two, namely, the conceptual framework for the programme. Based on the categories described in Chapter 3, the applicable models and theories used in decision making in the prevention of unplanned pregnancies in adolescents discussed in Chapter 4, and the operational definitions from the concept analysis and the qualities of the emancipatory education programme presented in Chapter 5, the conceptual framework for the emancipatory education programme is described in this chapter.

The use of education for liberation has been echoed by Kofi Annan (in Bankole et al., 2007:28), who states that: “Knowledge is power, information liberating, and education is the premise of progress to every society and in every family.”

6.2 THE CONCEPTUAL FRAMEWORK

According to Chinn and Kramer (2011:246), a conceptual framework is regarded as a logical grouping of related concepts or theories that is usually related to several different aspects relevant to a complex situation such as a practice setting or an educational programme. The conceptual framework that underpins the programme in this study makes use of the logic model (Lewin Group, 2007:9; McCawley, 2013:4) to indicate the relationship of the concepts (Wittmann-Price theoretical concepts) identified in this study, which were analysed in the previous chapter.

The logic model was chosen as a reference for this conceptual framework, as it is a systematic and visual way used to describe the logical linkages among the programme resources, context, activities and outcomes related to a specific problem or situation (Lewin Group, 2007:9) such as the problem of lacking emancipated decision making in the prevention of unplanned pregnancies in adolescent girls. Logic models are narrative
or graphical depictions of processes in real life that communicate the underlying assumptions upon which an activity is expected to lead to a specific result. The model illustrates a sequence of cause-and-effect-relationships, a systems approach to communicate the path towards desired results. Logic models are used by programme managers and evaluators to describe the effectiveness of their programmes (Lewin Group, 2007:9; McCawley, 2013:1). The logic model is therefore used, in this study, as a framework to guide the process of emancipatory education programme construction for the prevention of unplanned pregnancies in adolescent girls. Emancipatory education was identified in the previous chapter as the method used for emancipation.

The conceptual framework in this study, based on the logic model, has its components reflected as assumptions, inputs, context, activities, outputs and outcomes (Lewin Group, 2007:9; McCawley, 2013:4). Table 6.1 below illustrates the thinking map of the programme according to the logic model (Lewin Group, 2007:9; McCawley, 2013:4).

**Table 6.1: Thinking map according to the logic model**

<table>
<thead>
<tr>
<th>COMPONENTS OF THE LOGIC MODEL</th>
<th>APPLICATION TO THIS STUDY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assumptions</strong></td>
<td>Adolescent girls lack emancipated decision making to prevent unplanned pregnancies. The assumption is that the emancipatory education programme for adolescent girls will enhance emancipated decision making in the prevention of unplanned pregnancies.</td>
</tr>
<tr>
<td><strong>Inputs</strong></td>
<td>Enabling policies and legislation. Resources for the programme.</td>
</tr>
<tr>
<td><strong>The context</strong></td>
<td>The primary health care clinic: Where the interventions of the programme operate. Consists of the intrapersonal, interpersonal, institutional factors/organisational factors.</td>
</tr>
<tr>
<td><strong>Activities</strong></td>
<td>Facilitation of the process of emancipatory education.</td>
</tr>
<tr>
<td><strong>Facilitators of the programme</strong></td>
<td>Professional nurses. Multidisciplinary health team.</td>
</tr>
</tbody>
</table>
## Conceptual framework

<table>
<thead>
<tr>
<th>COMPONENTS OF THE LOGIC MODEL</th>
<th>APPLICATION TO THIS STUDY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recipients of the programme</strong></td>
<td>Adolescent girls.</td>
</tr>
<tr>
<td><strong>Outputs</strong></td>
<td>The number of adolescent girls trained, the number of emancipatory education programmes completed.</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td><strong>Short-term outcomes:</strong> Empowered adolescent girls, improved adolescent girls’ personal knowledge, reflection, awareness of social norms, and provision of a flexible environment. <strong>Long-term outcomes:</strong> Ability to make emancipated decisions by adolescent girls to prevent unplanned pregnancies.</td>
</tr>
</tbody>
</table>

(Lewin Group, 2007:9; McCawley, 2013:4)

The conceptual framework for the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls is described with reference to the assumptions, inputs, context, recipients, facilitators, activities, outputs and outcomes. The programme activities, discussed as the facilitation of the process of emancipatory education, are discussed in the next chapter.

### 6.2.1 The assumptions

Assumptions refer to the key underlying suppositions about what the problem is, why it is a problem, who is affected by the problem, reasons for the proposed interventions and what the sources of the assumptions are (Lewin Group, 2007:9; McCawley, 2013:3).

Adolescent girls’ inability to make emancipated decisions in the prevention of unplanned pregnancies is the focus of this study. The programme therefore assumes that adolescent girls need to be able to make emancipated decisions to be able to prevent unplanned pregnancies. Wittmann-Price sets out the conditions for emancipated decision making in women’s health issues as the presence of the sub-concepts of the theory: empowerment, personal knowledge, reflection, flexible environment and awareness of social norms (Wittmann-Price, 2004, 2006; Wittmann-Price &
Bhattacharya, 2008). Data revealed that adolescent girls’ lack of empowerment, personal knowledge, reflection, flexible environment and experience of restrictive social norms contribute to their inability to make emancipated decisions to prevent unplanned pregnancies. Therefore, the assumption is that the emancipatory education programme for adolescent girls’ will enhance emancipated decision making in the prevention of unplanned pregnancies.

Figure 6.1 below indicates the conceptual framework for the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls. Each component of the conceptual framework is discussed according to the logic model (Lewin Group, 2007:9; McCawley, 2013:3).
6.2.2 The national level inputs

According to Lewin Group (2007:9), these inputs are the enabling policies, legislation and resources necessary to operate the programme – in this study, the emancipatory education programme. Describing the inputs needed for the programme provides an

Figure 6.1: The conceptual framework for the emancipatory education programme for the prevention of unplanned pregnancies of adolescent girls
opportunity to communicate the quality and importance of the programme. McCawley (2013:4) contends that institutional, community and public policies have a supporting role in the programme. In this study, the national level inputs include policies and resources.

6.2.2.1 Policies

Many South African policies have both direct and indirect influences on the emancipatory education programme for adolescent girls’ decision making in the prevention of unplanned pregnancies. Panday et al. (2009:40) contend that highly-politicised debates on public policy have the capacity to determine the direction of policy, the type of services that are made available to young people (adolescent girls in this study) and to raise the consciousness of the public about the issue being discussed, often with the potential of producing a shift in norms. WHO (2011:3) recommends that policy-makers must put legislation in place to enable adolescents to access contraceptive information and services, thereby ensuring flexible environments for emancipated decision making in pregnancy prevention.

In South Africa, acts, policies and guidelines have been put in place to promote reproductive and sexual rights and enable adolescents to access contraceptives. Applicable policies, legislation and resources necessary for the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls in this study are briefly described below.

The Bill of Rights, section 27 of the South African Constitution (1996) as amended, enshrines reproductive rights. The act specifically recognises the right to access to reproductive health care, stating that “everyone has the right to have access to health care services, including reproductive health care. Everyone has the right to bodily and psychological integrity which includes the right to make decisions concerning reproduction, to security and control over the body.”

Section 134 of the Children’s Act (2005) as amended by Act 41 of 2007 (Mahery et al., 2010:27) specifically alludes to access to contraceptives, indicating that contraceptives other than condoms may be provided to a child, on request from the child and without
the consent of the parent or caregiver of the child, if the child is at least twelve years of age, proper medical examination is done and medical advice is given to the child. The act further indicates that any person who disregards these provisions is guilty of an offence.

The Choice on Termination of Pregnancy Act (1996) as amended, makes the option of termination of pregnancy available to women on request in accordance with the constitutional mandate to take reasonable legislative and other measures to progressively realise the right to access to reproductive health care services and recognises the constitutional rights of women to reproductive choices.

Chapter 2 of the South African Sexual Offences Act (2007) makes it mandatory for adults to report any incident of sexual abuse. Kandakai and Smith’s (2007:175) assertion that members of public service institutions have a professional, ethical and legal responsibility to protect children (adolescent girls in this study) through reporting actual or suspected cases of child sexual abuse, is in support of the mandatory reporting of adolescent girls’ sexual abuse to prevent unplanned pregnancies.

The purpose of the National Contraception Policy Guidelines (2012) is to enable all people to exercise their contraceptive choices safely and freely. As South African citizens, adolescent girls are therefore entitled to such contraceptive choices in reproductive health services.

The standards of the National Adolescent Friendly Initiative (NAFCI) (WHO, 2009:15), an accredited programme designed to improve the quality of adolescent health services at primary care level, strengthen the public sector’s ability to respond to adolescents’ health needs and indicate that policies and processes that support the reproductive health rights of adolescents are important in health services.

Other policy benefits for the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls have accrued, some of which are described below.
Increased access to education and the availability of social grants, such as old age pension, which assist parents with the provision of basic needs for daily living in many families and enable families to take their children to school (Panday et al., 2009:40). The progressive approach of the Department of Education to allow pregnant girls to remain in school and return to school post-pregnancy has to some extent mitigated the educational and economic consequences of teenage pregnancy (Chigona & Chetty, 2008:20; Panday et al., 2009:40).

The Social Assistance Amendment Act (2010) describes the different strategies developed by the South African government to alleviate poverty to improve the socio-economic status of families and communities addresses (including adolescents). The government of South Africa is still challenged by poverty and the need to reduce it by half by 2015 in line with its commitments to the Millennium Development Goals (MDGs) (Public Service Commission, 2007:ii). One of the MDGs developed at the Millennium Summit intends to eradicate extreme poverty.

Poverty alleviation strategies under the Social Assistance Amendment Act (2010), such as the aged persons grant, child support grant, foster care grant, enabling the poor to access basic education, school nutrition programmes and providing adequate shelter for the poor, have been developed and are available for South African citizens (including adolescent girls) who meet the criteria.

The National Policy on Drug Abuse Management in Schools (2012) offers guidelines on the prevention and management of substance abuse in schools. According to the Department of Basic Education (2012), SGBs strive to prohibit the use of alcohol and other dependence-producing substances within school premises. Alcohol is readily available in South Africa, even to school-age students. According to the report on substance abuse in South Africa (McFadden, 2012:1), school-age youths have an easy time securing alcohol from supermarkets, bottle stores, shebeens and bars. Prevention efforts for substance abuse to school-going adolescents include in-school talks and lessons, increased research, and programmes developed to treat affected populations. While progress has been made, McFadden (2012:1) asserts that additional
efforts are needed to prevent and manage substance abuse in adolescents to enhance emancipated decision making in the prevention of unplanned pregnancies.

Despite the availability and application of these policies and legislation in South Africa, data in this study revealed that there is still a need for improvement in their application. The improved application will ensure flexibility of environments, improvement in the socio-economic conditions of adolescent girls and prevention, control and management of substance abuse in adolescents for emancipated decision making in general and for the emancipatory education programme in particular in this study.

6.2.2.2 Resources

Resources are an important input to the programmes in general and the emancipatory education programme in this study in particular. Resources refer to the material and human resources needed (South African Human Rights Commission, 2009:34) for operating the emancipatory education programme in this study.

Human resources refer to health workers who are integral to the functioning of the health care system. Without a sufficient number of adequately trained and motivated health workers, no health care system can fulfil its human rights obligations (South African Human Rights Commission, 2009:34). Manpower provision is the responsibility of the national government as an input for the success of the health care programmes (Panday et al., 2009:40; South African Human Rights Commission, 2009:34), including the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls in this study. Professional nurses who will facilitate the emancipatory education programme in this study have to be adequately trained in order to meet the needs of adolescent girls to be able to meet the programme outcomes.

Material resources in public clinics include waiting areas, appropriate space for privacy and confidentiality during contraceptive counselling, and a variety of contraceptive methods which influence the implementation of health programmes (South African Human Rights Commission, 2009:39). Such material resources for the implementation of the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls in this study are necessary inputs for the success of the programme.
The context within which the programme operates is discussed below.

6.2.3 The context: The primary health care (PHC) clinic

The context denotes the environment in which the emancipatory education programme operates and has implications for the successful implementation of the programme (Lewin Group, 2007:9). The context for the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls in this study is the PHC clinic in the Hammanskraal community. This context, which has multiple spheres of influence on adolescent girls' behaviour as described by the ecological model (Chapter 4), consists of intrapersonal, interpersonal and institutional/organisational/community factors (Panday et al., 2009:29; Winch, 2012:3). Below is the description of the multiple spheres of influence on adolescent behaviour within the context.

6.2.3.1 Intrapersonal factors

Intrapersonal factors represent those individual factors that increase the likelihood of adolescent girls to engage in risky sexual behaviour. Factors such as sexual experience, sexual partnerships, sexual frequency, contraceptive use and knowledge, beliefs and attitudes about contraceptive use are regarded as intrapersonal factors that influence adolescent girls’ emancipated decision making in the prevention of unplanned pregnancies (Panday et al., 2009:20).

The findings of this study revealed that sampled adolescent girls had intuitive knowledge, lack of experience, myths and negative attitude about contraceptives and pregnancy prevention (lack of personal knowledge, Chapter 3). These intrapersonal factors within the context impact negatively on adolescent girls’ ability to make emancipated decisions about unplanned pregnancy prevention.

6.2.3.2 Interpersonal factors

Within the context of the emancipatory education programme, interpersonal factors represent the social environment in which adolescent girls grow and develop. Family, sexual partners and peers have a significant influence on identity formation (Erikson cited in Weiten et al., 2009:341) and decision making regarding sexual behaviour and
pregnancy prevention. The findings in this study revealed that the family, peers and sexual partners are sources of information for decision making about pregnancy prevention in adolescent girls. They have an influence on emancipated decision making about the prevention of unplanned pregnancies in adolescent girls (refer section 3.4.3).

6.2.3.3 Institutional/organisational/community factors

Health care services, the school, social norms, and the media are the institutional/organisational/community factors within the context which influence adolescent girls in making emancipated decisions about pregnancy prevention.

The findings of this study revealed that institutional factors such as limited flexibility of environment (Wittmann-Price, 2004:442), sub-categorised as negative nursing staff attitudes, unacceptable health service delivery, and inaccessibility health services in emergencies, were barriers to emancipated decision making in preventing unplanned pregnancies within the context (refer section 3.4.1.4). On the other hand, adolescent girls who participated in this study described religious and community norms as restrictive for decision making about pregnancy prevention (refer section 3.4.1.3). The experience by adolescent girls of religious norms such as ‘no sex before marriage’ and the prohibition of the use of contraceptives in some churches and communities were regarded as prescriptive for decision making in pregnancy prevention.

A short discussion of the programme activities discussed as facilitation of the process of emancipatory education follows below. These activities are discussed in detail in Chapter 7.
6.2.4 The programme activities

![Figure 6.2: Activities](image)

Activities of the emancipatory education programme outline the processes, tools, events and actions that are part of the emancipatory education programme implementation. The programme activities are intended to bring about the programme outcomes (W.K. Kellogg Foundation, 2004:2). The activities of the emancipatory education programme are discussed as facilitation of the process of emancipatory education. The facilitation process describes how the activities of the programme will be carried out. Facilitation of the process of emancipatory education in this study aims at the development of critical thinking and critical consciousness raising, through dialogue and active participation leading to action-reflection and action (praxis) to change the situation (state of oppression) of adolescent girls (Galloway, 2012:164; Mooney, 2013:5). The assumption of the programme for the prevention of unplanned pregnancies in adolescent girls is that facilitation of the process of emancipatory education will improve personal knowledge, reflection, flexible environment and awareness of social norms for and empower adolescent girls in emancipated decision making in the prevention of unplanned pregnancies.

A full discussion on facilitation of the process of emancipatory education for the programme for the prevention of unplanned pregnancies in adolescent girls follows in the next chapter.
6.2.5 Recipients of the programme

Adolescent girls are recipients of the emancipatory education programme. In this study, biographical data of adolescent girls, as described according to their ages, educational level, marital status, number of pregnancies, number of sexual partners, religion, ethnic group and living arrangements (refer section 3.2) informed the programme design.

6.2.6 Facilitators of the programme

Figure 6.4: Facilitators
The facilitators of the emancipatory education programme in this study are professional nurses in the PHC clinic. However, the facilitators will enlist the services of other multidisciplinary health team members, such as doctors, psychologists, social workers and lay counsellors during the facilitation of the emancipatory education programme whenever needed. Nolte (2005:3) refers to multidisciplinary teams as participants representing several disciplines working together on a limited and transient basis. While members of the multidisciplinary team may not meet, they work in a coordinated and collaborative fashion (Nolte, 2005:3).

Multidisciplinary members of the team function in several roles, such as care provider, adolescent advocate, coordinator of care, counselling and care of social security. Each member of the team brings discipline-specific expertise (Nolte, 2005:3). As shown by the concept analysis in this study, emancipated decision making requires a collaborative team approach with the person facilitating the emancipatory process possessing professional knowledge and skills, acting as a leader and a guide to involve others in setting goals for decision making (Chapter 5).

### 6.2.7 The programme outputs

![Outputs Diagram](image)

**Figure 6.5: The outputs**

Outputs are described by Silverman, Mai, Boulet and O’Leary (2009:11) as the product or direct services resulting from programme activities. McCawley (2013:4) denote that outputs are the people reached by the programme and recipients of the programme (the emancipatory education programme). Outputs describe the linkage between the
problem and the intended outcomes (McCawley, 2013:4). The outputs of the programme in this study will be denoted by the number of adolescent girls who have been educated by the emancipatory education programme as well as the number of emancipatory education programmes completed.

6.2.8 The programme outcomes

![Diagram of programme outcomes]

Figure 6.6: The outcomes

The outcomes identify the change, that is, the results expected to be achieved by the programme. They denote the specific changes in programme recipients' behaviour, knowledge, skills, status and level of functioning (W.K. Kellogg Foundation, 2004:3). Short-term outcomes represent the most immediate effects attributable to the programme, attainable within one to three years. Long-term outcomes are the conditions that change as a result of action, what the programme is expected to affect (Silverman et al., 2009:12), such as emancipated decision making in the prevention of unplanned pregnancies in adolescent girls in this study. Long-term outcomes can take four to six years to attain, are less attributable to the programme and are difficult to measure (W.K. Kellogg Foundation, 2004:3; Silverman et al., 2009:12). The outcomes are specifically related to the adolescent girls in the Hammanskraal community.
The short-term outcomes for the programme in this study are improved personal knowledge of adolescent girls, empowerment of adolescent girls, provision of a flexible environment, improved awareness of social norms and reflection. The long-term outcome is emancipated decision making by adolescent girls to prevent unplanned pregnancies.

6.2.8.1 Short-term outcomes

Short-term outcomes as reflected above are discussed below.

6.2.8.1 (a) Improved personal knowledge of adolescent girls

The operational definition for personal knowledge has been described as the recognition of new patterns of knowledge and behaviour; the ability to understand oneself; a component of self-awareness, self-reflection, acquired through overlapping of learning, practice and personal experience. Personal knowledge is also acquired through a dialogical, interactive process of collaboration between adolescent girls, health care professionals, parents, friends, peers, sexual partners, the school and the community. Improved personal knowledge of adolescent girls induces a feeling of energy, passion about the knowledge, a sense of responsibility and finding meaning to undergo transformation to be able to make emancipated decisions in preventing unplanned pregnancies.

Based on the operational definition, adolescent girls' intuitive knowledge, myths and negative attitudes about pregnancy prevention and fertility regulation methods will be corrected. The outcomes to measure personal knowledge are based on the outcomes identified in the concept analysis, namely, feeling energised and passionate about the knowledge, having conviction, intellectual satisfaction, and a sense of responsibility including the need to communicate the new knowledge and persuade others of its validity, finding meaning and be able to undergo transformation (Chapter 5).

6.2.8.1 (b) Empowerment of adolescent girls

Empowerment has been operationally defined as an enabling social, interactive and collaborative process by the empowerer, who possesses and uses professional
knowledge and skills. The empowerer acts as a facilitator to guide adolescent girls within a nurturing and caring environment. Empowerment requires open communication, honesty, mutual trust and respect, using resources and tools to enable adolescent girls to realise their strengths and abilities and to develop positive self-esteem, autonomy and responsibility. The adolescent girls should be able to set and reach goals and communicate better with their family, peers and sexual partners to be able to make emancipated decisions about the prevention of unplanned pregnancies. For empowerment to occur, adolescent girls must be committed and motivated, as well as have good interpersonal skills to be able to make emancipated decisions in preventing unplanned pregnancies.

Based on the operational definition, adolescent girls’ low-self-esteem, lack of autonomy, lack of dialogue and parental guidance will be addressed. The outcomes to measure empowerment are based on the outcomes identified in the concept analysis, namely, increased problem-solving ability, better communication, improved self-esteem, autonomy and responsibility, ability to set and reach goals, sense of control over life and change process, positive self-concept, personal satisfaction and self-efficacy (Chapter 5).

6.2.8.1 (c) Provision of a flexible environment

A flexible environment has been operationally defined in this study as a physical, social and psychological environment which is non-judgemental, integrative and evolving, with resilient response to change and uncertainty based on openness, shared vision and willingness to change, and results in greater diversity of choice, effectiveness and efficiency, empowerment, and emancipation, in order to enhance emancipated decision making in adolescent girls for the prevention of unplanned pregnancies. A flexible environment enhances self-esteem, broader thinking, better understanding and participation in decision making for adolescent girls’ emancipated decision making in the prevention of unplanned pregnancies.

Based on this operational definition, negative staff attitude, unacceptable health service delivery and inaccessible health service delivery in emergencies will be addressed. The
outcomes to measure flexibility in the environment are based on the outcomes identified in the concept analysis, namely, effectiveness and efficiency, increased choice, enhanced self-esteem, better understanding and thinking, participation in decision making, and emancipation (Chapter 5).

6.2.8.1 (d) Awareness of social norms

Awareness of social norms has been operationally defined as conscious and dynamic knowledge, perception and comprehension by adolescent girls of social norms as standards of customary behaviour that is required or acceptable, through which their behaviour may be judged as correct or incorrect. For adolescent girls to develop awareness of social norms, they have to be indifferent, angry, frustrated, helpless or in despair about these norms. Awareness of social norms results in creativity, compassion, coherency, heightened sensitivity, increased understanding, a humanistic approach, the potential for making meaningful choices, and connection with social norms as customary rules of behaviour.

Awareness of social norms entails adolescent girls being aware that social norms denote an interaction between the person, the environment and its social and cultural context and that social norms are inevitable, and allows them to appraise these norms in relation to personal knowledge and empowerment through reflection in a flexible environment to be able to make emancipated decisions in the prevention of unplanned pregnancies.

Based on the operational definition, restrictive religious and community norms will be addressed. The outcomes to measure awareness of social norms are based on the outcomes identified in the concept analysis, namely, creativity, compassion, coherency, heightened sensitivity, increased understanding, the potential for making meaningful choices and connection with customary rules of behaviour.

6.2.8.1 (e) Reflection

Reflection has been operationally defined as an activity of thinking for an extended period, a consciousness, a learned method of perceiving society and its oppressive
influence, a form of critical thinking, developing a perception of questioning practices that are based solely on tradition or authority, which requires the presence of a triggering event, open-mindedness, conscious awareness, deliberate choice and responsibility by adolescent girls in making emancipated decisions in the prevention of unplanned pregnancies. Reflection is described in the light of reflection-on-action and reflection-in-action, the outcomes of which include, but are not limited to, freedom of choice, acquisition of personal knowledge, and empowerment and increased capacity for change of adolescent girls for making emancipated decisions in the prevention of unplanned pregnancies. The processes and techniques that foster reflection include physical activity, the use of language, the use of principles of andragogy in education, reflective practice, coaching, role modelling, the use of structured experience, the use of reflective journals or group discussions to enable adolescent girls to make emancipated decision in the prevention of unplanned pregnancies.

Based on the operational definition, critical thinking and change will be enhanced. The outcomes to measure reflection are based on the outcomes described in the concept analysis as learning, change in habits and expectations, development of accurate perceptions, avoiding premature cognitive commitment, increased freedom of action, flexibility, innovation and creativity, effectiveness, effective coping with divergent situations, critical thinking, acquisition of knowledge, empowerment and increased capacity for change (Chapter 5).

6.2.8.2 **Long-term outcome: emancipated decision making**

Emancipated decision making is described as the process through which adolescent girls reach a more positive state of being, a state of freedom in choice, by first acknowledging the effective experience of oppression. Emancipated decision making is arrived at through conscientisation, dialogue and cognitively reflecting upon the choices. Attributes of emancipated decision making are personal knowledge, empowerment, awareness of social norms, flexible environment and reflection for the prevention of unplanned pregnancies in adolescent girls. The outcomes of emancipated decision making have been conceptualised as free choice with concepts such as critical thinking, reflective judgement, problem solving, autonomy, intentional action and active
participation, regarded as related to the outcomes of adolescent girls’ emancipated decision making in the prevention of unplanned pregnancies.

The outcomes to measure emancipated decision making are based on the outcomes described in the concept analysis as free choice, critical thinking, reflective judgement, problem solving, autonomy, intentional action and active participation. Adolescent girls have to achieve these emancipated decision making outcomes for the prevention of unplanned pregnancies.

6.3 CONCLUSION

This chapter discussed the conceptual framework for the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls. The conceptual framework was guided by the logic model and the Wittmann-Price Theory of Emancipated Decision Making in women’s health issues as the theoretical framework. Each component of the conceptual framework was discussed. In the next chapter, the programme activities are discussed as facilitation of the process of emancipatory education for the prevention of unplanned pregnancies in adolescent girls.
CHAPTER 7
DESCRIPTION OF PROGRAMME ACTIVITIES AND IMPLEMENTATION GUIDELINES

7.1 INTRODUCTION

“Adult women, all of us, have to come to grips with how we have been affected by gender norms, and how we have been silenced. We have to help our daughters. Understanding oppression within ourselves and helping our young girls stand up for themselves is one way, if you can intervene early in the lives of girls here and in other parts of the world, you can begin to change the prospects for the future.” Jane Fonda (BrainyQuote, 2014b)

Chapter 6 discussed the conceptual framework for the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls. This chapter describes the programme activities based on the conceptual framework. The programme activities are discussed as the facilitation of the process of emancipatory education. Guidelines for the implementation of the programme are also discussed in this chapter.

7.2 OVERVIEW OF THE EMANCIPATORY EDUCATION PROGRAMME ACTIVITIES

The programme activities are described as the facilitation of the process of emancipatory education by professional nurses in collaboration with the multidisciplinary health team. According to Freire (in Ferreira & Ferreira, 2009:5), emancipatory education is the type of education and learning where the adolescent girls are the subject of their own destiny in the learning process. In Pedagogy of the oppressed, Freire (2000:71) opposes the ‘banking’ concept of education which regards adolescent girls as passive recipients of education and the facilitators, who are educators, as experts who have the knowledge and impart it to adolescent girls. According to Freire (2000:71), the ‘banking’ concept of education is regarded as an instrument of oppression and the emancipatory education as an instrument of liberation. Freire
Chapter 7
Programme activities

(2000:71) proposes that education should make oppression and its causes the objects of reflection by the oppressed (adolescent girls).

The facilitators of the programme and adolescent girls are equal participants in the facilitation process for emancipatory education. The purpose of emancipatory education is to develop an understanding of and knowledge about the nature and root causes of unsatisfactory circumstances in adolescent girls’ lives in order to develop real strategies to change the unsatisfactory conditions (Thompson, 2000:1). Freire suggests that emancipatory education ‘raises the awareness’ so that adolescent girls become subjects, rather than objects, in the emancipatory education process (Thompson, 2000:1).

The emancipatory education process is facilitated through a group process (Yalom & Leszcz, 2005:143) because emancipated decision making has been described as the process through which adolescent girls reach a more positive state of being, a state of freedom in choice, by first acknowledging the effective experience of oppression (Chapter 5). The facilitation process is discussed in three phases, namely, the relationship, work and termination phases. The relationship phase consists of building rapport and identification of the problems. The work phase includes analysing the factors and acting to change the situation through consciousness raising, enhancing life skills and reproductive health education. The termination phase includes evaluation of the emancipatory education programme.

The outcome, as described in Chapter 6, is to enhance emancipated decision making, through empowerment, improving personal knowledge and reflection, providing flexible environments and awareness of social norms (Wittmann-Price, 2004, 2006; Wittmann-Price & Battacharya, 2008).

Figure 7.1 below illustrates the programme activities of the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls.
Chapter 7
Programme activities

Figure 7.1: The programme activities
7.3 FACILITATION OF THE PROCESS OF EMANCIPATORY EDUCATION FOR THE PREVENTION OF UNPLANNED PREGNANCIES IN ADOLESCENT GIRLS

Facilitation of the process of emancipatory education in the prevention of unplanned pregnancies in adolescent girls is discussed with reference to two role players: the facilitators of the programme and the adolescent girls. The process unfolds in three phases: the relationship phase, the work phase and the termination phase.

7.3.1 Facilitators in the process of emancipatory education

The facilitators of the process of emancipatory education in the programme for the prevention of unplanned pregnancies in adolescent girls in this study are professional nurses. The professional nurses will act as agents for facilitating the emancipatory education programme. Due to the sensitivity of the programme content, it is proposed that two professional nurses per group will be there throughout the programme to ensure continuity and engagement (Yalom & Leszcz, 2005:155) with adolescent girls, even on a personal level, rather than having many facilitators.

The Nursing Act (2005) defines a professional nurse as a person who “is educated and competent to practice comprehensive nursing, assumes responsibility and accountability for independent decision making in such practice, and is registered and licensed as a professional nurse under the Nursing Act”. Professional nurses in the clinics work with adolescent girls on a daily basis and have the professional knowledge and skills of dealing with adolescent girls' decision making in unplanned pregnancy prevention.

The facilitation process in the emancipatory education programme will be a team work approach. The multidisciplinary health team members will include doctors, social workers, lay counsellors and psychologists. These members of the multidisciplinary team will be available for referral of adolescent girls who need their expert services. However, these members of the multidisciplinary health team may be co-opted during the process of the programme for their expertise.
7.3.1.1 Preparation of facilitators

Training and skills development of health care professionals on the requirements necessary to teach comprehensive sexuality in adolescents is done at national level, and is managed, sustained and supported at community level by health care institutions (South African Human Rights Commission, 2009:38). In this process of emancipatory education for the programme for the prevention of unplanned pregnancies in adolescent girls, short workshops and seminars will be provided at the clinic to prepare facilitators for the process of emancipatory education.

Facilitators in this programme have to be trained in and understand the group facilitation process of emancipatory education and learning, reproductive health and enhancing life skills. Facilitators will be trained by a member of the multidisciplinary health team who has knowledge and skills about group facilitation and emancipatory education. The training of facilitators will be based on their knowledge and clinical experience to equip them with knowledge in the group facilitation of emancipatory education, reproductive health and enhancing life skills.

Yalom and Leszcz (2005:155) indicate that group facilitator training should prepare facilitators for:

- Participant observation, to afford them objectivity in making observation about cyclic or sequence of events in group facilitation;
- Recognising the process of interaction;
- Articulating the group dilemma in a balanced, non-blaming manner.

7.3.1.2 The role of facilitators

The roles of the facilitators in facilitating the group process are to:

- Provide support and assist adolescent girls as individuals and to increase group effectiveness;
- Observe the group process and focus on facilitating the group;
• Create a flexible and safe environment in which adolescent girls can contribute their ideas;
• Balance the process and content, as well as encourage adolescent girls to express their feelings openly;
• Assist adolescent girls to overcome barriers to direct communication;
• Assist adolescent girls to integrate what they are learning in the group with their everyday life through creating scenarios and role plays;
• Terminate the facilitation process effectively (Jefferson & Rahman, 2014:3; Yalom & Leszcz, 2005:558).

Mayo (1995:369) and Mooney (2013:4) add to the role of facilitators, indicating that the programme facilitators’ role in emancipatory education is not to be authoritative figures, but their responsibilities include: acting as guides rather than experts, introducing thought-provoking scenarios or questions which have no right or wrong answers, recording group themes, modelling active listening and providing information and clarification when asked. The role of facilitators in the process of emancipatory education programme is to work hand-in-hand with the adolescent girls in order for learning and personal growth to take place to achieve the outcome of the programme, that is, emancipated decision making in the prevention of unplanned pregnancies.

7.3.1.3 Values of facilitators

The values of facilitators in facilitating group process of emancipatory education have been summarised as:

• Having valid information: sharing all relevant information with the group members and inviting debates about information to reach consensus (Bressen, 2013).
• Allowing free and informed choice: taking consideration that, while external control generates compliance, internal control generates commitment, thus seeking to increase the extent to which adolescent girls make their own choices during group interaction (Bressen, 2013; Yalom & Leszcz, 2005:558).
• Serving everyone’s interest: understanding that, to be effective, groups of adolescent girls must maintain their ability to work together and meet their
personal needs as well as the needs of the groups in the process of emancipatory education. Facilitators should shift focus from blaming to understanding how problems arise and how they can be solved to enhance emancipated decision making in the prevention of unplanned pregnancies (Yalom & Leszcz, 2005:558).

- *Increasing responsibility and ownership, and reducing dependence:* recognising that systematic solutions lie in facilitating the group’s ability to address the root cause of their problems in emancipated decision making in the prevention of unplanned pregnancies and their ability to address such problems (Bressen, 2013; Yalom & Leszcz, 2005:558).

- *Creating conducive conditions for learning:* sharing core values, principles and ground rules with the group, asking for feedback, and modelling values so that the group can make informed choices in the prevention of unplanned pregnancies (Bressen, 2013; Chapter 5).

Facilitators need the following skills in order to enhance emancipated decision making.

**7.3.1.4 Skills of facilitators**

The following skills necessary for facilitators in emancipatory education have been summarised by Casey, Roberts & Salaman (1992:4), Chapter 5 of this study and Vidal (2013:3) as:

- *Educator with professional knowledge and skills:* sharing professional knowledge and experience in the process of emancipatory education to enhance knowledge and skills of adolescent girls for improving personal knowledge, empowerment, the ability to reflect, being able to assist in improving flexibility in the decision making environment and awareness of social norms in making emancipated decisions in the prevention of unplanned pregnancies.

- *Counsellor:* for identifying, assisting and referring those adolescent girls presenting with problems during the process of emancipatory education.

- *Resource consultant and mobiliser (human and material resources):* planning for materials such as preparing the venue, resources to be used and human
resources such as mobilising and enlisting the services of other multidisciplinary team members needed in the process of emancipatory education in the programme.

- **Enabler and advocate**: enabling adolescent girls through the group process to be able to engage in dialogue and actively participate. Facilitators must also be able to talk on behalf of adolescent girls when necessary.
- **Communication**: putting points across using all techniques available both verbally and non-verbally, as well as being receptive listeners.
- **Leadership**: being able to focus, stimulate constructive debates, support, and have respect for the adolescent girls and only being a leader if and when necessary as adolescent girls must have their own group leaders during group interactions.
- **Interpersonal relationships**: being able to deal with adolescent girls' problems as individuals and as a group.
- **Authenticity**: being consistent in approach, not moving the goalpost, and becoming trustworthy to individual adolescent girls and within the group as a whole throughout the process of emancipatory education in the programme for the prevention of unplanned pregnancies.
- **Patience and perseverance**: appreciating difficulties of group work and having the determination to see the process of emancipatory education completed.
- **Integrity**: being an example to adolescent girls on how to conduct oneself in a group context.

Corey (2001:39), Jefferson and Rahman (2014:11), and Yalom and Leszcz (2005:558) add the following skills required by facilitators in group process in the emancipatory education programme in this study as:

- **Initiating**: being able to start any task in the process of emancipatory education, and having the group working; acting as a catalyst to get adolescent girls to focus on meaningful work and employing various techniques to promote deeper exploration of feelings in the emancipatory education process.
- **Setting goals**: assisting adolescent girls to select and clarify their own specific goals as well as setting goals for the group in the process of emancipatory education.

- **Active listening**: paying total attention and being sensitive to both verbal and non-verbal communication for individual adolescent girls and the group.

- **Supporting**: being able to bring out information even from introverted adolescent girls by providing encouragement and reinforcement, and instilling confidence in them as individuals and as a group through appearing purposeful and in control, subduing group insecurities.

- **Flexibility**: being able to fulfil different group roles to keep the group process fluid and maximising potential to encourage adolescent girls to participate actively in group interactions.

- **Clarifying**: responding to confusing and unclear aspects of the message and helping adolescent girls to sort out conflicting feelings during their engagement in group discussions about issues influencing emancipated decision making in unplanned pregnancy prevention.

- **Summarising**: pulling together important elements of group interaction during adolescent girls’ group work and allowing adolescent girls to develop the skill of doing so in their own small groups.

- **Giving feedback**: giving specific and honest feedback based on observation of adolescent girls’ group interaction and encouraging them to give each other feedback.

- **Evaluation**: an ongoing process throughout the duration of group process whereby, at the end of each session, an assessment is done of what is happening to individual adolescent girls and to adolescent girls in groups. Facilitators should apply ongoing evaluation of the process of emancipation in order to determine achievement of the outcomes of the programme at the end.

- **Terminating**: facilitators in this programme have to learn when and how to terminate their work with individuals and with groups. Termination includes group facilitators’ ability to provide adolescent girls with suggestions for applying what they have learnt to their daily lives, providing for evaluation, follow-up sessions
suggesting resources for further references and being available for individual consultation for adolescent girls should the need arise. Termination of the process of emancipatory education should be done at the end of the process and should be gradual, with all adolescent girls taking part in the termination process at the end of the programme.

Below is a discussion of adolescent girls’ role in the process of emancipatory education.

### 7.3.2 Adolescent girls in the process of emancipatory education

Adolescent girls will be recipients of the emancipatory education programme. The emancipatory education will transform the adolescent girls who are in the learning process in this programme from object status to that of subject through conscientisation using problem-posing, dialogue and active participation (Freire in Darwish, 2009:64). Freire (2000:71) proposes that education should make oppression and its causes the objects of reflection by the oppressed (adolescent girls); from reflection will come adolescent girls’ necessary engagement in the struggle for liberation. Critical reflection on the situation of oppression by church norms, community norms, sexual partners and the health care system (inflexible environment) by adolescent girls will be facilitated in this process of emancipatory education to enhance emancipated decision making in preventing unplanned pregnancies. Action-reflection-action (praxis) of adolescent girls is facilitated through actively involving them from planning of the programme, through the use of dialogue, active participation and consciousness raising to change the situation in a concrete, objectively verifiable way (Mooney, 2013:6).

Concept analysis in this study indicates that adolescent girls should have heightened consciousness to establish contact with reality (Chapter 5). To be able to change the situation of oppression, Ferreira and Ferreira (2009:4) and Mooney (2013:5) state that adolescent girls need personal knowledge and empowerment acquired through reflection upon their experience in a flexible environment which brings greater insight and understanding.
Ferreira and Ferreira (2009:5) and Thompson (2000:2) indicate that the role of adolescent girls (the oppressed) in the process of emancipatory education should be:

- Being the subjects and not objects of the learning process, through which they can become subjects of society, by not being recipients of knowledge but learning to question rather than merely answer questions, therefore being co-creators of knowledge.
- Being actively involved in the process of emancipatory education through dialogue and critical thinking that will raise their consciousness about realities in their lives in decision making about pregnancy prevention through the thought-provoking questions raised by facilitators.
- Being able to critically think about the issues that affect their lives (awareness of social norms; inflexible environments in health care settings), being able to question the inequalities, injustices and the abuse of power by society, including the health care services, against adolescent girls in decision making about preventing unplanned pregnancies. Consciousness raising, critical thinking, dialogue, reflection and active involvement in the process of emancipation will enhance adolescent girls’ achievement of deepening awareness of social reality that shapes their lives and of their capacity to transform that reality. They will therefore be able to reflect, gain personal knowledge and be empowered.
- Being able to act-reflect-act (praxis), that is, act to bring about change. They will be able to make a connection between experiences, understanding, and social reality and be able to bring about change (Ferreira & Ferreira, 2009:5; Thompson, 2000:2).

Jefferson and Rahman (2014:3) add to the role of adolescent girls in the process of emancipation, arguing that adolescent girls should bring ideas to the group, be open, be prepared to participate, be prepared to share ideas and assist to develop group members’ ideas.

A discussion of the facilitation of the process of emancipatory education follows below.
7.3.3 Facilitation of the process of emancipatory education

Facilitation in the emancipatory education programme is a process in which the facilitators are acceptable to all adolescent girls in the group. The facilitators should be substantively neutral, have no substantive decision making authority, diagnose and intervene to assist adolescent girls improve how they identify and solve problems and makes decisions. The group facilitators should increase the group’s effectiveness (Crockett & Foster, 2005:1; Schwarz, 2006:5).

The process of emancipatory education used in this programme takes the form of adult facilitation of learning (problem-posing), which stresses the importance of a dialectical relationship of self and society, personal experience and the society, the self and involvement in the learning process, and active involvement of the self in the emancipatory education and learning process (Dirkx, 1998:8).

The rationale for the appropriateness of emancipatory adult facilitation of learning in the process of emancipatory education in this programme is to assist adolescent girls in identifying factors acting as constraints to emancipated decision making in the prevention of unplanned pregnancies. The emancipatory education process further aims at freeing adolescent girls from the coercive influence of constraints for emancipated decision making through reflection, dialogue, critical thinking, critical consciousness raising and active participation in action-reflection-action in the programme (Dirkx, 1998:8; Thompson, 2000:4). Adolescent girls in this process of emancipatory education are conscientised to critically analyse the factors which act as constraints on emancipated decision making, including factors such as poverty, substance abuse, restrictive social norms and inflexible environment. Conscientisation enables adolescent girls to become aware of their own capabilities in improving their circumstances. The emancipatory education process leads to adolescent girls’ self-education and self-actualisation (Thompson, 2000:4).

Thompson (2000:4) states that education on its own cannot change societies in which there are economic and class systems which encourage discrepancies of wealth and access to resources, including access to information. Furthermore, the author argues
that education can play a significant part in assisting people (adolescent girls) in their various struggles against social injustices and inequalities when heightened awareness gets connected to increased understanding and joint action to bring about change. Concept analysis (Chapter 5) in this study shares the notion of education as a strategy for liberation, indicating that education and training are the methods used for emancipation in decision making.

In the facilitation of the process of emancipation, adolescent girls are encouraged to take more control of their learning process, learn with and from each other as they identify and implement solutions to challenge problems or other issues within the group, set objectives, and be involved in assessment of their learning (Crockett & Foster, 2005:1; Schwarz, 2006:5). Two professional nurses will facilitate the process of emancipatory education in this programme for continuity and deeper engagement with adolescent girls throughout the programme. The services of other multidisciplinary health team members will be enlisted when needed in order to draw skills from different experts in the health care profession, as recommended in Chapter 5 (Concept analysis).

The environment for emancipatory education for emancipated decision making in this programme should be nurturing and caring, and there should be openness, honesty, genuineness, open communication, acceptance of people as they are, mutual trust and respect, value of others, courtesy and shared vision (Chapter 5).

Planning for the process of emancipatory education is discussed below.

7.3.4 Planning for facilitation of the process of emancipatory education

Planning for facilitation of the emancipatory education will be done by facilitators and adolescent girls. Facilitators, who are professional nurses working in the primary health care clinic, will recruit adolescent girls visiting the reproductive health clinics to participate in the emancipatory education process of the programme for the prevention of unplanned pregnancies. Adolescent girls who already had unplanned pregnancies will also form part of the group that is recruited in the programme to enable them to share their experiences.
The ages of adolescent girls recruited and participating in the programme will range between 16 and 21 for their insight and experience in group discussions with reference to unplanned pregnancy prevention. Parental consent will be obtained for adolescent girls under the age of 18 (Children’s Act, 2005; National Health Act, 2003).

The duration of the programme will be twelve weeks, with meetings held once a week on Saturdays for five hours, from 08H00-13H00, when adolescent girls are not at school. Yalom and Leszcz (2005:292) recommend shorter periods in group meeting as longer hours may have the disadvantages of diminished inputs and participant drop-out. The venue for the meeting will be the primary health care clinic in a room identified by professional nurses who are facilitators. The room for facilitation of emancipatory education must afford adolescent girls privacy and be free from distractions. Yalom and Leszcz (2005:292) suggest that an ideal size for an interactional group is five to ten members. The group size for the emancipatory education process in this programme will be ten adolescent girls to enhance critical thinking, active participation and dialogue during group interaction (Mooney, 2013:6).

On completion of the process of emancipatory education in the programme, the health facility will award recognition certificates to adolescent girls who completed the process of emancipatory education in the programme for the prevention of unplanned pregnancies. Adolescent girls who completed the process will be recruited to participate as facilitators in the following groups of adolescent girls enrolling in the process of emancipatory education. The adolescent girls who will be prepared for facilitation will undergo a ‘Train the Trainer’ course offered by facilitators of the process of emancipatory education in the programme at the primary health care clinic. The duration of their training will depend on the needs of the programme. Yalom and Leszcz (2005:545) recommend a period of six to ten observations, which provides sufficient time for development, group interaction and interpersonal growth to facilitate group processes.
7.3.5 The phases of facilitation of the process of emancipatory education

Facilitation of the process of emancipatory education for adolescent girls in the prevention of unplanned pregnancies is divided into the *relationship phase, work phase* and *termination phase*. The division and flow of events between the phases are flexible, cyclic and overlapping (Yalom & Leszcz, 2005:310). Figure 7.2 below illustrates the phases of facilitation of emancipatory education in adolescent girls’ prevention of unplanned pregnancies.

![Figure 7.2: The process of emancipatory education](image_url)
7.3.5.1 The relationship phase

The relationship phase in the process of emancipatory education includes building rapport and problem identification. During the relationship phase, the role of the facilitators is to clarify misconceptions, unrealistic fears and expressions, and to provide the adolescent girls with a realistic structure that facilitates effective group participation (Yalom & Leszcz, 2005:310). At this stage, adolescent girls are still not knowledgeable about emancipated decision making, as indicated by the smaller size of the spiral in the diagram of the process of emancipatory education (Figure 7.2).

- **Building rapport**

  Building rapport involves facilitators and adolescent girls getting to know one another, demonstrating openness to one another without judgement, and getting to know the perceptions of the self and the others. The group facilitators will introduce the emancipatory education process of the programme for the prevention of unplanned pregnancies to adolescent girls and programme objectives, meeting dates and times. The programme objectives, meeting dates and times will be discussed and agreed upon.

- **Problem identification**

  The facilitators will engage adolescent girls in a participatory discussion in identifying problems (Freire in Martinez, 2013:7) related to the emancipated decision making in the prevention of unplanned pregnancies. Facilitators and adolescent girls will critically engage in getting to know one another particularly adolescent girls’ lives with regard to the school, the community, the church, the health care system and generally the issues they face on an ongoing basis with regard to emancipated decision making in the prevention of unplanned pregnancies (Freire in Martinez, 2013:7; Mooney, 2013:6).

  Material representative of the problems will be produced where adolescent girls can create a drawing, video, audio tape, or flipchart (Mooney, 2013:6) which indicates a list of issues to be discussed. Weekly, during meeting days, the list of problems will be re-visited and any new problems from adolescent girls will be added to the list. The
problems identified will be analysed and a plan of action drawn in the next phase, the work phase.

7.3.5.2 The work phase

During the work phase, facilitators engage adolescent girls in exploring the problems as identified. During this phase, facilitators relieve anxiety within the group by creating a conducive environment, shaping group norms of support, acceptance and group autonomy. Facilitators establish appropriate objectives that can be addressed in the time available, moderating the moves so that the pace is neither too fast nor slow and ending well (Yalom & Leszcz, 2005:545). The work phase in this process of emancipatory education is discussed as analysing the factors that influence emancipated decision making and acting to change the situation. During this phase, adolescent girls are growing in their ability to make emancipated decisions as indicated by the size of the spiral in Figure 7.2.

- Analyse the factors that influence emancipated decision making in the prevention of unplanned in adolescent girls

Both the adolescent girls and the facilitators will analyse the intrapersonal, interpersonal and institutional/community factors that influence emancipated decision making in the prevention of unplanned pregnancies as indicated by the ecological systems model (Panday et al., 2009:4). All the factors influencing emancipated decision making in unplanned pregnancies prevention as identified in data (refer section 3.4) will be analysed. A plan of action will be drawn to address the identified issues (Martinez, 2013:8; Mooney, 2013:6), which leads to the next step, namely, acting to change the situation.

- Act to change the situation

Acting to change the situation in this study involves the facilitators engaging adolescent girls in acting on the identified problems through critical consciousness raising, enhancing life skills and reproductive health education. The process of acting to change the situation involves the following: critical consciousness raising, enhancement of
life skills and reproductive health education. The process of acting to change the situation commences with critical consciousness raising.

7.3.5.2 (a) Critical consciousness raising

The process of emancipation is believed to begin with critical consciousness raising, a dialectical process that involves assisting adolescent girls to name the multiple conditions of their lives influencing emancipated decision making in unplanned pregnancy prevention, identify the limits imposed by their situation, develop awareness of oppression, and take action to transform the conditions (Martínez, 2013:5). Critical consciousness raising involves critical thinking, an element of consciousness raising. Through critical thinking, which is defined by Vihar (2013:5) and Thompson (2000:2) as the ability to analyse information and experiences in an objective manner, adolescent girls will make things happen, that is, they will act to change the situation rather than have things happen to them (Thompson, 2000:2). Critical thinking assists adolescent girls to recognise and assess the factors that influence attitudes and behaviour, such as values and peer pressure (Vihar, 2013:5).

Conscientisation involves recognising the inequalities imposed by the oppressor and willingness to take action to change these inequalities or to oppose oppression (Darwish, 2009:64). Recognising the inequalities imposed by the oppressor involves adolescent girls recognising the community and church norms, sexual partners and the health care system, lack of flexibility in reproductive health services, and socio-economic conditions of poverty and substance abuse as oppressive for their emancipated decision making in pregnancy prevention.

Critical consciousness is demonstrated by four qualities, namely, power awareness, critical literacy, desocialisation and self-education. (Martínez, n.d.:5; Van Wyk, 1999:30):

*Power awareness* is explained by the fact that, if adolescent girls do not realise that they are capable of behaviour change over a prolonged period of time, they cannot be motivated by a professional person to change. It entails adolescent girls becoming their own *locus of control* in knowledge generation and acquisition. Power awareness not
only enables the adolescent girls to become knowledgeable but also attaches value to own experience and expertise, which increases self-value. The approach focuses on what adolescent girls already know and the facilitator determining the structure of the process of emancipatory education in the programme through the problem-posing adult education approach (Baum, MacDougall & Smith, 2006:855; Martinez, n.d.:5; Van Wyk, 1999:30).

Power awareness enables empowerment and improvement of personal knowledge which is sustained by offering adolescent girls knowledge, the opportunity for decision making and the use of available resources in a flexible environment (Martinez, n.d.:5; Van Wyk, 1999:30). Power awareness in this study is also enhanced through enhancing life skills and reproductive health education as identified from the findings of this study (Chapter 3).

It is, however, important to realise that power awareness needs a certain degree of literacy (Van Wyk, 1999:30).

According to Freire (in Van Wyk, 1999:32), critical literacy, referred to as critical thinking and reflection, is the characteristic that distinguishes people (adolescent girls) from animals. Animals are not able to change their situation but people (adolescent girls) make decisions through critical thinking and reflection and are therefore able to change their situation. Critical elements of critical literacy which enable adolescent girls to be able to make decisions and change their situation include dialogue and active participation.

Freire (2000:87) indicates that the essence of education as the practice for freedom uses dialogue in search for programme content of education and awakening consciousness. According to Kawalilak (2006:5), dialogue is aimed at fostering shared meaning; it is a form of narrative learning. Its nature is to explore and to gain a deepened understanding of the perspectives and lived experiences of self and others. Dialogue provides opportunities for the co-creation of knowledge by inviting adolescent girls in a process of creativity, within safe spaces, to make new meaning of perspectives.
and experiences of their lives in pursuit of emancipated decision making in the prevention of unplanned pregnancies.

Dialogue creates pathways for discovery; it encourages lateral thinking, suspends judgement and welcomes ambiguity. Through authentic trust and openness, there is a potential for perspective and relationship transformation for adolescent girls and their parents, peers, sexual partners and the health care system for enhancing emancipated decision making in the prevention of unplanned pregnancies. Suspending judgements and tightly-held convictions by adolescent girls and facilitators in the process of emancipatory education promotes collective exploration of experience and perception, thus testing traditional definitions, beliefs and assumptions (Kawalilak, 2006:5; Torres, 2013:4).

Freire (in Darwish, 2009:50) believes that when dialogue takes place, adolescent girls are no longer docile listeners but critical co-investigators. The same author suggests that dialogue is an act of creation which distinguishes critical knowledge and cultural action for freedom; it is not some kind of conversation, but a social praxis. When facilitators through dialogue encourage adolescent girls to view the world through their own critical lens, and to see how it is related to them, dialectical co-investigation develops a democratic attitude in adolescent girls. The democratic attitude can help adolescent girls to learn from, listen to and criticise others as well as to participate in forming public policies and community and church norms, and to resist or transform them (Freire in Darwish, 2009:50).

Active participation in learning is a process that promotes critical thinking, dialogue, and growth which can be measured through praxis, that is, by understanding the realities in adolescent girls’ lives and committing to change. Dialogue between facilitators and adolescent girls entails active learning that is not based on mere repeating and memorising but that requires an intense faith in humankind, faith in the power to make and remake, to create and re-create, and at the heart of such a relationship is respect (Darwish, 2009:37).
Active participation in learning involves both dialogue and critical thinking. However, this learning does not become active just by engaging in dialogues and by critically thinking; it becomes active only when adolescent girls take the next step to change the inequalities and injustices inflicted by the oppressors (Darwish, 2009:37) in making emancipated decisions in the prevention of unplanned pregnancies. Active learning then translates into the act of freedom or breaking out of the culture of silence. Experience, communication and reflective thinking are necessary tools (Darwish, 2009:37) in the process of emancipation for decision making in preventing unplanned pregnancies in flexible environments (Wittmann-Price, 2004:440).

Desocialisation recognises the myths and values which have been conveyed to adolescent girls about emancipated decision making in unplanned pregnancy prevention and questioning them. Through desocialisation, adolescent girls become aware of the constraints that they have allowed to influence emancipated decision making in the prevention of unplanned pregnancies as well as the right to their own action and life. Through desocialisation, adolescent girls are empowered to take control of their own life, make their own decisions and no longer allow others (sexual partners, health care system, community and the church) to make decisions for them or prevent them from making emancipated decisions on pregnancy prevention. Through the process of action-reflection-and-action, the walls and boundaries which have constrained adolescent girls in making emancipated decisions are broken. Adolescent girls critically evaluate the lack of positive self-image, adherence to myths and values (Chapter 4) through the process of desocialisation and transform or challenge them.

Self-education is regarded by Martinez (n.d.:5) as the ability of adolescent girls to take the initiative to transform relationships and society away from authoritarian relations and the undemocratic, unequal distribution of power. Freire (in Van Wyk, 1999:33) accentuates the advantage that collective knowledge developed through dialogue and active participation holds for adolescent girls. Such a process is regarded as empowerment education, as adolescent girls empower themselves. Self-education involves adolescent girls actively taking initiative in the process of emancipation in this programme to identify those constraints in society (oppressive community and church
norms, sexual partners, inflexible environments in reproductive health services) and actively participating in the emancipatory education process of the programme to transform or challenge them to be able to make emancipated decisions in pregnancy prevention.

7.3.5.2 (b) Enhancing life skills

The second step of acting to change in the process of emancipatory education for adolescent girls’ emancipated decision making in the prevention of unplanned pregnancies addresses enhancing life skills. WHO (Module 7: Life skills, 2014:2) has defined life skills as, “the abilities for adaptive and positive behaviour that enable individuals (adolescent girls) to deal effectively with the demands and challenges of everyday life”. UNICEF in Module 7: Life skills (2014:2) on the other hand defines life skills as “a behaviour change or behaviour development approach designed to address a balance of knowledge, attitude and skills” in adolescent girls for emancipated decision making in the prevention of unplanned pregnancies.

Childhood and adolescence are the developmental periods during which one acquires life skills through various methods and people (Srikala & Kishore-Kumar, 2010:344). According to Bender (2002:26), life skill enhancement covers the competencies and skills that adolescent girls need for sustaining and enriching life and also the behaviour-based learning to cope with everyday life. Life skills consist of knowledge, attitudes and skills that enable adolescent girls to deal with the demands of everyday life (Bender, 2002:26). According to Bender (2002:27), knowledge is the dimension involving ‘knowing how to do it’; attitude is the demand that adolescent girls must assume personal responsibility for acquiring, maintaining and using the skill; and the skill entails putting the knowledge and attitude into practice which entails: ‘knowing how to do it, wanting to do it and doing it right’.

Life skills are indispensable for empowering adolescent girls in the process of emancipatory education in this programme to engage and cope successfully with challenges of life such as social norms and inflexible environments (Wittmann-Price, 2004:440). Development of life skills promotes psychosocial competence, enhances an
individual’s coping and promotes personal and interpersonal competence and confidence (Srikala & Kishore-Kumar, 2010:344). Central to the philosophy of life skills are the concepts of empowerment, personal knowledge and reflection (Wittmann-Price, 2004:440) and the belief that life skills can be learned, modified and improved as adolescent girls develop and adjust to life challenges. The notion that all young people, including adolescent girls, should be prepared for life at all levels, physically, emotionally, cognitively and socially, if society is to have adults capable of making rational and emancipated decisions (Bender, 2002:27), is in line with the study purpose.

The importance of life skills in adolescent girls has been summarised as:

- Helping adolescents to translate knowledge, attitudes and values into healthy behaviour.
- An efficacious tool for empowering adolescent girls to cope with the demands of life, act responsibly, take initiative, control and build their capacity.
- Capacity-building, which implies the growth and development of people (adolescent girls), a process which assists adolescent girls in becoming actively involved in the various initiatives in the reconstruction of their communities.
- Life skills are based on the assumption that, when adolescents are in control and able to rise above life challenges arising from peer pressure and entangled relationships, they are less likely to resort to anti-social or high-risk behaviour such as unplanned pregnancies (Bender, 2002:29; Module 7: Life skills, 2014:4; Vihar, 2013:7).

Although the nature and description of life skills are likely to differ across social and cultural contexts, an analysis of life skills fields suggests that core life skills are integral for promoting social functioning and healthy well-being. This set of skills includes: problem solving, effective communication, interpersonal relations, self-awareness, empathy, critical thinking, coping with stress, coping with emotions and creative thinking (Vihar, 2013:7).

Reflection, as a skill necessary for emancipated decision making in women’s health issues (Wittmann-Price, 2004, 2006; Wittmann-Price & Battacharya, 2008) applied in
this study, adds to the list of life skills for adolescent girls in the process of emancipatory education in the programme for the prevention of unplanned pregnancies in this study. These life skills are briefly described below:

- **Problem solving**

Problem solving helps adolescent girls to deal constructively with problems in their lives (Vihar, 2013:6). It is a component of decision making, as adolescent girls have to be able to think critically and creatively about a problem before taking a decision.

- **Effective communication**

Effective communication implies adolescent girls’ ability to express themselves, both verbally and non-verbally, in ways that are appropriate to their cultures and situations, the ability to express opinions and desires, needs and fears. Effective communication also means being able to ask for advice and help in a time of need (Vihar, 2013:6).

Effective communication is regarded as the ability to listen and understand others’ needs, negotiation/refusal skills and **assertiveness** skills that influence one’s ability to manage conflict. Development of this skill enables adolescent girls to be accepted, engage in group work, express respect for others and be accepted in society. The skill further assists in adolescent girls’ awareness of social norms that provide the foundation for adult social behaviour (Module 7: Life skills, 2014:3; Vihar, 2013:6). Effective communication is a crucial skill for adolescent girls in this study for active involvement and dialogue in the process of emancipatory education.

- **Interpersonal relationship skills**

Interpersonal relationships are regarded as the nature of interactions that occur between two or more people (adolescent girls and facilitators, adolescent girls within their group/s) who interact covertly or face-to-face. Interpersonal relationship skills are the life skills we use every day to communicate and interact with other people, both individually and in groups, to fill each other’s explicit or implicit physical, emotional or psychological needs. Interpersonal relationship skills help adolescent girls to be able to relate in positive ways and be able to make and keep friendly relationships. It also
means the ability to keep good relations with friends and family members, which is an important source of social support. **Empathy**, which is the ability to listen and understand others’ needs, is also a key interpersonal skill in emancipated decision making in adolescent girls’ prevention of unplanned pregnancies (Module 7: Life skills, 2014:3; Vihar, 2013:5).

- **Self-awareness**

  Self-awareness includes adolescent girls’ recognition of their ‘self’, character, strengths, weaknesses, likes and dislikes, and enables them to set goals. Self-awareness is often a requirement for effective communication and interpersonal relations as well as self-esteem and self-management (Module 7: Life skills, 2014:3; Vihar, 2013:5). The skill is important for adolescent girls in this study to improve self-esteem for emancipated decision making.

- **Creative thinking**

  The skill entails adolescent girls doing things that are characterised by fluency (generating new ideas), flexibility (shifting perspective easily), originality (conceiving of something new) and elaboration (building on other ideas). Adolescent girls need this skill when dealing with difficult decisions (Module 7: Life skills, 2014:3; Vihar, 2013:5), such as emancipated decision making in the prevention of unplanned pregnancies.

- **Decision making**

  The skill assists adolescent girls on how to actively make decisions about their actions, making healthy assessment of situations, viewing different decision options and dealing constructively with consequences of decisions in their lives (Commendador, 2007:615; Fantasia, 2008:85; Module 7: Life skills, 2014:3).

- **Coping with stress**

  Coping with stress entails recognising the source of stress and the effect it has on adolescent girls, and developing coping or management strategies which include how to avoid the source of stress if possible (Vihar, 2013:6).
• Coping with emotions

Coping with emotions involves teaching adolescent girls to recognise the emotions within them and others, being aware of how emotions influence behaviour and developing the ability to respond appropriately to emotions (Module 7: Life skills, 2014:3; Vihar, 2013:6).

• Reflection

Becoming a reflective learner (2013:1) defines reflection as the practice that facilitates the exploration, examination and understanding of what one is feeling, thinking and learning. Through reflection, one is able to challenge assumptions, ask new questions and try to make sense of experience. Moon (2003:1), on the other hand, regards reflection as a form of mental processing used to fulfil a purpose or to achieve some anticipated outcome. Reflection is applied to gain better understanding of relatively complicated or unstructured ideas, based on the processing of knowledge, understanding and emotions that a person already possesses (Becoming a reflective learner, 2013:1; Taggart & Wilson, 2013:8).

Through reflection, adolescent girls become active creators of their personal knowledge, integrate theory and practice through a process of reflection-on-action (making sense of experience after the fact) and reflection-in-action (trying to make sense of experience while it is occurring).

The findings of the study (Chapter 3) indicated a reproductive health knowledge gap in adolescent girls. A discussion of reproductive health education in the process of emancipatory education in this study follows below.

7.3.5.2 (c) Reproductive health education

According to the International Women’s Health Coalition (Germain, 2008:7), international agreements affirm that all adolescents have the right to receive age-appropriate sexual and reproductive health information, education, and services that will enable them to make decisions in a positive and responsible way to prevent unplanned pregnancies. According to such agreements, adolescents’ access to information and
services is not to be restricted by discriminatory legal, regulatory or social barriers based on age, marital status or by the attitude of health care providers. This stance of access to information about emancipated decision making in the prevention of unplanned pregnancies in adolescent girls is shared by the researcher.

Sexuality, included in reproductive health, is a central aspect of humanity and encompasses sex, gender identities and roles, sexual orientation, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviour patterns, roles and relationships. Sexuality is affected by the interaction of biological, social, economic, political, cultural, ethical-legal, religious and spiritual factors (WHO, 2006:3).

The content of reproductive health education, including sexual health, which emerged as a knowledge gap in adolescent girls in the findings in this study (Chapter 3), will be included in the process of emancipatory education. However, any other reproductive health information needs identified by adolescent girls during the problem identification will also be addressed.

The role of facilitators in conducting reproductive health education will be to engage adolescent girls to identify their existing knowledge about reproductive health, which is dealt with in the school curriculum (Department of Basic Education, 2012:3), and fill the identified gaps in knowledge. The following areas of reproductive health are important in the emancipatory education programme:

- **Adolescence**

Adolescence will be addressed in collaboration with the school curriculum (Department of Basic Education) to add to and reinforce what adolescent girls learn in class. The *definition, stages and challenges* of adolescence, *parental involvement* in adolescent development and *decision making* and *emancipated decision making* in pregnancy prevention have to be addressed.
• The menstrual cycle and available methods of contraception

The menstrual cycle (cross refer school curriculum) should be handled with the contraceptive methods to indicate their mechanism of action in regulating fertility. According to the Department of Health (2012), the following contraceptive methods are available in the Republic of South Africa: injectable methods, oral contraceptive methods, intra-uterine contraceptive device (IUCD), the emergency contraceptive (the morning-after pill), sterilisation and condoms. Etonogestrel implant is a contraceptive method that has just been made available at public health facilities including PHC clinics. It is effective for three years when inserted just beneath the skin of the upper arm.

• Areas providing reproductive health services

Contraceptive methods are provided free of charge by the reproductive health clinics in all public PHC service points which include clinics, community health centres and district hospitals. The private sector is playing an increasing role in the provision of primary care. The population accesses family planning services through private sector providers, predominantly medical practitioners, although there are also a number of family planning pharmacists who are licensed to provide contraception services directly to the public (Department of Health, 2012b). Although adolescent girls are aware of these areas providing family planning reinforcement, it is important to include them in the programme to enable them to make emancipated decisions in pregnancy prevention about where to get their contraceptives.

• Legislation facilitating adolescent emancipated decision making in pregnancy prevention

Legislation and policies are important to the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls. Facilitators of the programme should be aware of such legislation. Legislation such as the Constitution of the Republic Of South Africa (1996) as amended, which includes human rights, reproductive and sexual health rights, and all other policies which will enhance emancipated decision
making for the prevention of unplanned pregnancies in adolescent girls must be considered as discussed as inputs for the programme (refer section 6.2.2).

The other multidisciplinary team members will offer specialised education, such as psychological counselling, social assistance like accessing child support grants and other specialised reproductive health care services.

**7.3.5.2 (d) Other strategies used during the work phase**

During the work phase of the process of emancipatory education, adolescent girls will be involved in other strategies that can be used to act to change their situation of inequalities or to oppose oppression. Such strategies include:

- Involvement of adolescent girls in workshops to health care professionals about improving flexibility in the reproductive health services. Workshops and seminars will assist in the personal and professional growth of professional nurses.
- Use of mechanical media such as school newsletters, parents’ personal letters, school notice boards, local newspapers and pamphlets can also be used to address the problems such as social norms as identified by adolescent girls in the process of emancipatory education. Adolescent girls will be taught how to write small-scale articles in the local news-letters about such issues. Electronic media such as television are common media readily available and used by many communities in addressing social issues such as social norms.
- The use of the local radio services has also proven to be effective in many programmes and can thus be used in this process of emancipatory education for addressing diverse issues as identified in the programme (Center for the Advancement of Human Rights, 2010:7; Commonwealth of Kentucky, 2013:10).

The final phase of facilitation of the process of emancipatory education follows below.

**7.3.5.3 The termination phase**

During the termination phase, which is the concluding phase of the process of emancipatory education, monitoring and evaluation done on a continuous basis is discussed. Monitoring is defined as a systematic collection and analysis of information
(Shapiro, 2013:3) during the facilitation of the process of emancipatory education. Monitoring and evaluation is based on the activities and intended outcomes of the programme. Programme monitoring is done to improve the efficiency and effectiveness of the programme and is used as a base for evaluation of the programme at the end of the process of the programme (International Federation of Red Cross and Red Crescent Societies, 2011:11; Shapiro, 2013:3). Efficiency is regarded as a measure that indicates whether the input into the work is appropriate in terms of the output, implying the time, money, staff, and equipment needed, given the benefits of the programme. Effectiveness, which is defined as the extent to which the aims and objectives of the process and programme are met (Shapiro, 2013:3; International Federation of Red Cross and Red Crescent Societies, 2011:11), will also be monitored in this process of the programme.

During the termination phase, reflections by adolescent girls about the progress made at the end of each contact day will be summarised. Evaluation, a systematic and objective way of judgement based on careful assessment of an ongoing or completed programme, its design, implementation and the intended outcomes (Shapiro, 2013:3) will be done to determine the achievement of outcomes. Evaluation will be done by both adolescent girls and facilitators in this process of emancipatory education. Monitoring and evaluation entails judging the progress made by adolescent girls in addressing the identified problems, that is, meeting both the long-term and short-term programme outcomes.

Peer assessment and self-assessment will be used to continuously monitor the progress made by adolescent girls in achievement of the programme outcomes. Peer assessment is regarded as a useful method which can give useful feedback about how a particular presentation has gone, what others think about it and how one can improve on it. The role of the peer assessors is to look at the work of the fellow adolescent girl/s very closely and commenting on the output, giving feedback and putting the work in the context of the topic under discussion (Koivista & Jokinen, 2013:40). Self-assessment will be carried out by adolescent girls to assess their own progress in the programme.
Continuous monitoring of the progress made by adolescent girls will be done using peer assessment, self-assessment and assessment by facilitators.

Evaluation of the programme will be done by facilitators and the group to judge the progress of the programme in meeting the stated outcomes of the programme. Other stakeholders such as the clinic management staff can also be invited to take part in programme evaluation.

The next discussion handles the implementation guidelines.

**7.4 GUIDELINES FOR THE IMPLEMENTATION OF THE PROGRAMME ACTIVITIES**

The programme activities entail the facilitation of the process of emancipated decision making. During this process, the adolescent girls and facilitators will move from the relationship phase, to the work phase, to the termination phase. The role of facilitators is to guide adolescent girls through the process. Implementation guidelines to facilitate the process of emancipatory education are discussed with reference to the objectives and strategies for each phase of the process.

**7.4.1 The relationship phase**

- **Objective**

The objective of the relationship phase is rapport building between facilitators and adolescent girls and problem identification for the process of emancipatory education programme activities.

- **Strategy and actions**

The facilitators, who are professional nurses, will engage adolescent girls in building rapport and identifying factors influencing emancipated decision making in the prevention of unplanned pregnancies. During this phase, facilitators introduce the programme for emancipatory education and the process of facilitation. The role of facilitators during this phase is to clarify misconceptions, unrealistic fears and expressions, and provide the group with realistic structure that facilitate effective group participation (Yalom & Leszcz, 2005: 310).
Facilitators create a relaxed, trusting, non-threatening, and collaborative climate to promote a positive facilitation climate. Adolescent girls who are adult learners respond when they are in mutual negotiation, when they can learn and contribute at their own pace, and when they can participate in their own assessment process. The clinic setting, a room where there is flexibility for free dialogue, active participation and facilitation of deep meaningful group interaction, should be arranged by facilitators. The room should be appropriate for physical, affective, social and intellectual interaction (Dominick, 1992:5).

The physical climate is concerned with the ergonomics, the interaction of adolescent girls with their physical and spatial environment. Facilitators will attempt to provide adolescents with an environment with adequate lighting, comfortable temperature, cleanliness, quiet surroundings and access to internet facilities. Seating arrangements should be sufficient and flexible to allow different group activities. A circle arrangement of seating is best for group interaction such as discussions and any group work (Dominick, 1992:9).

Facilitators also create an affective-social environment, which is an environment reflecting how adolescent girls feel about what they are learning, and how the facilitators and adolescent girls relate and interact with one another. The affective social environment refers to an environment in which adolescent girls experience safety, understanding, trust, caring, acceptance, respect, humour and support (Chapter 5; Van der Merwe & Albertyn, 2009:15).

Facilitation of the process of emancipatory education is both an affective and rational endeavour which entails maintaining the ability to use the emotions intelligently and maintaining a balance between reason and emotion. The facilitation setting should be both safe and challenging to encourage originality and differences of opinions in adolescent girls. Thought-provoking scenarios provide both the facilitator and adolescent girls with opportunities to examine beliefs, thoughts, actions and traditions. Different opinions from adolescent girls and facilitators allow facilitators and adolescent girls to review their own beliefs and traditions and seek new information to understand
the tradition about emancipated decision making in the prevention of unplanned pregnancies in adolescent girls (Dominick, 1992:9; Van der Merwe & Albertyn, 2009:15).

The group, consisting of ten members, should be a closed group who will start from the beginning of the process of emancipatory education of the programme to the end with no new members joining the group in order to ensure continuity (Yalom & Leszcz, 2005:292). Resources that will facilitate engagement of adolescent girls and facilitators in the discussion, such as videos, audio tapes or a flipchart, should be provided by facilitators. Internet facilities should be made available to enable adolescent girls to search for information during group sessions. The internet facilities should be made available even after the contact session for those adolescent girls who wish to stay behind or do their group work any day of the week.

7.4.2 The work phase

- **Objective**

The objective of the work phase is to analyse the factors that influence emancipated decision making and act to change the situation. Acting to change the situation of oppression involves critical consciousness raising, enhancing life skills and reproductive health education.

- **Strategy and action**

During the work phase, actions are carried out to address the identified problems. Facilitators work with adolescent girls to create thought-provoking scenarios for critical consciousness raising. The elements of critical consciousness rising, power awareness, critical literacy, desocialisation and self-education are applied. Adolescent girls are engaged in conscientisation, a dialectical action proposed by Freire as the process that proceeds by cooperation, unity, organisation and cultural synthesis, a process by which adolescent girls can reach praxis, a process which leads to desocialisation. Through conscientisation, adolescent girls will be able to question the normative expectations and roles (desocialisation) about unplanned pregnancy prevention. Critical thinking,
self-reflection, dialogue and consciousness-raising, facilitated in participatory circumstances, facilitate the process of desocialisation and enable adolescent girls to move from awareness of issues that confront them on a daily basis to challenging the issues (Van der Merwe & Albertyn, 2009:153; Vihar, 2013:10).

Scenarios from experience, the school, the community, the family or from literature can be used to engage adolescent girls in dialogue, active participation and reflection for conscientisation. Such scenarios may be created by:

- Giving adolescent girls a text or journal article to read, or asking them to visit a website which deals with social issues influencing adolescent decision making in the prevention of unplanned pregnancies.
- Asking the adolescent girls to then share their reaction to the material read with the group.
- Stimulating dialogue through questions from the facilitator as well as from the group.

Example of such questions could be:

1. What are your reactions to the readings?
2. How do the readings fit in with your personal experiences?
3. What additional information could be useful?
4. What can you/I do to create change? (Becoming a reflective learner, 2013:5; Taggart & Wilson, 2013:20).

Dialogue created by discussing the questions requires adolescent girls' critical thinking, reflection and engaging in finding solutions or answers to questions which usually do not have right and wrong solutions or answers.

*Enhancing life skills* is done by facilitators to enable adolescent girls to engage in dialectical debates and discussions in learning the skills. Adolescent girls need to have knowledge and use of life skills. Enhancing life skills requires a systematic and appropriate approach. In facilitation of skills, the facilitator creates an environment
conducive to learning and provides the resources that encourage adolescent girls to explore, discover and learn the skills (Bender, 2002:43).

According to Bender (2002:43) and Mooney (2013:4), the role of the facilitators in enhancing life skills includes: introduction of the topic and setting the scene for the session, dividing the group into smaller groups for the purpose of active participation and group effectiveness, organising feedback sessions, summarising essential issues that come out of the sessions such as feelings, and challenging adolescent girls to critically think and reflect about the session, what they think and feel about the session and what they learned. In facilitating life skills, facilitators ensure that knowledge, attitude and behaviour change are incorporated. Criteria for effective life skills facilitation, such as reinforcement and application to real life, must be taken into consideration (Module 7: Life skills, 2013:4; Vihar, 2013:8).

Furthermore, tasks or homework must be given to allow for continuity and progression of adolescent girls in learning the skills.

Reproductive health education involves facilitators using relevant facilitation strategies to engage adolescent girls in reproductive health information sharing. Topics such as puberty (including menstruation) and the different contraceptives and their modes of action will be discussed to address the attitudes and myths about contraception which emerged in the findings (Chapter 3). Adolescent girls will be involved in debating about the applicable reproductive health policies which have a role in adolescent girls’ emancipated decision making about pregnancy prevention. Reproductive and sexual health rights, which are important in reproductive health for making emancipated decisions by adolescent girls about the prevention of unplanned pregnancies, will also be discussed.

Facilitation strategies commonly used to facilitate reflection, dialogue and active participation in the emancipatory education as recommended by Vihar (2013:9); Van der Merwe and Albertyn (2009:15) will be used. These facilitation strategies, which include role play, brainstorming, case studies, small group discussions, critical incident
analysis, journaling (reflective journals), audio and visual activities, storytelling, debates, educational games and simulations, are briefly discussed below.

- **Role play**

Role play is an informal dramatisation in which adolescent girls act out a suggested situation such as decision making in unplanned pregnancy prevention. The procedure for role play includes describing the situation to be role played, selecting role players, giving instructions to role players, starting the role play and discussing what happened. The facilitators assist adolescent girls to interpret and clarify the meaning of the play with regard to the content/skill. Role plays are beneficial as they provide an excellent strategy for practicing skills; experiencing how one might handle a potential situation in real life, increasing empathy for others and their point of view, and increasing insight into one’s own feelings (Dominick, 1992:6; Hudson, 2010:3; Vihar, 2013:10).

- **Brainstorming**

Brainstorming is a method of creative thinking that is used to come up with new ideas to solve problems. Adolescent girls actively generate a broad variety of ideas about a particular topic or questions in their real life about emancipated decision making in unplanned pregnancy prevention in a given, brief period of time. Brainstorming is a good discussion starter because adolescent girls can creatively generate ideas in the brainstorming session using given criteria. Brainstorming can be conducted as follows: no criticism allowed, all ideas must be accepted, adolescent girls may suggest any idea that comes to mind, ideas should not be discussed when they are first suggested, ideas must be recorded in a place where everyone can see them, the ideas should be reviewed, and at the end, the ideas should be added to, deleted where appropriate, and categorised. The facilitator helps the group to review the ideas and add, delete and categorise according to the given criteria at the end (Vihar, 2013:10).

- **Case studies**

Case studies are methods directed towards a real life or imaginary story that describes what happened in the community, family or school, or to an individual regarding
emancipated decision making in unplanned pregnancy prevention. Case studies assist adolescent girls in examining the interrelationship of multiple phenomena in real life situations and generate creative approaches to finding solutions to problems in real life. The use of case studies assist adolescent girls to acquire problem solving, decision making skills, learn how to organise ideas logically, practice creative, critical and innovative thinking. The procedure of case study formulation involves guiding questions to trigger thinking and discussion, and giving adequate time for creative thinking and processing. The facilitators act in guiding adolescent girls to clarify the process, not to give answers (Vihar, 2013:10).

- **Small group discussions**

In a small group discussion, adolescent girls are divided into smaller groups of five and given a short time to accomplish a task, carry out an action, and discuss a specific topic, problem or question. The goal is better understanding of an issue or skill, or developing new ideas and directions for the group. Small group discussions can be conducted as follows: state the purpose of the discussion and the amount of time available, form small groups, arrange the seating so that members can hear one another easily, ask the groups to appoint a leader and recorder, and have the recorder describe the group’s discussion at the end. Small group discussions promote leadership and assist adolescent girls to develop skills in listening, assertiveness and empathy (Hudson, 2010:3; Van der Merwe & Albertyn, 2009:153; Vihar, 2013:10).

- **Critical incident analysis**

Critical incidents are specific occurrences, positive or negative, considered significant in adolescent girls’ lives, the school, the community or the family. Critical incidents could be moments when adolescent girls become aware of the problem of unplanned pregnancy or a solution to a problem (McClure, 2013:5). An example of a critical incident could be an adolescent girl, suddenly realising that somebody has disclosed information about a decision taken about an unplanned pregnancy that she has kept as a secret, being faced with a difficult situation of decision making about unplanned pregnancy in her life which has no right or wrong answer. Critical incidents often lead to
generalisable ideas and solutions which are transferable to other groups or situations (Becoming a reflective learner, 2013:5; Taggart & Wilson, 2013:20).

- **Reflective journals**

Reflective journals are personal expressions and are a vehicle for reflection. Journals can take different forms, such as electronic, sketchbook, audiotape or a combination of some of them. Adolescent girls can choose what their reflective journals should look like to suit the uniqueness of their individual qualities and personalities. A record in the reflective journal includes things such as written reflections, drawings, pictures, quotes and descriptions of dreams. Through the process of reflective journaling, more ideas, feelings and creative energy about emancipated decision making in the prevention of unplanned pregnancies are opened up and adolescent girls should not be limited to using one style, but a combination according to their abilities. The reflective journal is flexible, is a useful back-up for adolescent girls’ learning, and accentuates favourable conditions for learning such as time, space and reflection about emancipated decision making in unplanned pregnancy prevention. Reflective journal writing creates the possibility to provide adolescent girls with a systematic approach to development of reflection and critical thinking (Becoming a reflective learner, 2013:5; Koivista & Jokinen, 2013:8; Moon, 2003:4).

- **Storytelling, audio and visual activities**

In storytelling, the story related to emancipated decision making in unplanned pregnancy prevention is read, told or shown to the group, and pictures or video can be used to supplement the story. Adolescent girls are encouraged to think about the story and discuss the implications of the story to the topic as it is told. Storytelling can be used to assist adolescent girls to develop critical thinking skills related to emancipated decision making in the prevention of unplanned pregnancy locally, nationally or internationally. It can be used to develop their abilities to write, draw and narrate, as well as their problem solving skills. The procedure of developing a story includes keeping the story simple, making sure that the story, and pictures if also included, relates to adolescent girls’ emancipated decision making in the prevention of unplanned
pregnancies, making the story dramatic enough to be interesting, including mixed situations such as sadness, happiness, excitement, thought provoking, decision making and problem solving (Becoming a reflective learner, 2013:5; Koivista & Jokinen, 2013:8; Moon, 2003:4).

- **Educational games and simulation**

Adolescent girls are requested to play games as an activity for facilitation of skills such as critical thinking, problem solving and decision making. Simulations are meant to pretend or mimic situations which are experienced by adolescent girls about emancipated decision making in unplanned pregnancy prevention. They are activities structured to feel like real life experience. Educational games and simulation create fun, active learning and are a rich source of learning. They require combined use of knowledge, attitudes and skills, and allow adolescent girls to test their abilities in safe, supervised environments. In games, the facilitator should always remind adolescent girls that the activity is meant to be enjoyable and that it does not matter who wins. Simulations should be brief and discussed immediately (Dominick, 1992:6; Vihar, 2013:14).

- **Debates**

In a debate, the problem is presented to adolescent girls and they must try to solve the problem by engaging in an educational argument about an issue on emancipated decision making in unplanned pregnancy prevention as the whole group, or they may break into small groups. Debate offers adolescent girls an opportunity to learn in-depth arguing about the problem and a chance to practice critical thinking. The facilitators in debates should allow adolescent girls to take the position of their choice (if too many choose one position, volunteers are requested for the less-represented choice), provide an opportunity for adolescent girls to research the topic, make sure adolescent girls show respect for the opposing group, not allow dominance by one group over the other, maintain control, keep the discussions within the topic and summarise at the end (Dominick, 1992:6; Vihar, 2013:14).
Giving feedback is of importance in group facilitation. Both adolescent girls and facilitators should know how to give feedback.

- **Giving feedback**

Feedback is non-judgemental communication, constructive observations and suggestions on work done, skills acquired, emerging capabilities, and ideas for directing adolescent girls for further learning. Feedback can be formal or informal. Feedback is a general process that enables adolescent girls to integrate learning and practice in a real life setting (McClure, 2013:11). A facilitation process without feedback would be incomplete and any form of assessment must be followed by feedback. It is, however, important for facilitators to remember that feedback should not be unexpected by adolescent girls but provided while the behaviour is still fresh in their memories. Feedback should deal with observable behaviour that is remediable. For feedback to be effective, facilitators must always set the stage for the feedback session, the timing should be appropriate for adolescent girls to receive feedback, and the actual content of feedback given should be appropriately able to correct the behaviour (Maritz, 2006:227).

Facilitation of the process of emancipatory education is not complete unless some monitoring and evaluation strategies are put in place and implemented to monitor the progress towards achievement of the outcomes of the programme. Guidelines for monitoring and evaluation are discussed as the next and final phase of the emancipatory education process for adolescent girls’ prevention of unplanned pregnancies, which is the termination phase.

**7.4.3 The termination phase**

- **Objective**

The objective of the termination phase is to end the process of the programme for emancipatory education for the prevention of unplanned pregnancies in adolescent girls. Monitoring and evaluation are the strategies used in this process of emancipatory
education to assess the progress made by adolescent girls in achievement of the outcomes of the programme.

- **Strategy and actions**

During the termination phase, the facilitators and adolescent girls end the process of emancipatory education by assessment of the progress made by adolescent girls towards empowerment, improvement of personal knowledge, reflection, awareness of social norms, provision of flexible environments in health care services and, finally, towards emancipated decision making in the prevention of unplanned pregnancies. Yalom and Leszcz (2005:389) argue that, for successful termination to occur, the facilitators should regularly remind adolescent girls of approaching termination so that they continuously work towards a successful termination.

Monitoring and evaluation applied in the process of emancipatory education include the use of continuous peer assessment, self-assessment and assessment by the facilitators. Through self-assessment, adolescent girls are involved in their own assessment process, which signifies taking into account their opinions about their progress in the process of emancipatory education (Koivista and Jokinen, 2013:40). Reflective journals can be a valuable way used by adolescent girls in this process of emancipatory education, reflecting critically about what they have been doing, if it has worked well or badly, how it relates to theory, and how they can improve (Becoming a reflective learner, 2013:5; Koivista & Jokinen, 2013:8) in making emancipated decision making in the prevention of unplanned pregnancies.

In peer assessment, the role of the peers is to look at the work of the fellow adolescent girls very closely and in depth. The actual assessment consists of asking for the rationale behind the work, commenting on the output, giving feedback and putting the work in the context of the topic they are focusing on (Koivista and Jokinen, 2013:40). Peer assessment is regarded as a method which can give useful feedback about how a particular presentation has gone, what others think about it and how it can be improved (Koivista and Jokinen, 2013:40).
Facilitators can use any of the facilitation and assessment methods described above, such as critical incidents, reflective journals and presentations, to assess the progress of individual adolescent girls as well as the groups.

Programme evaluation is discussed in the next and final chapter.

7.5 CONCLUSION

The activities of the programme, discussed as the facilitation of the process of emancipatory education for the programme for the prevention of unplanned pregnancies in adolescent girls, have been described. The following chapter discusses evaluation of the programme, conclusions, and recommendations of the study.
CHAPTER 8
PROGRAMME EVALUATION, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

8.1 INTRODUCTION

In Chapter 7, facilitation of the process of emancipatory education for prevention of adolescent girls’ unplanned pregnancies was discussed. This chapter describes the final phase, phase four, of the programme, evaluation by critical reference group and adolescent girls, conclusions, limitations and recommendations by the researcher.

8.2 EVALUATION OF THE RESEARCH

Evaluation of the programme requires an analytical process in order to understand the nature and value of the programme to practice, education and research (Chinn & Kramer, 2011:197). There are no normative criteria for the questions used; therefore, there are no correct answers for them. The process of evaluation creates a basis for critical reflection and the categories used for descriptive purposes are interrelated. The questions used can also be used for other forms of evaluation of empiric knowledge (Chinn & Kramer, 2011:197).

8.2.1 Evaluation by critical reference group

The first strategy used to evaluate the research in this study was the use of critical reference groups consisting of supervisors, peers and experts in the clinical field. The critical reference groups’ evaluation of the research was utilised in the following ways: Firstly, the research was supervised by two study supervisors with experience as supervisors in model and programme development, implementation and evaluation. Secondly, the programme was presented and evaluated to a critical reference group consisting of peers and experts in the clinical field at a seminar. This critical reference group consisted of eleven people, of whom:

- Two were lecturers, one with a doctoral degree;
- One was the CEO of the hospital;
• One was the doctor working in the gynaecological ward and the reproductive health clinic;
• Two were nursing service managers;
• Two were professional nurses from the reproductive health clinic;
• Two were professional nurses from the Antenatal ward;
• One was a lay counsellor from the reproductive health clinic.

The programme was further sent to an expert colleague who has a doctoral degree: a specialist in programme development and qualitative research. The researcher used the evaluation criteria of Chinn and Kramer (2011:197), namely, clarity, simplicity, generality, accessibility and importance.

8.2.1.1 Clarity

This category considers how clear the programme is, considering the semantic clarity, semantic consistency, structural clarity, and structural consistency (Chinn & Kramer, 2011:198).

The programme was rated as clear, with all concepts fitting in the programme. Structural alterations in the input for the programme were suggested and implemented.

8.2.1.2 Simplicity

This category describes how simple the programme is. The number of elements within each descriptive category is reflected upon. Concepts and their interrelationship statements should be minimal (Chinn & Kramer, 2011:201).

The programme was evaluated as: “Simple, easy to understand and applicable to all areas such as schools, Nursing Education, Nursing practice especially PHC and research.”

8.2.1.3 Generality

This category answers the critical reflective question: How general is the programme? In describing the generality of the programme, the scope and purpose of the programme are addressed (Chinn & Kramer, 2011:202).
The group’s comments were that:

“The programme is a general one which can be applied at all levels of health care but specifically at Primary Health Care level. The reference group indicated that a bigger symposium should be arranged where primary health care nurses should be invited and the programme be presented.”

8.2.1.4 Accessibility

The critical reflective question answered in this category is: How accessible is the programme? Accessibility describes the extent to which the empiric indicators for the concepts can be identified and to what extent the purpose of the programme can be attained (Chinn & Kramer, 2011:203).

Some of the comments from the reference group were:

“This programme is an eye opener; some of us will need to be trained as well to deal with adolescents to be able to meet their needs. The concepts are clearly indicating that we as healthcare professionals are not sensitive to the needs of adolescent girls. A flexible environment and accessibility of services to adolescents can assist in reducing unplanned pregnancies generally thus realising the MDG’s.”

8.2.1.5 Importance

This category describes how important the programme is. In describing the importance of the programme, the clinical significance of the programme to practice, research and education with reference to emancipated decision making in the prevention of unplanned pregnancies in adolescent girls is addressed (Chinn & Kramer, 2011:204).

A comment from a member of the group:

“With its futuristic view, the programme has a potential to greatly influence nursing research, education and practice especially Primary Health Care nurses who are the first contact with clients in the community.”
8.2.2 Evaluation by adolescent girls

The researcher further held an evaluation of the research by adolescent girls. The purpose of the evaluation was based on the Wittmann-Price Theory which proposes equal rights, equal treatment and caring, authentic ‘voice’ within safe space and a flexible environment for decision making (Kuokkanen & Leino-Kilpi, 2000:237; Wittmann-Price & Bhattacharya, 2008:225).

Therefore, the objective of the evaluation was to determine adolescent girls’ perspective about the programme’s feasibility, relevance and acceptance.

In conducting the evaluation, the researcher held an open discussion with ten adolescent girls in the reproductive health clinic. Six of the adolescent girls who participated in the evaluation session had unplanned pregnancies and had come for counselling and advice about their pregnancies, and four had come for family planning. The programme was presented to the adolescent girls in a group. The researcher explained a brief background of the study and the purpose of the evaluation, and made a PowerPoint presentation of the programme to the adolescent girls.

The researcher used the evaluation criteria of feasibility, relevance and acceptance (International Federation of Red Cross and Red Crescent Societies, 2011:17; Shapiro, 2013:14) of the programme. The researcher made use of open-ended questions and allowed adolescent girls to comment on the programme.

8.2.2.1 General

The adolescent girls generally alluded that the programme will be highly accepted because such an initiative is not available in the community. They further indicated that it will give adolescent girls a platform to discuss emancipated decision making in pregnancy prevention without fear. According to adolescent girls, discussions about decision making about pregnancy prevention are not held at home or at school. Adolescent girls contended that the clinics only give contraceptives, do not have time for individual concerns and never address issues of emancipated decision making in pregnancy prevention.
The programme was seen as an eye-opener for all adolescent girls, and the fact that it will be presented on Saturday will make it even more acceptable and feasible for girls to attend.

This is a quote from an adolescent girl:

“This programme will help most adolescent girls who are not aware of decision making about pregnancy prevention. Some adolescents grow up living with their grand-parents who do not know much about pregnancy prevention. Even those adolescent girls who know about pregnancy prevention, with group discussions they will learn more about decision making in pregnancy prevention.”

8.2.2.2 Feasibility

The programme was perceived by adolescent girls to be feasible as the proposed Saturday was seen as an appropriate day when they are not at school and will thus be able to attend.

A quote from an adolescent girl:

“I cannot wait to see this programme starting, especially that it will be on Saturday when we are at home we will be able to attend.”

8.2.2.3 Relevance

Adolescent girls perceived the programme to be relevant. They indicated that the programme will be an opportunity for empowerment for adolescent girls in making decisions in pregnancy prevention.

These are some of the quotes:

“Some parents are working and they come back late therefore never have time to talk to their adolescent girls. The clinics never educate girls about decision making and about pregnancy prevention, they just give contraceptives, so this programme will help a lot.”
“The programme will be an empowerment for adolescent girls. We need to be able to break the secrecy that prevails in the community between mother and daughter in relation to pregnancy prevention.”

8.2.2.4 Acceptance

Adolescent girls alluded that the programme is an acceptable endeavour which will assist adolescent girls, some of whom have never heard anything about decision making in pregnancy prevention. They indicated that it will be acceptable to the community, the school and the church as there is a general complaint in the community about unplanned pregnancy which is not managed.

8.2.2.5 General summary

From the evaluation of the emancipatory education programme by adolescent girls, the researcher’s perception is that the programme is relevant, important and acceptable, and will be feasible.

8.3 THE PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of the study was to construct a programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making. The objectives of the study were:

- To explore and describe the factors contributing to the occurrence of unplanned pregnancies.
- To explore and describe the existing sources of information for decision making about pregnancy prevention.
- To describe applicable models and theories used in decision making in the prevention of unplanned pregnancies in adolescent girls.
- To describe the programme and implementation guidelines for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.
- To evaluate the programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.
The following is a discussion of how the purpose and objectives of the study were reached.

8.4 CONCLUSIONS OF THE RESEARCH

The conclusions of the study are described according to each phase of the programme construction to address the objectives and purpose of the study, presented firstly as **empiric conclusions** based on the findings of the study and secondly as **conceptual conclusions** aligning the conclusions of the study with the conceptual framework to reinforce the conceptual foundation of the research.

8.4.1 Empiric conclusions


The **first phase** involved a situational analysis; the **second phase** involved a concept analysis and the conceptual framework, the **third phase** entailed description of the programme activities and implementation guidelines and the **fourth phase** entailed evaluation of the programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making.

**Phase one**, the **situational analysis**, entailed describing the factors contributing to the occurrence of unplanned pregnancies in adolescent girls, exploring and describing the existing sources of information for decision making about pregnancy prevention in adolescent girls. The situational analysis further involved a description of the applicable
models and theories in decision making in the prevention of unplanned pregnancies in adolescent girls. The situational analysis was discussed in terms of population and sampling, data collection, data analysis and literature control. The Wittmann-Price Theory (Wittmann-Price, 2004, 2006; Wittmann-Price & Bhattacharya, 2008) was used as the framework for the study.

Data collection involved one-to-one interviews as the topic is sensitive and involves a vulnerable population; thus, no other data collection technique was found suitable. Analysis followed the thematic method of qualitative data analysis according to Polit and Beck (2012:562).

The findings of the study revealed that adolescent girls lack personal knowledge, which is needed for empowerment, a flexible environment, the ability to reflect and awareness of social norms to be able to make emancipated decisions to prevent unplanned pregnancies. Data revealed the schools, which include school health nurses and life orientation lessons, as the major source of information for adolescent decision making about pregnancy prevention. The clinic, family, community and media followed the school in ranking as sources of information. Socio-economic conditions, substance abuse and poverty emerged as factors influencing decision making in unplanned adolescent pregnancy prevention.

Literature on factors in emancipated decision making, socio-economic factors and existing sources of information about pregnancy prevention and categories which emerged during data analysis were discussed. Literature control contextualised these findings, comparing and contrasting them with other similar studies nationally and internationally.

The use of theories and models in adolescent girls’ decision making affirmed that no single theory can provide the ‘best’ solution for designing, delivering, and/or evaluating effective adolescent pregnancy prevention programme. The Wittmann-Price Theory of Emancipated Decision Making in women’s health issues, the theoretical framework of which forms the basis for this study, dual process models which incorporate the normative models commonly used in adolescent decision making and developmental
theories all shed light onto emancipated decision making in the prevention of unplanned pregnancies in adolescent girls. The ecological model recognises that behaviour takes place in a dynamic social context further uncovering that decision making in adolescent girls regarding the prevention of unplanned pregnancy is influenced by the intrapersonal, interpersonal and institutional factors.

The findings of the study formed the basis for the conceptual framework and culminated in the programme design and guidelines for the implementation of the programme.

Phase two focused on concept analysis and the conceptual framework. A concept analysis clarified the concepts of the Wittmann-Price Theory (Wittmann-Price, 2004, 2006; Wittmann-Price & Bhattacharya, 2008) on which the study was based. A conceptual framework, guided by the logic model, described the framework of the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls. The conceptual framework consisted of the inputs, the programme activities, described as the process of emancipatory education, the outputs and the outcomes. Based on the concept analysis, the conceptual framework and the findings, facilitation of the emancipatory education programme was described.

Phase three described the programme activities, that is, facilitation of the process of emancipatory education and the implementation guidelines. Facilitation of the process of emancipatory education was discussed with reference to the relationship, work and termination phases. Two professional nurses will guide adolescent girls who are the recipients of the programme through the process of emancipatory education. During the process of emancipatory education, adolescent girls and facilitators will move from the relationship phase and the work phase to the termination phase. Implementation guidelines to facilitate the process of emancipatory education were discussed with reference to the objectives and strategies for each phase of the process.

Phase four entailed evaluation of the programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making. The strategy used to evaluate the programme for the prevention of unplanned pregnancies in adolescent girls involved a critical reference group and adolescent girls. The critical
reference consisted of supervisors, peers and experts in the clinical practice. The researcher used the evaluation criteria of Chinn and Kramer (2011:196). Ten adolescent girls, six of whom had unplanned pregnancies and four of whom came for family planning, further evaluated the programme.

The programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making was successfully evaluated with regard to its clarity, simplicity, generality, accessibility and importance. The programme was further evaluated by adolescent girls for relevance, feasibility and acceptance.

Finally, reaching the facilitation of the process of emancipatory education in prevention for unplanned pregnancies in adolescent girls, the researcher can safely conclude that the research question “What should a programme and implementation guidelines for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making consist of?”, has been answered and the purpose of the study has been achieved.

8.4.2 Conceptual conclusions

The study applied the logic model, consisting of the assumptions, inputs, context, activities, outputs and outcomes, as a framework to guide the process of constructing an emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls, which culminated in reaching the outcomes of the study. The conditions set out by the Wittmann-Price Theory of Emancipated Decision Making in women’s health issues necessitated an understanding and approach to decision making in prevention of adolescent girls’ unplanned pregnancies from a broader perspective.

The broader perspective of decision making focused on emancipated decision making, which includes empowerment, improvement of personal knowledge, reflection, provision of flexible environment and awareness of social norms to enhance emancipated decision making in the prevention of unplanned pregnancies for adolescent girls.

The cognitive developmental theories and the ecological model which recognises the multiple spheres of influence on health behaviour, the dual process models used to
address social, emotional and reactive process, and the psychosocial theories which emphasises the social and cultural influences validated the commitment in this study to view decision making in adolescent girls in the prevention of unplanned pregnancies from a multi-theoretical perspective. The multi-theoretical approach to emancipated decision making in the prevention of unplanned pregnancies in adolescent girls resulted in the conclusion that no single theory can address decision making in the prevention of unplanned adolescent pregnancies.

Facilitation of the process of emancipatory education in the prevention of unplanned pregnancies in adolescent girls is crucial for professionals who are involved in unplanned pregnancy services. The process is an injunction for professionals to view the prevention of unplanned adolescent pregnancies from an emancipated decision making perspective by incorporating the use of critical consciousness, dialogue and active involvement in daily adolescent health care delivery. It is clear that the process of emancipatory education not only entails education by professionals, but also involves research, improving collaborative, multidisciplinary, interdisciplinary and trans-disciplinary quality of care, and ethical and professional practice.

8.5 LIMITATIONS OF THE STUDY

Based on the qualitative research approach of this study, adolescent girls with unplanned pregnancies were purposively selected. Due to the sensitivity of the topic, one-to-one interviewing was selected as the appropriate data collection method and only sixteen adolescent girls were interviewed, at which point saturation was reached. It will thus be valuable to use other methods of data collection in following studies.

The study focused exclusively on adolescent girls with unplanned pregnancies. However, it might be valuable to get inputs from adolescent boys and adolescent fathers about emancipated decision making in unplanned pregnancy prevention.

8.6 RECOMMENDATIONS OF THE STUDY

Recommendations are made with regard to nursing practice, nursing education and research.
8.6.1 Recommendations for nursing practice

It is recommended that the emancipatory education programme for the prevention of unplanned pregnancies in adolescent girls be implemented, continuously evaluated for efficiency and effectiveness, and refined in terms of content and processes. Adolescent girls need to be constantly involved in the evaluation of the programme to ensure that the content remains updated and that the programme offers what adolescent girls need for making emancipated decisions in preventing unplanned pregnancies.

Adolescent girls' emancipated decision making can be made a daily practice by health care professionals. Health care professionals have the responsibility to practice ethically, be guided by applicable public policies on adolescent girls' pregnancy prevention, benchmark the best practices, and engage in reflective dialogue with adolescent girls and colleagues to improve the programme and practice.

The researcher further recommends the inclusion of professional nurses in the emancipatory education process in future to enhance flexibility of environments.

8.6.2 Recommendations for nursing education

The emancipatory education programme can be used in teaching nursing students who are adolescents to prevent unplanned pregnancies, as nursing institutions are currently challenged by escalating numbers of student nurses having unplanned pregnancies. Emancipated decision making can be included in teaching theory and practice to empower students who are advocates for clients and their families in the clinical settings in decision making. Professional nurses working in reproductive health services can include emancipated decision making in continuing education, seminars and workshops to remain updated on the phenomenon. Such continuing education can also be used to enhance flexibility of environment in reproductive health care.

8.6.3 Recommendations to nursing research

There is enormous potential for contextual research on emancipatory education for enhancing emancipated decision making in adolescents. Scientific research into the long-term benefits and effects of emancipatory education for enhancing emancipated
decision making in adolescent girls about the prevention of unplanned pregnancies needs to be investigated. Considering the country’s diversity in terms of age, race, gender and skills, it is necessary to investigate approaches to and styles of emancipatory education in decision making in the prevention of unplanned pregnancies that most comfortably accommodate diversity.

There is a need for research on the factors contributing to adolescent boys’ emancipated decision making in the prevention of unplanned pregnancy and parenting programmes. There are limited publications on emancipated decision making and the effectiveness of reflective approaches as change models in emancipated decision making; thus, the researcher recommend that this be investigated.

There is a need for participatory action research that would address the flexibility of environment to enhance emancipated decision making for all stakeholders in the reproductive health services.

8.7 UNIQUE CONTRIBUTION OF THIS RESEARCH

This study addressed the empirical void that existed in terms of a described programme for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making. The study required a multi-factorial approach that included adolescents, their families and their communities. It also required a multi-theoretical approach by health care professionals to adolescent girls’ emancipated decision making in the prevention of unplanned pregnancies. The theoretical contribution from this study assimilated personal knowledge, empowerment, flexible environment, and awareness of social norms, including the intrapersonal, interpersonal and institutional factors in emancipated decision making in adolescent girls’ prevention of unplanned pregnancies. The use of dialogue with and active participation of adolescents in planning, implementation and evaluation of decisional practice environments is an added contribution to the practice world.

Considering the cognitive and psychosocial development of adolescent girls for decision making in the prevention of unplanned pregnancies, skilled, ethical and professional
practice is a requirement for health care professionals working with adolescents. Furthermore, the programme also focuses not only on the adolescent girls, but also on the facilitators and the environment for decision making. The research added information on the concept analysis of the Wittmann-Price theoretical concepts, which was difficult to research. There is limited information on emancipated decision making in general and emancipated decision making in pregnancy prevention among adolescent girls in particular. The researcher identified the importance of conceptual knowledge with regard to emancipated decision making in the prevention of unplanned pregnancies.

8.8 REFLECTIONS BY THE RESEARCHER

In the journey of development of this study, the researcher experienced personal and academic growth through perusing volumes of dictionaries and other literature. The researcher’s growth was also realised through academic consultation with colleagues both locally and internationally in the clinical field as well as consultation with clients during the interviews in the situational analysis phase. During data collection, it was emotionally challenging to listen to those adolescent girls, some of whom needed help which the researcher was unable to provide at that particular moment, but at the same time it was an experience that required the researcher to go deeper in getting information about how such problems are solved in empirical settings. It was at this point that the researcher reflected about her personal emancipation, and realised that she also still has to work on her own emancipation.

The researcher needed to really ‘bracket’ her perceptions and feelings about decision making with regard to decision making about the prevention of unplanned pregnancies in order to gather information-rich data. This was achieved through putting aside all beliefs and knowledge with regard to unplanned pregnancy in order to remain neutral during interviews.

Working through the concept analysis and conceptual framework, the researcher spent many hours to identify, describe, refine and apply the concepts of the Wittmann-Price Theory within the context of the study. This resulted in the researcher being able to
approach the research from a more advanced and informed level. Finally, having to construct the programme which included a variety of clinical fields in nursing (such as primary health care, nursing education, nursing practice and psychiatric nursing) was a strenuous exercise, but looking at the final product, that is, the programme and its implementation guidelines, it was a rewarding one.

8.9 CONCLUSION

Chapter 8 reflected that the purpose of the research has been met. The purpose of the study was to construct a programme and implementation guidelines for the prevention of unplanned pregnancies in adolescent girls through emancipated decision making. The emancipatory education programme and implementation guidelines were constructed in this research. This chapter brought this research to a close and included the evaluation of the programme as well as the conclusions, limitations and recommendations of the research. The chapter also highlighted the unique contributions of the research, as well as the reflections by the researcher.

This reminded the researcher of an important quotation by Kofi Annan (BrainyQuote, 2014a) applicable to this study:

“Gender equality is critical to the development and peace of every nation. There is no tool for development more effective than the empowerment of women. Women themselves have the right to live in dignity and in freedom from fear. When women thrive, all of society benefits, and succeeding generations are given a better start in life.”
REFERENCES


References


Motsoaledi, M.P. (2014). *Delegation of powers to consent for research or experimentation to be conducted with minors for a non-therapeutic purpose as prescribed by section 71 (3)(A)(II) of the National Health Act No. 63 of 2003 to health research committees registered with the National Health Research Ethics Council*. Pretoria: Ministry of Health. Rec Reference No. Rec. 250408-005-RA Level 02.


References


References


ANNEXURE A
ETHICAL CLEARANCE CERTIFICATE
UNIVERSITY OF LIMPOPO MEDUNSA CAMPUS

UNIVERSITY OF LIMPOPO
Medunsa Campus

MEDUNSA RESEARCH & ETHICS COMMITTEE
CLEARANCE CERTIFICATE

MEETING: 09/2010
PROJECT NUMBER: MREC/H/291/2010; PG

PROJECT:
Title: Construction of a program for the prevention of unplanned pregnancies in adolescent girls Hammanskraal
Researcher: Ms MM Madlamo
Supervisor: Prof EU van Aswegen
Co-supervisor: Ms Y Havenga
Department: Nursing Science
School: Health Care Sciences
Degree: PhD (Nursing Science)

DECISION OF THE COMMITTEE:
MREC approved the project.

DATE: 05 October 2010

PROF DA QUNGBANI
CHAIRPERSON MREC

Note:
1) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
2) The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.
ANNEXURE B
ETHICAL CLEARANCE CERTIFICATE
TSHWANE METSWEDENG REGION

TSHWANE METSWEDENG REGION RESEARCH ETHICS COMMITTEE

CLEARANCE CERTIFICATE

Meeting: 01/2011

PROJECT NUMBER: TMREC 2011/01

PROJECT:

Title: Construction of a program for the prevention of unplanned pregnancies in adolescent girl Hammanskraal

Researcher: Ms MM Madune
Supervisor: Prof EJ van Anwagen
Co-Supervisor: Ms Y Havenga
Department: Health Care Science
Degree: PhD (Nursing Science)

DECISION OF THE COMMITTEE

Permission is granted.

Date: 20th January 2011

Dr K.E.Letebele-Hartell
Chairperson Tshwane Metswedeng Research Ethics Committee
Tshwane Metswedeng Region

Ms M Pits
Director, District Health Services Support
Tshwane Metswedeng Region

NOTE: Resubmission of the protocol by researcher(s) is required if there is departure from the protocol procedure as approved by the committee.

ALL CORRESPONDENCE TO INCLUDE PROTOCOL NUMBER

The Fields Building, 427 Hilda Street, Hatfield, 0028, Pretoria

309
CONSENT BY PARTICIPANT: ENGLISH

CONSTRUCTION OF A PROGRAMME FOR THE PREVENTION OF UNPLANNED PREGNANCIES IN ADOLESCENT GIRLS IN HAMMANSKRAAL

I have read the information on the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurised to participate in any way.

I understand that participation in this Study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for my condition.

I know that this Study has been approved by the Medunsa Campus Research and Ethics (MCREC), University of Limpopo (Medunsa Campus). I am fully aware that the results of this Study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this Study.

............................................................  ........................................................
Name of participant  Signature of participant

........................................  ........................................  ........................................  ........................................
Place.  Date.  Witness

Statement by the Researcher

I provided verbal and/or written* information regarding this Study

I agree to answer any future questions concerning the Study as best as I am able.

I will adhere to the approved protocol.

........................................  ........................................  ........................................  ........................................
Name of Researcher  Signature  Date  Place
CONSENT BY PARTICIPANT: SETSWANA

CONSTRUCTION OF A PROGRAMME FOR THE PREVENTION OF UNPLANNED PREGNANCIES IN ADOLESCENT GIRLS IN HAMMANSKRAAL

Ke buisitse tshedimosetso mo */ke utlwile maikemisetso a* patlisiso e e tšitshintsweng mme ke fiwe tšhono ya go botsa dipotso le go fiwa nako e e lekaneng ya go akanya gape ka ntíth a e. Maithlomo le maikemisetso a patlisiso e a thaloganyega sentle. Ga ka a patelediwa ke ope ka tselo epe go tsaya karolo.

Ke thaloganya gore go tsaya karolo mo Patlisiso ke boithaopo le gore nka ikogела morago mo go yona ka nako ngwe le nngwe kwa ntle ga go neela mabaka. Se ga se kitla se nna le seabe sepe mo kalahfong ya me ya go le gale ya bolwetsi jo ke nang le jona e bie ga se kitla se nna le tšotholetse epe mo tšokomeleng e ke e amogelang mo ngakeng ya me ya go le gale.

Ke a itse gore Patlisiso / e e rebotswe ke Patlisiso le Molao wa Maitsholo tsa Khpase ya Medunsa (MCREC), Yunibesithi ya Limpopo (Khpase ya Medunsa. Ke itse ka botlalo gore dipholo tsa Patlisiso di tla dirisetswa mabaka a saentifiki e e bile di ka nna tsa phasaladiwa. Ke dumelana le seno, fa fela go netefadiwa gore se e tla nna khupamarama.

Fano ke neela tumelelo ya go tsaya karolo mo Patlisiso e.

........................................................................................................................................................................................................

Leina la moithaopi Tshaeno ya moithopi
........................................................................................................................................................................................................

Lefelo Letlha Paki

........................................................................................................................................................................................................

Seteitemente ka Mmatlisisi

Ke tlame tsetsa tshedimosetso ka molomo le/kgotsa e e kwadilweng malebana le Patlisiso / e.

Ke dumela go araba dipotso dingwe le dingwe mo nakong e e tiang tse di amanang le Patlisiso / ka moo nka kgonang ka teng.

Ke tla tshegetsa porotokolo e e rebotsweng.

........................................................................................................................................................................................................

Leina la Mmatlisisi Tshaeno Letlha Lefelo
CONSENT BY PARENT: ENGLISH

UNIVERSITY OF LIMPOPO (Medunsa Campus) ENGLISH CONSENT FORM

Statement concerning participation in the study

NAME OF STUDY

CONSTRUCTION OF A PROGRAMME FOR THE PREVENTION OF UNPLANNED PREGNANCIES IN ADOLESCENT GIRLS IN HAMMANSKRAAL

I have read the information on the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurised to consent to my child to participate in any way.

I understand that participation in this Study is completely voluntary and that my child may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for my child’s condition.

I know that this Study has been approved by the Medunsa Campus Research and Ethics (MCREC), University of Limpopo (Medunsa Campus). I am fully aware that the results of this Study will be used for scientific purposes and may be published. I agree to this, provided that the privacy of my child is guaranteed.

I hereby give consent to participate in this Study.

............................................................ ............................................................

Name of participant Signature of parent/guardian

............................................. ............................................. .............................................

Place. Date Witness

_________________________________ ____________________________________________

Statement by the Researcher

I provided verbal and/or written* information regarding this Study

I agree to answer any future questions concerning the Study as best as I am able.

I will adhere to the approved protocol.

............................................. ............................................. ............................................. .............................................

Name of Researcher Signature Date Place
CONSENT BY PARENT: SETSWANA

UNIVERSITY OF LIMPOPO (Medunsa Campus) SETSWANA CONSENT FORM

Seteitemente se se ka ga go tsaya karolo mo Porojeke ya Patlisiso.

LEINA LA PATLISISO

CONSTRUCTION OF A PROGRAMME FOR THE PREVENTION OF UNPLANNED PREGNANCIES IN ADOLESCENT GIRLS IN HAMMANSKRAAL

Ke buisitse tshedimosetso mo */ke utlwile maitlhomo le maikemisetso a* patlisiso e e tshitshintsweng mme ke filwe tšhonolo ya go botsa dipotso le go fiwa nako e e lekaneng ya go akanya gape ka ntšha e. Maithlomo le maikemisetso a patlisiso e a thaloganyega sentle. Ga ka a patelediwa ke ope ka tsela epe go tsaya karolo.

Ke thaloganya gore go tsaya karolo mo Patlisiso ke boithapo le gore ngwanake a ka ikgogela morago mo go yona ka nako nngwe le nngwe kwa ntšle ga go neela mabaka. Se ga se kitša se nna le seabe sepe mo kalafong ya ngwanake ya go le gale ya bolwetsi jo a nang le jona e bile ga se kitša se nna le tšhotheletsou epe mo tšhotokomeleng e a e amogelang mo ngakeng ya gagwe ya go le gale.

Ke a itše gore Patlisiso / e e rebotswe ke Patlisiso le Molao wa Maitsholo tsa Khampase ya Medunsa (MCREC), Yunibesithi ya Limpopo (Khampase ya Medunsa). Ke itše ka botlalo gore dipholo tsa Patlisiso di tla dirisetswa mabaka a saentifiki e e bile di ka nna tsa phasaladiwa. Ke dumelana le seno, fa fela go netefadiwa gore se e tla nna khupamarama.

Fano ke neela tumelelo ya go tsaya karolo mo Patlisiso e.

............................................................  ............................................................
Leina la moithaopi                                 Tshaeno ya motsadi /motlamedi

............................................................  ............................................................  ............................................................  ............................................................
Lefelo                                             Leilha                                           Paki

Sateitemente ka Mmatlisisi

Ke tlametse tshedimosetso ka molomo le/kgotsa e e kwadilweng malebana le Patlisiso / e.

Ke dumela go araba dipotso dingwe le dingwe mo nakong e e tlang tse di amanang le Patlisiso / ka moo nka kgonang ka teng.

Ke tla tshegetsa porotokolo e e rebotsweng.

............................................................  ............................................................  ............................................................  ............................................................
Leina la Mmatlisisi                                 Tshaeno                                           Leilha                                           Lefelo
## A. BIOGRAPHICAL DATA

1. Age

2. Marital status

3. Number of children
   - 3.1 How many times have you been pregnant?
   - 3.2 How many children do you have?

4. Level of education

5. School attendance

6. Employment status
   - 6.1 Income (how much are you earning)
   - 6.2 Household income

7. Receiving social grant

8. Religion

9. Ethnic group

10. Partners
   - 10.1 Age of starting fertility
   - 10.2 How many partners since starting fertility
   - 10.3 Partner’s age
   - 10.4 Partners’ level of education
   - 10.5 Partner’s employment status
   - 10.6 Partner’s involvement in the current unplanned pregnancy

11. Living arrangements

## B. FACTORS CONTRIBUTING TO THE OCCURRENCE OF UNPLANNED PREGNANCIES

The following questions based on the Wittmann-Price theoretical framework were asked:

1. Please tell me how it happened that you became pregnant.

2. What do you think contributed to you having an unplanned pregnancy?

### Personal knowledge and empowerment

3. How did your **knowledge** about sex, fertility (“getting pregnant”) and contraceptives contribute to your unplanned pregnancy?
4. If you did use contraceptives, how might the way in which you used them have contributed to your unplanned pregnancy?

**Flexible environment**

5. How did the clinic/health services contribute to your unplanned pregnancies?
   5.1 Staff attitude
   5.2 Availability, accessibility and acceptability of services

**Social norms and self-reflection**

6. What are your norms and beliefs about preventing unplanned pregnancies?
   6.1 How do you think these norms and values influenced you having this unplanned pregnancy?

7. What are your family’s norms and values about preventing unplanned pregnancies?
   7.1 How do you think these norms and values influenced you having this unplanned pregnancy?

8. What are your friend’s norms and values about preventing unplanned pregnancies?
   8.1 How do you think these norms and values influenced you having this unplanned pregnancy?

9. What are the norms and values of your religion about preventing unplanned pregnancies?
   9.1 How do you think these norms and values influenced you having this unplanned pregnancy?

**Empowerment and social norms**

10. Please tell me about your relationship with your partner
   10.1 How did your relationship with your partner contribute to you having this unplanned pregnancy?
   10.2 Please tell me about your ability to decide about sex and contraceptives in your relationship.

**Reflection**

11. When you look back at the factors that led to your unplanned pregnancy, what would you change to prevent this from happening in the future?

12. If you could give advice to other girls/young women about preventing unplanned pregnancies, what would you tell them?

**C. THE EXISTING SOURCES OF INFORMATION ABOUT PREGNANCY PREVENTION IN ADOLESCENT GIRLS**
1. **Where** did you get information about pregnancy prevention from, on the following:
   1.1 Fertility (becoming pregnant)
   1.2 Sex (sex education)
   1.3 Ways to prevent unplanned pregnancies (contraceptives and other pregnancy prevention methods)?

2. **How** was this information given to you?

3. **When** was this information given?

### INTERVIEW SCHEDULLE: SETSWANA

**PATLISISO YA DITEKO**

#### A. TSHEDEMOSETSO KA GA MOTSAAKAROLE

1. Dingwaga
2. O nyetwse
3. O na le bana ba ba kae?
   3.1 O imile ga kae?
   3.2 O na le bana ba ba kae?
4. O badile go fitlha kae ka dithuto
5. O tsena sekolo?
6. O a dira?
   6.1 Dituelo (Ba go duela bokae?)
   6.2 Lotseno la lelapa
7. A o duelwa madi a puso a dikhutsana
8. Kereke
9. Setso sa lena (o mokae?)
10. Balekani
   10.1 Fa o simolola go ratana o ne o na le dingwaga tse kae?
   10.2 O banne le baratani ba ba kae fa e sale o simolotsi go ratana?
   10.3 Dingwaga tsa molekani
   10.4 Molekani o badile go fitlha kae ka dithuto?
   10.5 Molekani o a dira?
   10.6 Molekani o tsaya karolo mo go hlokomeleng mpa e o e imileng?
11. Paakanyo ya madulo

#### B. MABAKA A A KA HLOHLELETSANG GO IMA O SA BAAKANYA

Motsaakarolo o ile a botswa dipotso tse di lateago:

1. Go tille byang gore o be moimana?
### Annexure D
*Interview schedules: English and Setswana*

#### Matlafatso le Kitso le go ipotsa dipotso (Empowerment and personal knowledge)

<table>
<thead>
<tr>
<th>Question</th>
<th>Setswana</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. <em>O nagana gore ke eng se se go dirileng gore o ime o sa baakanya?</em></td>
<td>Molotodi gore ke eng se se go dirileng gore o ime o sa baakanya?</td>
<td>Matlafatso le Kitso le go ipotsa dipotso (Empowerment and personal knowledge)</td>
</tr>
<tr>
<td>3. <em>Kitso ya gago kaga thobalano, go ima le dithibela pelegi di tsere karolo efeng mo go imeng ga gago o sa baakanya?</em></td>
<td>Molotodi ya gago kaga thobalano, go ima le dithibela pelegi di tsere karolo efeng mo go imeng ga gago o sa baakanya?</td>
<td>Flexible environment</td>
</tr>
<tr>
<td>4. <em>Fa ele gore one o dirisa dithibela pelegi, <em>mokgwa o o neng o di dirisa ka teng</em> o ka be o hlohleditse jang go ima ga gago o sa baakanya?</em></td>
<td>Molela gore one o dirisa dithibela pelegi, <em>mokgwa o o neng o di dirisa ka teng</em> o ka be o hlohleditse jang go ima ga gago o sa baakanya?</td>
<td>Flexible environment</td>
</tr>
</tbody>
</table>

#### Flexible environment

<table>
<thead>
<tr>
<th>Question</th>
<th>Setswana</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. <em>Kliniki e kabe e hlohleditse gotsa e tsere karolo e feng go imeng ga gago o sa baakanya?</em></td>
<td>Molotodi e kabe e hlohleditse gotsa e tsere karolo e feng go imeng ga gago o sa baakanya?</td>
<td>Flexible environment</td>
</tr>
<tr>
<td>5.1 <em>Maaitsholo a baoki (manese)?</em></td>
<td>Molotodi a baoki (manese)?</td>
<td>Flexible environment</td>
</tr>
<tr>
<td>5.2 <em>Thuso ya kliniki</em></td>
<td>Molotodi ya kliniki</td>
<td>Flexible environment</td>
</tr>
</tbody>
</table>

#### Melao ya motse le go ipotsa dipotso (social norms and reflection)

<table>
<thead>
<tr>
<th>Question</th>
<th>Setswana</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. <em>Tumelo le maikutlo a gago</em> ke eng mabapi le goima o sa baakanya?</td>
<td>Molotodi le maikutlo a gago ke eng mabapi le goima o sa baakanya?</td>
<td>Melao ya motse le go ipotsa dipotso (social norms and reflection)</td>
</tr>
<tr>
<td>6.1 <em>O gopola gore tumelo e mmogo le maikutlo a di ka be di susumeditse jang mo go imeng o sa baakanya?</em></td>
<td>Molotodi gore tumelo e mmogo le maikutlo a di ka be di susumeditse jang mo go imeng o sa baakanya?</td>
<td>Flexible environment</td>
</tr>
<tr>
<td>7. <em>Tumelo le maikutlo a ka mo gae</em> ke eng mabapi le go ima o sa baakanya?</td>
<td>Molotodi le maikutlo a ka mo gae ke eng mabapi le go ima o sa baakanya?</td>
<td>Flexible environment</td>
</tr>
<tr>
<td>7.1 <em>O gopola gore tumelo e mmogo le maikutlo a di ka be di susumeditse jang mo go imeng o sa baakanya?</em></td>
<td>Molotodi gore tumelo e mmogo le maikutlo a di ka be di susumeditse jang mo go imeng o sa baakanya?</td>
<td>Flexible environment</td>
</tr>
<tr>
<td>8. <em>Tumelo le maikutlo a ditsala</em> tsagago ke eng mabapi le go ima o sa baakanya?</td>
<td>Molotodi le maikutlo a ditsala tsagago ke eng mabapi le go ima o sa baakanya?</td>
<td>Flexible environment</td>
</tr>
<tr>
<td>8.1 <em>O gopola gore tumelo e mmogo le maikutlo a di ka be di susumeditse jang mo go imeng o sa baakanya?</em></td>
<td>Molotodi gore tumelo e mmogo le maikutlo a di ka be di susumeditse jang mo go imeng o sa baakanya?</td>
<td>Flexible environment</td>
</tr>
<tr>
<td>9. <em>Tumelo le maikutlo a kereke</em> ya gago ke eng mabapi le go ima o sa baakanya?</td>
<td>Molotodi le maikutlo a kereke ya gago ke eng mabapi le go ima o sa baakanya?</td>
<td>Flexible environment</td>
</tr>
<tr>
<td>9.1 <em>O gopola gore tumelo e mmogo le maikutlo a di ka be di susumeditse jang mo go imeng o sa baakanya</em></td>
<td>Molotodi gore tumelo e mmogo le maikutlo a di ka be di susumeditse jang mo go imeng o sa baakanya</td>
<td>Flexible environment</td>
</tr>
</tbody>
</table>

#### Matlafatso le melao ya motse (Empowement and social norms)

<table>
<thead>
<tr>
<th>Question</th>
<th>Setswana</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. <em>Ke kopa gore o mpolelle ka ga botsalano</em> ba gago le molekani wa gago</td>
<td>Molotodi ka ga <em>botsalano</em> ba gago le molekani wa gago</td>
<td>Melao ya motse le go ipotsa dipotso (social norms and reflection)</td>
</tr>
<tr>
<td>10.1 <em>Mpolelle ka ga</em> <em>bokgoni ba gago go tsaya ditshwetso</em> ka ga thobalano le go thibela pelegi mobotsalanong ba gago le molekani wa gago.</td>
<td>Molotodi ka ga thobalano le go thibela pelegi mobotsalanong ba gago le molekani wa gago</td>
<td>Flexible environment</td>
</tr>
<tr>
<td>10.2 <em>Botsalano ba gago le molekani wa gago bo ka bo bo</em> <em>susumeditse jang</em></td>
<td>Molotodi ba gago le molekani wa gago bo ka bo bo <em>susumeditse jang</em></td>
<td>Flexible environment</td>
</tr>
</tbody>
</table>

#### Go ipotsa dipotso

<table>
<thead>
<tr>
<th>Question</th>
<th>Setswana</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. <em>Ga o leba</em> se se thodileng go ima o sa baakanya o ka dira eng go thibela gore go seke ga diragala gape?</td>
<td>Molotodi se se thodileng go ima o sa baakanya o ka dira eng go thibela gore go seke ga diragala gape?</td>
<td>Flexible environment</td>
</tr>
<tr>
<td>12. <em>Go fahlosa</em> makgarebana a mangwe ka go ima o sa baakanya, o ka ba fahlosa jang?</td>
<td>Molotodi makgarebana a mangwe ka go ima o sa baakanya, o ka ba fahlosa jang?</td>
<td>Flexible environment</td>
</tr>
</tbody>
</table>

#### C. Tshedimo Setsso ka Ga Goima le Thibela Pelegi
Annexure D  
Interview schedules:  
English and Setswana

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>13. O bona kae <strong>tshedimosetso</strong> ka ga:</td>
<td></td>
</tr>
<tr>
<td>13.1</td>
<td>Go ima</td>
</tr>
<tr>
<td>13.2</td>
<td>Thobalano gotsa thuto ka tsa thobalano</td>
</tr>
<tr>
<td>13.3</td>
<td>Mekgwa ya go thibela go ima o sa baakanya (thibela pelegi)</td>
</tr>
<tr>
<td>14.</td>
<td>Mokgwa wo o filweng thuto ka tsa thobalano</td>
</tr>
<tr>
<td>15.</td>
<td>Tshedimosetso o e filwe neng?</td>
</tr>
</tbody>
</table>
PARTICIPANT

18 years old with a first pregnancy

<table>
<thead>
<tr>
<th>PERSON</th>
<th>DIALOGUE</th>
<th>FIELD NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Ke kopa go botsa dipotso, pele ke tswela pele ka dipotso tsame ke rata go go bolelela gore se re tlo se buang fa, e tlile go nna khupamarama. Leina la gago ga le kitla le tligisiwa gope. Fa o rata o ka nna wa ikgogela morago. Mo puisanong ya rona ke tlile go gatisa mantswe a rona gape ke tlile go nna ke kwala. Puisano ya rona e tlile go tsaya metsotso e ka nnang 30-45. A o a dumela gore re buisane?</td>
<td></td>
</tr>
<tr>
<td>PERSON</td>
<td>DIALOGUE</td>
<td>FIELD NOTES</td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>E</td>
<td>I am requesting permission to ask you some questions. What we are going to discuss will be kept confidential. You can withdraw at anytime if you feel you cannot continue with the interview. I am going to use a tape recorder and take some notes at the same time. the interview is going take approximately 30-45 minutes. Do you agree to be interviewed?</td>
<td>The researcher allay the anxiety of the adolescent girl as she explain the purpose of the study, that the information will be confidential and that Participation is voluntary and she can withdraw at any point if she so feel.</td>
</tr>
<tr>
<td>P</td>
<td>Ee, ke a dumela</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Yes, I agree</td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Ke kopa gore o ntshaenele forome, e bontshang gore o a dumela go ba motsaakarolo mo patlisisong yaka.</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Please sign the consent form indicating that you agree to participate in this study</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Go siame</td>
<td>Motsaakarolo o saena foromo ya gore a dumela go tsay karolo mo dipatlisisong.</td>
</tr>
<tr>
<td>E</td>
<td>Ok</td>
<td>The participant sign the consent form</td>
</tr>
<tr>
<td>R</td>
<td>Mpolelele gore go tìle byang gore o be moimana</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Please tell me how it happened that you became pregnant.</td>
<td>The researcher allowed the participant to narrate without interruption</td>
</tr>
<tr>
<td>PERSON</td>
<td>DIALOGUE</td>
<td>FIELD NOTES</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>P</td>
<td>Ke ne ke berekisa injection ya 2 months (Nur-Isterate) and then one day ge ke ya kliniking ba mpotsa gore dinalata di fedile ke boye next week. Ka gore kene ke ya sekolong, next week ka lebala ka fetisa dikgwedi tse pedi and ke na le boyfriend. Ge ke ya kliniking ko cheka ka kereya gore ke imile</td>
<td>Motsaakarolo o bontsha go swaba mo sefatlhegong, o bua sefatlhego se lebile fatshe</td>
</tr>
<tr>
<td>E</td>
<td>I was on contraceptive method. I was using 2 months Injection (Nur-Isterate). When I went to the clinic for my injection they told me that they ran out of injecting needles and that I must come back the following week. I am still at school so the next week I forgot. After 2 months when I went, they first checked me and they found that I am pregnant.</td>
<td>Participant’s facial expression shows remorse as she also faces down when explaining</td>
</tr>
<tr>
<td>R</td>
<td>Mpolelele gore o nagana gore ke eng se se go dirileng gore o ime o sa baakanya?</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Please tell me what you think contributed to you having an unplanned pregnancy?</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Aaa, nna ke sa le ka lebala gore ba re ke boye beke e tlang go tlo tlhaba ka gore dinalata di ne di fedil letsetsi le ke ileng ka lona. Ke sa le ka boela ka morago ga dikgwedi tse pedi ge ke bona ke sa menstruate. Ke na le boyfriend so may be ke lona lebaka le le dirileng gore ke be pregnant.</td>
<td>O kgapa seatla, lentwse le sefahlugo di bontsha go swaba</td>
</tr>
<tr>
<td>E</td>
<td>Oh…I forgot that at the clinic they said I must come back the following week for my injection. I went to the clinic after 2 months when I realized that I missed my periods. I have a boyfriend may be that is how I fell pregnant.</td>
<td>Open hand wide, facial expression and tone of voice indicating disappointment</td>
</tr>
<tr>
<td>PERSON</td>
<td>DIALOGUE</td>
<td>FIELD NOTES</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>R</td>
<td>A ko mpolelele gore kitso ya gago ka ga thobalano, go ima le dithibela pelegi di tsere karolo efeng mo go imeng ga gago o sa baakanya?</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Can you tell me how did your knowledge about sex, fertility (“getting pregnant”) and contraceptives contribute to your unplanned pregnancy?</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Ko gae ba tlhola ba bolela ka family planning mara ba ne ba sa bolele ka sex le gore go tla bjang gore mosadi a ime. Nna ke ne ke sa itse thata ka sex go fithela ke robala le boyfriend. Ko mathomong ke ne ke re le nna ke nyaka go utlwa se batho base utlwang ka sex, then ka tswela pele ka se tlhole ke stopa.</td>
<td>O isa magetla ko godima, sesupo sa go se itse gotsa go se kgathale</td>
</tr>
<tr>
<td>E</td>
<td>At home they usually talk about family planning but they never talk about sex and how a woman fall pregnant. I did not know much about sex until I slept with my boyfriend. Initially I wanted to experiment to have a feeling that people talk about when they talk about sex. I continued until now when I fell pregnant.</td>
<td>Shrugs shoulders… an indication of not knowing, or not caring</td>
</tr>
<tr>
<td>R</td>
<td>Mmm.....Ke utlwa o re batho ba bolela ka ‘feeling’ ya sex. Ke bo mang batho ba ba bolelang ka ‘feeling’ ya sex?</td>
<td>Mmm.....Mmatlisisi o dumela ka tlhogo</td>
</tr>
<tr>
<td>E</td>
<td>When you say people talk about the feeling of sex, who are those people?</td>
<td>Mmm…The researcher nods her head</td>
</tr>
<tr>
<td>P</td>
<td>Ke dichomy le banyana ba ko sekolong.</td>
<td>Haa..O a tshega</td>
</tr>
<tr>
<td>E</td>
<td>My friends and other girls at school.</td>
<td>Haa…She laughs</td>
</tr>
<tr>
<td>PERSON</td>
<td>DIALOGUE</td>
<td>FIELD NOTES</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>R</td>
<td>A ko mpolelele, Fa e le gore o ne o dirisa dithibela pelegi, mokgwa o o neng o di dirisa ka teng o ka be o hlohleditse jang go ima ga gago o sa baakanya?</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Please tell me, if you did use contraceptives, how might the way in which you used them have contributed to your unplanned pregnancy?</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Ke tshedisitse dikgwedi tse pedi ke sa tlhaba injection</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>I skipped two months not getting my injection (Nur-Isterate) for prevention of pregnancy</td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Kliniki e kabe e hlohleeditse gotsa e tsere karolo e feng go imeng ga gago o sa baakanya?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Maaitsholo a baoki (manese)?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• ka mokgwa o ba le thusang ka teng?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Thuso ya kliniki ea fumanega ka dinako tsohle, ga e kgakala, le dumelana le yona?</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>How did the clinic /health services contribute to your unplanned pregnancy?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Staff attitude.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Availability, accessibility and acceptability of services.</td>
<td></td>
</tr>
<tr>
<td>PERSON</td>
<td>DIALOGUE</td>
<td>FIELD NOTES</td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>P</td>
<td>Kliniki ga e ko kgole, re tsamaya ka maoto. Manese ba a re thu sa go tshwenya fela ka gore ka nako e nngwe ba re dinalata di fedile and then ba re o boye may be beke e tlang. Kliniki e bula Monday-Friday, 08H00-16H00. Ka di week-end ga e bereke re tshwanela ke go yak o dikliniking tse dingwe di berekang 24 hours, ene tsona di ko kgole. Re namela taxi go yak o go tsona.</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>The clinic is not far, we walk to the clinic. Nurses are helpful the only problem is that sometimes they run out of stock for needles and tell us to come back sometimes the following week. The clinic is open Monday-Friday, 08H00-16H00 and closed over the weekend. We then have to use other clinics which opens 24 hours and those are far. We use a taxi to get there.</td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Ke kopa o mpolele gore tumelo le maikutlo a gago ke eng mabapi le go thibela go ima o sa baakanya?</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Please tell me what your norms and beliefs are about preventing unplanned pregnancies?</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Ke dumela go re banyana ba tshwanetse go dirisa dithibela pelegi gore ba se ke ba ima.</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>I believe that girls must use contraceptives to prevent unplanned pregnancies.</td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Ka mokgwa o o itseng lapa la ka mo geno, tumelo le maikutlo a ka mo gae ke eng mabapi le go ima o sa baakanya?</td>
<td></td>
</tr>
<tr>
<td>PERSON</td>
<td>DIALOGUE</td>
<td>FIELD NOTES</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>E</td>
<td>According to your knowledge of your family what do you think is your family’s norms and values about preventing unplanned pregnancies?</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Le ka mo gae ba dumela gore banyana ba tshwanetse bathibela pelegi. Le nna ba ne ba tlhola ba bolela ke le teng gore banyana ba tshwanetse gore ba ye family planning gore ba se ke ba ima.</td>
<td>O dumela ka tlhogo</td>
</tr>
<tr>
<td>E</td>
<td>My family also believes that young girls must go for family planning. They used to talk about family planning in my presence.</td>
<td>nods the head</td>
</tr>
<tr>
<td>R</td>
<td>A ko mplodelele gore tumelo le maiutlo a ditsala tsa gago ke eng mabapi le go ima o sa baakanya?</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Please tell me What your friend’s norms and values are about preventing unplanned pregnancies?</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Dichomy tsaka ba a dumela gore re tshwanetse re ye kliniking mara ba tshaba matlho a batho ka gore mo motseng ge ba bona o berekisa diprevention ba re o rata banna, o rata go robalana. So ba bang ba a tshaba go ya kliniking</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>My friends believe that we should go to the family planning clinic but they are afraid of what will people in the community say when they see us going to the clinic. The community members when they see a young girl going for family planning clinic they say you are ‘sleeping around’.</td>
<td></td>
</tr>
<tr>
<td>PERSON</td>
<td>DIALOGUE</td>
<td>FIELD NOTES</td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>R</td>
<td>Mmm ….ke a utlwa.. a ko mpolelele ka tumelo le maikutlo a kereke ya gago mabapi le go ima o sa baakanya?</td>
<td>Mmatlisisi o dumela ka tlhogo</td>
</tr>
<tr>
<td>E</td>
<td>Mmm.. I hear you. Please tell me about the norms and values of your <em>religion</em> about preventing unplanned pregnancies?</td>
<td>The researcher nods her head</td>
</tr>
<tr>
<td>P</td>
<td>Ko kerekeng ga ba nke ba bolela ka tsa diprevention. Mara rena re a itse gore kereke ga e dumele banyana ba robala le bashimane ba senke ba nyale.</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Pregnancy prevention is never discussed in church. we the church members know that the church does not allow sex before marriage.</td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>O gopolga gore ditumelo tse mmogo le maikutlo di ka be di susumeditse jang mo go imeng o sa baakanya?</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>How do you think these norms and values influenced you having this unplanned pregnancy?</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Nna ke ne ke sena taba le go re batho ba reng le gore ka mo gae ba reng. Kene ke batla go utlwa se batho ba bang ba se utlwang ka sex gore le nna ke kgone go bolela le bona, ke seke ka ba setlaela.</td>
<td></td>
</tr>
<tr>
<td>PERSON</td>
<td>DIALOGUE</td>
<td>FIELD NOTES</td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>E</td>
<td>I did not care about what people say, even what my family was saying all I wanted to experiment with sex and to feel what other people were talking about sex so that I can also share my experiences. I did not want to be left behind and be a fool.</td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>A ko mpolelle ka ga botsalano ba gago le molekani wa gago ka ga thibela pelegi. Botsalano ba gago le molekani wa gago bo ka bo bo susumeditse jang go ima o sa ipaakanya?</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Please tell me about your relationship with your partner. How did your relationship with your <em>partner</em> contribute to you having this unplanned pregnancy?</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Nna le boyfriend yaka gantsi re a tswa ka di weekend re ye departing and ke mo e leng gore re kereya chanse ya go heva sex after diparty.</td>
<td>Sefatlhego se edile o bontsha a batla go tshega</td>
</tr>
<tr>
<td>E</td>
<td>My boyfriend and I usually go out partying during the week-ends. That is where we usually get a chance of having sex after party.</td>
<td>smiling</td>
</tr>
<tr>
<td>R</td>
<td>Ke kopa gore o mpolelle ka ga bokgoni ba gago go tsaya ditshwetso ka ga thobalano le go thibela pelegi.</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Please tell me about your ability to decide about sex and contraceptives in your relationship.</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Boyfriend yaka ke yena a tsayang ditshwetso ka tse dintsi ka gore a re yena ga laole ke mosadi. Condom wa dumela go e berekisa nako e nngwe ka gore ba a re botsa ko sekolong ka yona.</td>
<td></td>
</tr>
<tr>
<td>PERSON</td>
<td>DIALOGUE</td>
<td>FIELD NOTES</td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
<td>------------</td>
</tr>
<tr>
<td>E</td>
<td>My boyfriend takes most of the decisions in the relationship about sex and the use of a condom as he says he cannot be controlled by a woman. He sometimes agrees to use a condom as they tell us about condoms at school.</td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Ga o leba se se tlhodileng go ima o sa baakanya o ka dira eng go thibela gore go seke ga diragala gape?</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>When you look back at the factors that lead to your unplanned pregnancy, what would you change to prevent this from happening in the future?</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Nka ya kliniking ka se tshedise kgwedi.</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>I would go to the family planning clinic and not skip a month.</td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Go fahlosa makgarebana a mangwe ka go ima o sa baakanya, o ka ba fahlosa jang?</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>If you could give advice to other girls/young women about preventing unplanned pregnancies, what would you tell them?</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Ba seke ba lebella gore batho ba bang ba etsa eng ene ba seke ba ya le dipolelo tsa batho mo motseng di tla ba lahletsa. Ba ye kliniking ba berekise dipilisi tsa go thibela pelegi ge ba na le diboyfriend.</td>
<td></td>
</tr>
<tr>
<td>PERSON</td>
<td>DIALOGUE</td>
<td>FIELD NOTES</td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>E</td>
<td>They must not look at what other people are doing nor listen to what people in the community are saying or doing as they will lead them astray. They must go to the clinic and get prevention pills if they have boyfriends and are sexually active.</td>
<td></td>
</tr>
</tbody>
</table>
| R      | O bona kae tshedomesetso ka ga  
• Go ima  
• Thobalano gotsa thuto ka tsa thobalano  
• Mekgwa ya go thibela go ima o sa baakanya (thibela pelegi)  
• Mokgwa wo o filweng thuto ka tsa thobalano  
• Tshedomesetso o e filwe neng? | |
| E      | Where did you get information from, about?  
• Fertility (becoming pregnant)  
• Sex (sex education)  
• Ways to prevent unplanned pregnancies (contraceptives and other methods)?  
*How* was this information given to you? | |
<p>| P      | Tshedomesetso ka sex, diprevention ke di kereile ko sekolong ka period ya Life Orientation. Ge ke kereya information ke ne ke setse ke na le boyfriend. Ko sekolong ga ba re botse gore mosadi o ima byang. | |
| E      | I got information about sex and prevention of pregnancy at school during the Life Orientation period. I was already dating when I got the information. At school they do not tell us about how a woman falls pregnant. | |</p>
<table>
<thead>
<tr>
<th>PERSON</th>
<th>DIALOGUE</th>
<th>FIELD NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>O ikemiseditse go dira eng ga o tloga mo ka bokamoso ba gago?</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>What are your plans for the future?</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Ke tlo dira abortion gore ke kgone go tswela pele ka sekolo, ga ke batle ngwana.</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>I am going to do an abortion so that I can continue with my life; I do not want a child.</td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Ke a leboga</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Thank you</td>
<td></td>
</tr>
</tbody>
</table>
Annexure F
Letter from the Independent Coder

Qualitative Data Analysis

PHD in Nursing
M. Madumo

This is to certify that
Dr. Annie Temane has co-coded the following qualitative data:

16 Individual Qualitative Interviews

For the study:

Construction of a Programme for Prevention of Unplanned Pregnancies in Adolescent in Hammanskraal

I declare that the candidate and I have reached consensus on the major themes, categories and codes reflected by the data during a consensus discussion. I further declare that adequate data saturation was achieved as evidenced by repeating themes.

Annie Temane

M.A. Temane (D.Cur; Research Methodology)
annie.temane@gmail.com
CONFIDENTIALITY AGREEMENT

CONFIDENTIALITY AGREEMENT WITH REGARDS TO INDEPENDENT CODING OF DATA FOR THE
STUDY

CONSTRUCTION OF A PROGRAMME FOR PREVENTION OF UNPLANNED PREGNANCIES IN
ADOLESCENT IN HAMMANSKRAAL

I understand that identities of all participants are personal and confidential and may not be
revealed to any person.

I understand that the research design and method of this study are intellectual property of the
researcher(s).

I understand that all material received for coding is personal and confidential.

I understand that all material received will be deleted on completion consensus discussion with
researcher(s).

I undertake herewith to treat the following information with utmost professional confidentiality:

a) The name of each participant wherein a name is indicated
b) Coding material received
c) Content of the information made known to me of each person
d) Content of the research design and method of this study

Independent Coder Name: Dr Annie Temane

Signature: _______________________

Date: 20 September 2011

Researcher’s name: _______________________

Researcher’s signature: _______________________

Date: 20 September 2011

332
LANGUAGE EDITING DECLARATION

I, SE Louw, hereby certify that the PhD thesis of Mankuku Mary Madumo, with the exceptions of verbatim quotes and addenda, was properly language edited.

Title of the thesis: **CONSTRUCTION OF A PROGRAMME FOR THE PREVENTION OF UNPLANNED PREGNANCIES IN ADOLESCENT GIRLS HAMMANSKRAAL**

For any further information, my contact information may be obtained through Mary Madumo.

SE Louw

5 December 2014