GUIDELINES FOR UNDERGRADUATE NURSING STUDENTS TO SUPPORT WOMEN TO MAKE INFORMED DECISIONS ABOUT FAMILY PLANNING METHODS

By

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A THESIS

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DECLARATION

I Theira Julia Maunye declare that the thesis entitled, “Guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods” is my original work and that it has not been submitted in part or as a whole to this and to another institution. All sources used or quoted have been indicated and acknowledged by means of complete references in the text and reference list.

____________________________________                             ________________
THEIRA JULIA MAUNYE                                                              DATE
DEDICATION

In remembrance of:

- My grandfathers, Paipai Maunye & Boas Thabane; my grandmothers, Ntloalona Dibakoane-Maunye & Sophia Thibela-Thabane
- My father Mmakgwadi Mokotoleng Julius Maunye, I will always hold dear to your memories
- My nephew, the late Tshepo Shadrack Mohlala, I will always draw strength from how you lived your life

This work is dedicated to the many people who provided me with their unconditional love and support during my studies:

- My mother, Roselina Meseta Thabane-Maunye
- My mother-in-law, Nana Christina Mgwenya
- My husband, Kenneth Mosupe
- My children, Thabo & Matshidiso Maunye
- My daughter-in-law, Mookgo Rankele
- My niece, Thulile Maunye, Charmaine Malinga & Taetso Mmola
- My brothers, Freddie, Nico & Solly Maunye
- My sisters, Lily, Neira, Reina, Girly & Sylvia
- My sister-in-law, Ntombikayise

Thank you all for your endless encouragement and for embracing me with your love every day. I will always adore you.
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GUIDELINES FOR UNDERGRADUATE NURSING STUDENTS TO SUPPORT WOMEN TO MAKE INFORMED DECISIONS ABOUT FAMILY PLANNING METHODS

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PROGRAMME: PhD

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Introduction: There are guidelines and policies available on family planning practices and yet women are still found having to deal with health professionals imposing methods on them. Guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods are key in ensuring that the health of women and that of their babies is improved.

Aim: The aim of the study was to develop guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods. The study was conducted in two phases.

Objectives: In phase one the objectives were to explore the views and opinions of undergraduate nursing students and lecturers/preceptors on: nurses’ ability to support women to make informed decisions about family planning methods, factors surrounding women’s health that impinge on their freedom to make decisions about family planning, and the type of content that needs to be included in nurses’ education and training to support women to make informed decisions about family planning methods. In phase two, the objective was to develop and evaluate guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods.

Methods: Descriptive and contextual qualitative research design and methods were used to achieve the study objectives. The study population consisted of eight lecturers/preceptors and 12 undergraduate nursing students selected through purposive sampling technique. Data were collected by means of focus group discussions. Field
and reflective journal notes were captured. Data were analysed using Tesch’s guidelines.

Findings: Nine categories and 21 subcategories emerged from the two focus group discussion and these were supported by literature. The Wittmann-Price Theory of Emancipated Decision-Making was also linked to the findings of this study. The guidelines were developed from results of phase one, field and reflective journal notes, literature review and literature used to control the findings of this study. The guidelines were evaluated by five participants who participated in the pilot study.

Conclusion: The study revealed that women’s access to decision making regarding family planning methods remains limited. According to the results of this study women seeking reproductive health services faces a plethora of problems ranging from low quality of contraception services, gender stereotypes, nurses negative attitudes, cultural and societal norms. It is therefore necessary for health care providers to accelerate provision of adequate information on women’s rights on matters of reproductive health care services in order to support their decision making capacity, among other. Increasing reproductive health care knowledge and skills for health care professionals is necessary to build their confidence on support for women when making choices on family planning methods, and this has been emphasized in this study. The study recommendations include implementation of the guidelines in practice to evaluate the applicability and feasibility of using these guidelines to support women to make informed decisions about family planning methods.
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CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Literature findings show that women are not emancipated to make decisions, largely due to structural health systems issues, social and cultural values, norms and beliefs, family traditions, religious barriers, and issues of women’s personal knowledge. Poverty, gender stereotypes and institutional cultures negatively impact upon women's educational outcomes. Women are always subordinate to men and consequently have low decision-making capacity in matters related to pregnancy and family size (McCracken, Unterhalter, Márquez & Chelstowska, 2015:10, 35; Qureshi & Shaikh, 2007:1460). Furthermore, women’s decision-making is restricted by various cultural traditions, and they do not have individual reproductive decisions independent from their husbands and their family networks (Woldemicael, 2009:165). To support the above notion regarding women decision-making, Mookamedi (2011:1) states that, traditionally, married women were robbed of their rights to make decisions, which include reproductive decisions. Their husbands had to decide for them. Mookamedi (2011:1) further asserts that this subordination tended to oppress them.

Women are faced with making health care decisions daily, especially about reproductive health. They are considered to be a vulnerable group, and can be affected by oppression brought about by social norms, which has an effect on their decision-making process. Wittmann-Price and Bhattacharya (2008:235) argue that nurses are well placed to support women to make emancipated decisions through the creation of flexible environments that encourage decision-making. However, nurses must embrace emancipation by accepting that there are diverse and complex issues surrounding women’s health that impinge on their freedom to make choices about their health issues. This skill can be developed through education and acknowledgement of women’s personal knowledge. The same view is also held by humanistic nursing paradigms which point out that nurses must be aware of the diverse factors surrounding
women’s health and how these factors affect their freedom to make choices (Wittman-

The concern regarding how to address women’s reproductive health needs has received attention over the past decades through various initiatives, such as increased attention to gender issues in health, a reproductive rights-based approach, adolescent health and HIV/AIDS at an International Conference on Population and Development in 1994, and the Millennium Development Goals (MDGs) adopted in 2000. Goals geared towards attainment of the MDGs include: promotion of gender equality and women’s empowerment, and improvements of political and socio-economical environments to support women’s emancipated decision-making (Jewkes, Morrell & Christofides, 2009:675; Lorentziaan, 2011:1). The MDGs were not achieved and have been replaced by the Sustainable Development Goals (SDGs), with achieving gender equality, ensuring healthy lives and promoting well-being for all ages mentioned here based on their relevance to this study (Barbier & Burgess, 2017:7).

The purpose of the SDGs is still to focus the attention of all countries on the attainment of the national agenda for women’s health as well as supporting national imperatives on human rights.

Though there is a need to strengthen reproductive health strategies, the approach of active participative and involvement of women, families and empowerment of communities is widely accepted by many countries as well as the Department of Health (South Africa, 2007:12). Improving access to health and reducing teenage pregnancy remain a challenge, hence health care workers need to be skilled through education to support women to make emancipated decisions (Jewkes et al., 2009:676). Furthermore, the lack of access to safe contraception is a widely occurring problem. This is confirmed by the renewed international focus on matters of contraception discussed at the 2012 Global Family Planning Summit. The emphasis at this summit was on the value of contraception to human development, gender empowerment, HIV, sexual and reproductive health (South Africa, 2012:2).
A brief perspective on reproductive health practices as documented internationally, nationally and locally highlights that access to reproductive health care remains a quality issue for women’s health. Internationally, the report compiled by Ibembe (2011:3) indicated that only 65.7% women globally had access to a skilled health care worker for issues of their sexual and reproductive ill-health. Other countries such as the United States of America (USA) are said to commit the required resources to greatly expand reproductive health education for all clinicians during their academic training and continuously while in employment (Shields, 2009:n.p.). In support of the above mentioned countries’ commitment, Decker, Berglas and Brindis (2015:686) advocate for focusing resources towards understanding and addressing the complexity of adolescents’ lives to deal effectively with the underlying causes of adolescent pregnancy and reproductive health education issues.

In 2005, only 33.7% to 46.5% of women in Africa accessed a skilled worker for their reproductive health issues (Ibembe, 2011:3). The concern about limited access to health and reproductive health is further raised by Decker et al. (2015:687), while Qureshi and Shaikh (2007:1459) state that social and cultural barriers in developing countries hinder women’s empowerment with a negative impact on their health status. These authors further assert that all efforts should be directed towards increasing gender equality and empowerment of women as other means for supporting them to achieve informed decisions about their reproductive health care.

In terms of education of health care workers, the South African Nursing Council (SANC) curriculum for undergraduate nursing students gives guidelines on programme content, but gaps still exist on reproductive health practice issues on an emancipated decision-making level. These gaps suggest that graduates will not immediately on completion of a programme be in a position to create health care practice environments that will enhance emancipated decision-making. However SANC scope of practice is compiled as broad framework to allow for the expansion and development of a nurses’ and midwives’ role to keep pace with the diverse health care needs (Geyer, 2016:51)
1.2 STUDY PROBLEM

During accompaniment of undergraduate nursing students, lecturers/preceptors encounter women with reproductive health needs and concerns in all health settings. More often at college academic meetings, these lecturers/preceptors raised concerns that students have limited knowledge on support for women to make decisions on family planning methods. Students were more often found administering injectable (nuristrate) family planning method, for example, to all women post-delivery, and could not provide a reason to this practice when asked. In meetings held with lecturers/preceptors they admitted that they also lacked knowledge regarding new family planning methods that are available in the health facilities and this could be a contributory factor on inability of nursing students to support women decision making about their family planning health needs. Furthermore, there were no guidelines for undergraduate nursing students for support of women to make informed decisions about family planning methods.

The interaction on issues of reproductive health practice the researcher had with a group of fourth-year Bachelor of Nursing Science students at a university in Gauteng, South Africa, also informed the choice of topic for this study, amongst others. This group of students underscored family planning as an area that needed attention by lecturers/preceptors during facilitation of students learning, in order to empower them for their role of supporting women/clients to make decisions about reproductive health care (specifically, family planning services). Also one of the objectives of the National Contraception Policy and Fertility Planning Policy and Service Delivery Guidelines is training and capacity building of health care providers, which will ensure that they have knowledge, good attitudes and skills to provide holistic, quality contraceptive and fertility planning services according to their scope of practice and the level of health care (South Africa, 2012:43), hence the necessity of guidelines for undergraduate nursing students for support of women to make informed decisions about family planning methods as another capacity building means.

The South African government, through its Constitution that was promulgated in 1996, has unequivocally committed itself to restoring the fundamental human rights, which
include (according to Chapter 2 of the Constitution) the right to health. The 
aforementioned right provides provision for an individual to make informed and 
understood reproductive health decisions. In line with section 12 of this Chapter, 
everyone has the right to freedom and security. For one to make an informed 
reproductive health decision, one needs to have information (South Africa, 1996:6).

The minimum requirements for education and the guide concerning the teaching of the 
undergraduate nursing students, as stipulated by SANC prescripts, give broad 
objectives on the content to be covered on the reproductive health topics. However, 
they lack specific guidelines that address how women’s empowerment in making 
informed decisions can be achieved by nurses. The scope only provide broad 
guidelines in order to make provision for various areas of practice and to allow for new 
developments in health and to keep up to speed with technology (Bell, 2005:2; Geyer, 
2016:51). This assertion provide an opportunity for lecturers at the nursing education 
institutions to explore various teaching and learning strategies that could be used to 
develop students’ competencies on decision-making.

Baxter and Boblin (2008:345) argue that, if lecturers want to teach students decision-
making skills, it is necessary to first understand the kinds of decisions students make at 
the clinical facilities. Learning opportunities need to be created for the students to 
possess leadership, patient teaching and reasoning skills. However creation of learning 
opportunities rests on each nursing discipline to interpret the scope of practice 
regulations appropriately to their specific field (Bell, 2005:2). Analogous nurses must 
have a clear understanding of the kinds of decisions women are making regarding their 
choices on reproductive health services and the factors playing a role in influencing their 
decisions. According to Wittmann-Price (2004:444), nurses themselves need 
emancipation from the constraints imposed on them by the health environments 
systems; hence, education, training and upgrading of their skills become imperative to 
attempt to create an emancipated health care environment for women. However, the 
nursing curriculum does not have specific guidelines on how to achieve this or how to 
support women faced with reproductive health care dilemmas.
1.3 AIM OF THE STUDY

The aim of the study was to develop guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods using Mpumalanga College of Nursing as a focal area.

1.4 OBJECTIVES FOR THE STUDY

To achieve the above aim, the study was conducted in two phases.

Phase one focused on exploration of views and opinions of participants. The objectives were:

- To explore and describe the views and opinions of undergraduate nursing students and lecturers/preceptors on their ability to support women to make informed decisions about family planning methods (step one).

- To explore and describe the views and opinions of undergraduate nursing students and lecturers/ preceptors on factors surrounding women’s health that impinge on women’s freedom to make informed decision about family planning methods (step two).

- To explore and describe the views and opinions of undergraduate nursing students and lecturers/ preceptors regarding the types of content that need to be included in the education and training of nurses to support women to make informed decision about family planning methods (step three).

Phase two focused on the development and evaluation of guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods. The objective was:

- To develop and evaluate guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods as described below.
The guidelines were developed using a combination of the following:

- results of phase one;
- field and reflective journal notes;
- literature review;
- literature used to control the findings of this study in line with that of other nursing education and training principles;
- guiding principles of existing contraceptive guidelines, such as those outlined in the Department of Health’s (South Africa, 2012:3) National Contraceptive and Fertility Planning Policy and Service Delivery Guidelines;
- strategies of evidence-based practice such as the WHO’s strategic approach to strengthening sexual and reproductive health policies; and
- programmes to address women’s contraception questions and concerns (Kols, 2008:4; South Africa, 2012:27).

The draft guidelines was presented for evaluation to five participants who participated in the pilot study.

Wittmann-Price’s (2004:441, 2006:378) Theory of Emancipated Decision-making (EDM) was used as a theoretical framework to direct the development of the guidelines in this study.

Themes, topics, categories and information identified during data collection were used to develop recommended guidelines. The draft guidelines were presented to the same participants as in the main study to validate and add their views, opinions, comments and recommendations (where necessary) to the guidelines. The researcher amended the draft guidelines based on the inputs from the participants. The draft guidelines were then presented for review, evaluation and correction through a pilot study using the same participants used for pilot data collection, instrument refinement and approval. Chinn and Kramer’s (2008:246, 2011:184) critical reflection guide was used to evaluate the guidelines for clarity, simplicity, generality, value, accessibility, perceived utility in relation to practice, as well as the importance of the guidelines in line with practice guidelines such as the National Contraception and Fertility Planning Policy and Service
Delivery Guidelines (De Vos, Strydom, Fouché & Delport, 2011:48; South Africa, 2012:3). This stage is essential to ascertain that information included in the guidelines is correct, clear, understandable and applicable.

In the development of guidelines, it is also critical that guideline developers ensure that guidelines are reliable and credible, and meet criteria for high-quality practice guidelines. Hence, the guidelines for this study were also measured by the application of the six-domain structure of the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument to determine whether they met criteria for high-quality practice guidelines (Fevers, Carretier & Bataillard, 2010:342).

Data from all categories of participants were collected through focus group discussions. Collection of data continued until no new information was emerging from participants, at which point the “principle of saturation” was reached (Burns & Grove, 2009:361).

The focus group method was used to explore the views and opinions of all participants about support for women to make informed decisions about family planning methods. Biographical data were collected for the purpose of describing the participants. The central leading discussion question was based on the objectives of the study and the Wittmann Price Theory of EDM in women’s health care (Wittmann-Price & Bhattacharya, 2008:440). The researcher was assisted by a co-facilitator during focus group discussions. The co-facilitator had experience in conducting focus group discussions and possessed knowledge of the topic under study (Polit & Beck, 2008:387).

De Vos et al. (2011:361) state that focus groups are planned group discussions aimed at obtaining participants’ perception about a phenomenon under study. Focus group discussions with all categories of participants in this study lasted for about an hour to prevent exhaustion of the participants (Burns & Grove, 2009:514).

1.5 RESEARCH QUESTIONS

The main research question which directed the study was:
• What is your opinion regarding women choices in reproductive health services?

In a quest to determine the type of reproductive health services offered to women, the study attempted to answer the following questions:

• What is your opinion on challenges experienced by women regarding making family planning method choices in the reproductive health services?
• What is your opinion on challenges experienced by nurses regarding women choices in the reproductive health services?
• What is the role of the nursing profession in the provision of reproductive health services?
• How are undergraduate nursing students prepared for the role of the nursing profession in the provision of reproductive health services?
• What teaching materials are used to prepare undergraduate nursing students to support women in making decisions regarding reproductive health services?
• What are the characteristics of nurses who are adequately prepared to support women in making decisions regarding reproductive health services?
• What are the indicators that women are able to make decisions regarding reproductive health services?

1.6 SIGNIFICANCE OF THE STUDY

According to Mookamedi (2011:26), reproductive health services are regarded as important services that need to be given priority. Included in reproductive health services are family planning programmes, which require recognition of women’s rights and self-determination. This study attempted to explore the views, knowledge and opinions of undergraduate nursing students and lecturers/preceptors regarding their ability to support women to make informed choices regarding family planning methods. Apart from self-determination for women, family planning services will ensure women's holistic healthiness (i.e., physical, social and emotional healthiness), which will ultimately lead to a healthy nation.
The results of the study, in the form of a set of guidelines, will assist the nursing profession to implement a curriculum which will empower nurses with knowledge, skills, attitudes and competences to assist women to make decisions about their reproductive health. The structured guidelines will also enable the nursing profession to monitor and evaluate the appropriateness of these guidelines in the future. Informed decision-making for women’s health care needs supports MDGs 3 (promotion of gender equality and empowering of women) and 5 (improving maternal health), which were not achieved and have since been replaced by the SDGs which include, relevant to this study, achieving gender equality, ensuring healthy lives and promoting well-being for all at all ages (Barbier & Burgess, 2017:7).

1.7 DEFINITION OF CONCEPTS

Undergraduate nursing students are students who are following a formal four-year nursing diploma programme and are registered with the SANC.

Empowerment refers to building women’s confidence, insight and understanding of responsibilities of making their own decisions about health care needs. It also means sharing information and power with women, and taking initiative and making decisions about health care needs (Baxter & Boblin, 2008:346). Similarly, Rahman (2013:14), defines empowerment as a process of positive change that improves women’s position and bargaining power within a patriarchal structure.

Emancipation refers to an individual’s freedom from legal, political or social constraints and from any other bondage that may hinder decision-making. An emancipated decision refers to creating a fertile environment in the health care settings and to making free decisions without pressure or fear of prejudice (Wittmann-Price & Bhattacharya, 2008:227).

Reproductive health refers to the reproductive processes, functions and systems at all stages of life. It implies that people are able to have responsible, satisfying and safe sex, and have the capability to reproduce and the freedom to make decisions about their reproductive matters (WHO, 2004:8).
**Family planning methods** refer to condom use, injectable and oral contraceptives, copper intrauterine device, levonorgestrel intrauterine system, single-rod progesterone implant and emergency contraception pill (South Africa, 2012:8).

### 1.8 LITERATURE REVIEW

The literature reveals that the wide range of services falling under the umbrella of sexual and reproductive health makes it difficult to define the scope (Dickinson, Attawell & Druce, and 2009:846). However, Ajakaiye and Mwabu (2007:2) outline these services as including maternal and child health, family planning products and services, abortion, information and counselling on sexually transmitted infections, including HIV/AIDS, and elimination of harmful practices against women, such as genital mutilation and forced marriage.

Considering that one in three women will have an abortion in their lifetime, supportive and non-judgemental counselling, with continual assessment, follow-up and ongoing contraception to prevent recurrence of unplanned pregnancy, should be offered to these women to support them in decision-making. These efforts are regarded as critical in the prevention of the consequences of unintended pregnancy and sexually transmitted infections, which continue to present major public health challenges worldwide, even in countries with high utilisation of modern contraceptives (ESHRI Capri Workshop Group, 2014:952; Royal Australian & New Zealand College of Obstetricians and Gynecologists, 2005:2). This underlines the importance of encouraging the readiness of undergraduate nursing students, through an education programme, to participate in support for women to make emancipated decisions about family planning methods. It is internationally reported that there is growing evidence that supports linkages between sexual and reproductive health and HIV services as leading to significant positive benefits to public health (Dickinson et al., 2009:847).

Wittmann-Price and Bhattacharya (2008:226) assert that the concepts of social awareness of norms, flexible environment, empowerment, personal knowledge and reflection need to be in place to create a fertile environment for women’s informed decision-making. The researcher in this study also believes that these concepts are
crucial attributes to be included as part of guidelines that can be used to support women to make emancipated decision about family planning methods.

The nursing education system globally then plays a major role with regard to ensuring that future professional nurses are prepared to use these concepts in their interventions to support women with decision-making skills about family planning methods and sexual issues. Reproductive units should be designed to incorporate the five concepts as stated above, and assumed by Wittmann Price and Bhattacharya (2008:226) to be essential attributes for emancipated decision-making. These units should also introduce undergraduate nursing students to current nursing issues regarding women’s empowerment to make informed decisions in the reproductive settings as the core concept. Nurses need to acknowledge that oppression of women still exists and that it has a tremendous negative impact on women faced with making personal choices, including women nurses themselves.

In their submission, AIDS Legal Network and Out LGBT Well-being (2007:3) raise the concern of lack of enabling environments to ensure effective implementation of reproductive health practices. They also state that the contexts in which reproductive health services are provided are limiting because the human nature of decision-making is not free from social, cultural and religious aspects. Access to reproductive health care services (RHS) is reported to be beset by disparities in the availability and quality of such services, coupled with non-availability of suitable environments to support decision-making for women who seek reproductive health services.

Singh, Sehgal, Kaur, Puri and Mangat’s (2008:2) report on contraceptive use indicates that there is minimal awareness of emergency contraception as a method of preventing unplanned pregnancy. Awareness and effective use of emergency contraception may also prevent consequences of having to face decision-making about termination of pregnancy and issues of reproductive health. Awareness of the diverse and complex issues affecting women’s decision-making will, according to the researcher, allow health practitioners to put in strategies that will minimise their negative effects in health care settings.
Educational requirements and recommendations cited in literature as having the potential to enhance understanding of the importance of quality decision-making during family planning consultations include (Barron & Pillay, 2013; Brown, Bohua & Padmadas, 2010:106; South Africa, 2012:23):

- training of service providers and educators to increase public knowledge on contraception using a variety of innovative methods and appropriate materials;
- revision or development of contraception training curricula in line with the latest national contraception policy for the different categories of service providers and students;
- review or revision of the scope of practice of identified categories of primary health care (PHC) providers to allow provision of certain contraceptive services;
- clarification and explanation of new contraceptive methods; and
- introduction of implementation of contraceptive guideline practices.

The literature records various evidence-based interventions and approaches to reinvigorate contraceptive services to meet the needs of women. These include:

- redesigning service delivery systems with a broad base of support cutting across many sectors, including politicians, government bureaucrats, academics, health professionals, community-based workers, school-based clinics and employment-based clinics, non-clinic-based delivery systems and community-based programmes;
- convenient clinic opening times;
- reasonable waiting times;
- clean and safe clinic environment;
- non-governmental organisations (NGOs), influential community members and organisations, religious institutions, and private institutions, as well as the people at large;
- implementing health sector reform by providing family planning services in the context of personalised integrated services with other policies, guidelines and other reproductive programmes; and
• using other countries’ strategies of evidence-based practice, such as the WHO’s strategic approach to strengthening sexual and reproductive health policies and programmes to address women’s questions and concerns (Kols, 2008:4; South Africa, 2012:27).

Evidence-based practice has further shown that removing unnecessary barriers, good counselling and communication, giving information about contraceptive side effects and reassurance about irregular bleeding tendencies, and providing recommendations for management of side effects may increase women’s use of contraception (Centers for Disease Control and Prevention, 2013:13).

The importance of development of guidelines to support women to make informed decisions about family planning is further supported by Perkins and Zimmerman (1995:569), who state that, theoretically, empowerment connects mental health to mutual help to create a responsive community. This has not been fully explored and determined in South Africa.

It is also stated in the literature that there is evidence that counselling alone, with or without specialised job aids, does not influence the rate at which contraceptives are used and that health professionals still express a need for more guidance on how to deal with women seeking contraception services. It is recommend that careful training, supervision and modelling that point out opportunities on how to support women about their contraceptive needs should be implemented (Chin-Quee, Janowitz & Otters, 2007:377; South Africa, 2012:27; Valdés, Alarcon & Munoz, 2013:306). According to Valdés et al. (2013:303), providing individualised information contributes to more informed decision-making than group information.

Providers of contraception services, amongst others, are urged to implement the existing contraceptive policy guidelines guided by evidence-based practice and to embark on regular modification of the policy while incorporating available evidence-based guidelines and tools to improve the quality of family planning services, local and international research towards assisting women to make informed decisions about their contraception needs. It is further suggested that new intervention strategies should be
explored to assist women to maintain use of family planning methods, with a focus on effects of culture on informed family planning choices, cultural elements, and aspects of the health system that facilitate or hinder informed decision processes (Barron & Pillay, 2013; Chin-Quee et al., 2007:382; Kim, Davila, Tellez & Kols, 2007:235; South Africa, 2012; Valdés, Alarcon & Munoz, 2013:306).

1.9 PARADIGMATIC PERSPECTIVE

Mookamedi (2011:28) states that various authors describe a paradigm differently. A paradigm means a belief regarding how things are done. Stommel and Wills (2004:441) describe a paradigm as approaches to research based on certain assumptions about the nature of reality. Polit and Beck (2012:11), and Creswell and Plano Clark (2011:41) describe a paradigm as a set of philosophical assumptions about the nature of reality (ontology), knowledge of that reality (epistemology), the language of research (rhetoric), the process followed to make that reality known (methodology), and the influence of values in understanding the phenomenon (axiology). Creswell and Plano Clark (2011:415) further assert that, in research, these philosophical assumptions consist of basic beliefs that guide a research study. Based on literature, research can be undertaken within two paradigms, namely, positivism (also known as empiricism) or constructivism (also known as naturalism).

1.9.1 Positivism or empiricism

Stommel and Wills (2004:436) describe positivism or empiricism as a philosophical outlook that is associated with the assumption that there is an objective reality (ontology) that exists independently of the human observer, even though the perception might be restricted by the limitations of human abilities to observe and process information about reality. In this study, the researcher's interest was in the participants' views and opinions regarding their ability to support women to make informed decisions about family planning methods.
1.9.2 Constructivism or naturalism

Polit and Beck (2012:12) state that a constructivist paradigm is also called a naturalistic paradigm, hence for the purpose of this study these concepts are used interchangeably. Constructivism is described by Creswell and Plano Clark (2011:409) as typically associated with qualitative approaches which are based on understanding or meaning of phenomena, formed through participants and their subjective views. This is created by the interaction between researchers and participants, which leads to the understanding of a phenomenon. A constructivist paradigm was applied in this study, as the participants’ interpretation or reality in many ways enabled the researcher to develop the guidelines for support for women to make informed decisions about family planning (Polit & Beck, 2012:12).

In this study, a qualitative, explorative and naturalistic approach was used to enable the researcher to understand the meaning the participants attached to nurses’ ability to support women to make informed decisions about family planning. Focus group discussions were conducted intensively until data saturation was reached in order to understand the phenomenon.

The researcher chose and accepted the commitment to collect data within the assumptions discussed in the next section.

1.10 ASSUMPTIONS OF THE STUDY

According to Polit and Beck (2012:12), an assumption is a basic principle believed to be true without being verified. Assumptions are said to be hidden in thoughts and behaviour. In order to recognise assumptions, introspection is necessary. The researcher in this study assumed that the absence of guidelines for undergraduate nursing students to support women to make informed decision about family planning methods violates the constitutional rights and prevents the improvement of the quality of life for women. It therefore became imperative that the following assumptions be included for further discussion and to guide the research study.
1.10.1 Ontological assumptions

Ontology describes the reality of the study. According to Creswell and Plano Clark (2011:41), constructivists (naturalists) view reality from multiple and subjective points of view constructed by individuals. In this study, this was reflected in the viewpoints provided by the participants of their own reality, based on their experiences and circumstances or context. During focus group discussions with the two groups of participants, the elicited information reflected the different realities as seen by participants in relation to their views and opinions regarding their ability to support women to make informed decisions about family planning. The type of content to be included in education and training of nurses to support women to make informed decision about family planning was also derived.

1.10.2 Epistemological assumptions

Creswell (2013:20) states that epistemology requires the researcher to be closer to the participants to gather and understand the participants’ knowledge regarding the topic of interest. The aforementioned will enable the researcher to gather the truth related to the topic. Through linguistic epistemology, the researcher as a person interacting with the participants will know the truth.

In this study, the researcher conducted focus group discussions, through which the researcher was closer to the lecturers/preceptors and undergraduate nursing students in order to understand their views and opinions regarding nurses’ ability to support women to make informed decisions about family planning, as well as the type of content to be included in education and training of nurses to support women to make informed decisions about family planning. The information gathered assisted in the development of the guidelines for undergraduate nursing students.

1.10.3 Axiological assumptions

According to Creswell (2013:20-21), axiological assumptions denote that the researcher acknowledges that research is based on values and that biases are present. To prevent biases in the study, the researcher kept a reflective journal in which her opinions and
views were written regarding the ability to support women to make informed decisions regarding family planning methods, as well as the content to be included in the education and training of undergraduate nursing students to support women to make informed decisions regarding family planning methods.

The abovementioned assisted the researcher to monitor her emotions throughout the research study.

1.10.4 Methodological assumptions

Methodological assumptions refer to the manner in which the research is undertaken. In line with the above, Creswell (2013:21) points out that the researcher uses inductive logic to conduct the study within the naturalistic setting and continuously revises questions from opinions in the field. In the current study, the researcher used a qualitative research approach to explore the views and opinions of undergraduate nursing students and lecturers/preceptors regarding their ability to support women to make decisions about family planning services, and the type of content to be included in education and training of nursing to enhance the ability of the lecturers/preceptors and undergraduate nursing students to support women in making informed decisions regarding family planning methods.

1.10.5 Rhetoric assumptions

Creswell and Plano Clark (2011:41) describe a rhetoric assumption as the language used in research. Researchers use language that will advocate for participants. In order to ensure that acceptable standards of research language have been used in the study, the researcher was granted permission to conduct the study by the Medunsa Research Ethics Committee (MREC) as well as Mpumalanga Department of Health Research Committee before the commencement of the study. This was done after perusal of the research proposal, whereby it was ensured that the acceptable language of research would be adhered to. The researcher only used language that would meet the purpose of the research.
1.11 RESEARCH METHODOLOGY AND DESIGN

Research methodology is described by Polit and Beck (2012:741) as the techniques used to gather and analyse data in a systematic approach. In this study, a qualitative method was used. Qualitative research is defined as an investigation of the phenomenon which is done holistically, in a natural setting, using multiple research designs to understand the participants' opinions and views. This method involves both inductive and deductive logic processes. The researcher becomes an instrument of data collection to continuously observe the meaning of a phenomenon as it is displayed by the participants (Creswell, 2013:45-46). The current study took place in the nursing college, and the researcher collected data and ensured that she captured verbal and non-verbal cues to understand the phenomenon as it occurred.

In order to obtain demographic information, a quantitative approach was found to be relevant. Polit and Beck (2008:763) describe a quantitative approach as an investigation of the phenomenon that aims at quantifying and giving precise measurement of through a structured form. In the present study, the researcher used a quantitative research design to collect demographic information from undergraduate nursing students and lecturers/preceptors as it is simple to analyse numeric information through statistical procedures.

1.11.1 Research design

According to Polit and Beck (2008:765), a research design is defined as “the overall plan for addressing the research question including specifications for enhancing the study’s integrity”. The researcher found it appropriate to use an exploratory, descriptive and contextual design, focusing on support for women to make informed decisions about family planning methods, to advance the researcher's desire to base the enquiry on realities, viewpoints and opinions of those participants under study (Polit & Beck, 2008:219). The research design is discussed in detail in Chapter 2.
1.11.2 Study setting

Qualitative researchers collect information through face-to-face interaction in a natural setting where the phenomenon occurs (Creswell, 2013:45). This enhances the understanding of the participants’ opinions and views regarding the study topic as the study occurs in the environment where the phenomenon takes place. Mpumalanga College of Nursing was found to be an appropriate setting as it is the only place in Mpumalanga Province, South Africa, where the education and training of undergraduate nursing students takes place regarding family planning methods. The study setting is expanded upon in Chapter 2.

1.11.3 Study population

All objects or individuals sharing the same attributes and characteristics relevant for the study are known as the study population or target population (Polit & Beck, 2012:738). The sample of that target population that will be feasible for the researcher to access is known as the accessible population.

In the current study, the researcher had two populations, namely, all undergraduate nursing students enrolled for a four-year nursing diploma in a nursing college and all lecturers/preceptors teaching theory and accompanying undergraduate nursing students in clinical training facilities in Mpumalanga. The study population is discussed comprehensively in Chapter 2.

1.11.4 Sample and sampling technique

According to Burns and Grove (2009:721), a sample is defined as a subset of the population selected for the study. The sample should have the same characteristics and attributes as the population. A sampling technique is a method used to select a sample. In research there are two sampling techniques, namely, probability and non-probability sampling techniques. A non-probability purposive sampling method was used in this study to identify and select participants who could best help the researcher to understand the problem and address the research questions (Creswell, 2009:178; Polit
The size of a sample in qualitative research is adequate when information required to gain insight into the topic under study has reached saturation and quality information has been obtained from participants (Burns & Grove, 2009:361). The researcher in this study collected data to the point of saturation (Polit & Beck, 2008:357). To support the above, Streubert-Speziale and Carpenter (2007:124) report that it is impossible to predetermine the number of participants for the study because qualitative researchers are more concerned with the quality of data collected as compared to the quantity of data. The participants for focus group discussion were selected from undergraduate nursing students and lecturers/preceptors, whereby 12 undergraduate nursing students and 8 lecturers/preceptors respectively were selected to participate in the study.

**1.11.6 Data collection**

Burns and Grove (2009:695) describe data collection as the systematic collection of information to answer the research question, meet the research objectives and research purpose, and prove the statement as true or false.

In this study, the researcher was a research instrument as she collected data for herself by means of conducting focus group discussions. The views and opinions of undergraduate nursing students and lectures/preceptors were sought regarding their ability to support women to make decisions about their health and the type of content to be included in nursing education and training to enhance their ability to support women in making informed decisions about family planning methods. The interview schedule, voice recorder, field notes, observations and reflective journals were tools used to collect data. Data collection is clearly explained in Chapter 2.
1.11.7 Pilot study

Fox and Bayat (2011:102) state that piloting the research instrument involves running a trial of investigation using a small sample to determine whether the research design and methodology are relative and effective. Piloting of the research instrument is therefore done to ensure its trustworthiness for the study. Fox and Bayat (2011:102) further assert that it is advantageous to run a pilot study because areas of misunderstanding will be identified and corrected without wasting money and time.

In this study, the researcher conducted a pilot study using one focus group discussion with five lecturers/preceptors who were not part of the main study. Piloting the research instrument enabled the researcher to institute some modifications on the study plan (De Vos et al., 2011:395) in case the research instrument did not yield the intended results. A voice recorder was also used to capture data with the aim of letting the researcher practise proper usage of the equipment and to supplement the captured data. Ethical considerations were also adhered to.

1.11.8 Data analysis

According to Polit and Beck (2008:758), data analysis is the systematic organisation of data, aiming at giving meaning to the data. The process of data analysis in qualitative research occurs simultaneously with data collection. As the researcher is conducting interviews, both verbal and non-verbal cues are also analysed and given meaning. To come up with a rich description of a phenomenon, the researcher will further transcribe data repeatedly, interpret the field notes, code the collected data and build themes and categories.

In the current study, analysis of qualitative data was done using Tesch’s steps, as outlined in Creswell (2009:185). The demographic profile of the participants was also analysed and presented in a table form.
1.11.9 Trustworthiness of data collection

Lincoln and Cuba (1985, as cited in Polit & Beck, 2008:539) cite four criteria for developing trustworthiness to diminish threats and thus maintain validity and reliability of the study, namely, credibility, dependability, confirmability and transferability. These criteria were used in this study to ensure trustworthiness of the collected data collected. Trustworthiness of data collection is described in detail in Chapter 2.

1.11.10 Ethical considerations

Approval to conduct the study was obtained from MREC and from the Mpumalanga Department of Health Ethics Committee, after intensive scrutiny of the research proposal. Participants were recruited after clearance certificates to conduct the study were obtained from both the University and Department of Health ethics committees.

The purpose of the study was explained to the participants. They were informed that participation was voluntary and they could withdraw at any time should they so wish without any penalty. The data were collected after the participants had signed the consent forms. Participants were assured that information elicited from them would be kept confidential. Anonymity of participants was also emphasised and they were informed that their names would not be used; codes were used instead.

Participants were informed that a voice recorder would be strategically used during discussions as the researcher could not capture all the information during the session; however, after transcription the recordings would be deleted. Participants were also informed that the results of the study may be used for publication in articles. Ethical considerations are further elaborated upon in Chapter 2.

1.12 OUTLINE OF THE STUDY

Chapter 1 discussed the orientation to the study, the research problem and significance, the purpose, objectives and research questions, paradigmatic perspective and assumptions of the study as well as literature review.

Chapter 2 covers research methodology and design.
Chapter 3 describes data analysis and interpretation.

Chapter 4 discusses the findings and literature control of qualitative data.

Chapter 5 covers the development of guidelines.

Chapter 6 discusses the overview, recommendations, implications, limitation and conclusion of the study.

1.13 CONCLUSION

This chapter outlined the background to the study, the research problem and significance, the purpose, objectives and research questions, the paradigmatic perspective and assumptions of the study, the literature review, the research design and methodology, and ethical considerations for the conduct of the study. Chapter 2 deals with research methodology and design.
CHAPTER 2
RESEARCH DESIGN AND METHODOLOGY

2.1 INTRODUCTION

Chapter 1 presented an orientation to the study. This chapter describes the detailed overall plan and the methodological dimensions of the way in which the study was conducted in order to explore the views and opinions of undergraduate nursing students and lecturers/preceptors on their ability to support women to make informed decisions about family planning methods. The study setting, research design, study population, sample and sampling techniques, data collection and analysis, trustworthiness of data collection, and ethical considerations are also discussed in detail in this chapter.

2.2 RESEARCH DESIGN

According to Grove, Burns and Gray (2013:25), a qualitative research design is used to explore a phenomenon in a holistic and flexible manner. Furthermore, Polit and Beck (2012:58) state that the research design is the overall plan for obtaining answers to the research questions.

In this study, a qualitative, descriptive, explorative and contextual research design was used to understand the views and opinions of the undergraduate nursing students and lecturers/preceptors on support for women to make informed decisions about family planning methods (Babbie, 2010:93; Burns & Grove, 2009:55; Creswell, 2009:173, 2013:45; Polit & Beck, 2012:58).

2.2.1 Qualitative design

A qualitative design is a systematic, interactive, subjective approach used when meaningful information on life experiences is required (Grove et al., 2013:24). It is most effective when gathering information regarding values, behaviours, views and opinions of a particular population (undergraduate nursing students and lecturers/preceptors in this study). Qualitative research is conducted when the researcher has an interest in understanding and describing how individuals or groups perceive social phenomena. It
occurs in naturalistic settings as researchers are interested in the contexts of people’s experiences and lives (Polit & Beck, 2012:50). Holloway and Wheeler (2010:5), and Polit and Beck (2012:15) add that the essence of qualitative research lies in the description of lived experience as it relates to human beings.

This design was suitable for phase one of this study, which focused on exploring the participants’ views and opinions of their ability to support women in making informed decisions about family planning methods and on factors surrounding women’s decision-making regarding family planning methods.

Using this design the researcher, being a key instrument in the data collection, obtained a comprehensive view of the participants expressing themselves in describing their views and opinions on the phenomenon under study. The researcher was also absorbed in the world of the participants through listening, observing, questioning and seeking out clarification of non-verbal cues from participants to deduce the correct meaning. This helped the researcher to have an in-depth understanding of the importance of support for women to make informed decisions about family planning methods.

2.2.2 Exploratory design

According to Grove et al. (2013:27), exploratory research is conducted to address a problem in need of a solution or to understand the phenomenon that is being studied. The phenomenon is rigorously investigated to generate or increase the existing information. Polit and Beck (2012:727) add that exploratory research focuses on the “what” and the significant facts related to the problem. According to Mookamedi (2011:54), exploratory research is done to enable the researcher to understand the phenomenon as it occurs to depict other factors to which it is related, to test the possibility of undertaking more extensive studies, and to design methods to be used in future studies.

The researcher in this study chose to use this type of research design to gather information on experiences of undergraduate nursing students and lecturers/preceptors
regarding factors surrounding women’s health that impinge on their freedom to make informed decision about family planning methods. The information elicited from the experiences of participants in that regard has generated new insight of the phenomenon under study. It has also been used to formulate guidelines on support for women to make informed decisions about family planning methods.

2.2.3 Descriptive design

The purpose of a descriptive research design is to describe a phenomenon as it is portrayed, or to provide an accurate account of the characteristics of a particular individual event or group of real life occurrences. This is done to describe what exists, determine the frequency at which a phenomenon occurs, categorise new information, and discover new meaning (Grove et al., 2013:12; Polit & Beck, 2012:226). A descriptive design was used in this study to collect descriptive information on support for women to make informed decisions about family planning methods. The design was also used to help the researcher to elicit an authentic description of the views and opinions of the participants regarding their ability to support women to make informed decisions, on factors surrounding women’s health that impinge on their freedom to make informed decision about family planning methods, and on the type of content that needs to be included in the education and training of nurses.

2.2.4 Contextual design

Streubert-Speziale and Carpenter (2007:459) mention that qualitative studies should be done in a way that does not disturb the natural context of the phenomenon studied. Participants in this type of research should provide information freely and honestly because the study is undertaken at a natural site which is free from manipulation. In recognising the above sentiment, Holloway and Wheeler (2010:41) define the context as the environment and conditions in which the research study takes place, including the culture of the participants. The researcher conducted the study at the nursing college where the lecturers/preceptors were working, as well as where the undergraduate nursing students were receiving education and training. The researcher was also the manager of the same nursing college, which made it easier to secure
permission for a suitable venue for conducting of the study. Sanjari, Bahramnezhad, Fomani, Shoghi and Cheraghi (2014:2) and Pannucci and Wilkins (2010:626) cite that the researcher’s personal relationship with participants maybe inevitable while collecting data and as such it is important that the researcher should identify and avoid biases. The risk of bias in this study was reduced through the following: development and piloting of the interview guide, adherence to ethical consideration, a detailed tape-recorded, confidential focus group discussion was conducted, and data was collected from multiple sources, namely undergraduate nursing students and lecturers/preceptors (Cresswell 2013: 251 & Vincet 2014: 277. The focus group discussions with the participants took place in a place where privacy and comfort were ensured. This enabled the researcher to capture the information as needed. Furthermore, the researcher was able to understand the participants’ views and opinions regarding the phenomenon under study as data were collected within the participants’ context (Brink, Van der Walt & Van Rensburg, 2011:151).

2.3 STUDY SETTING

According to Polit and Beck (2012:49), the study setting refers to two or more specific sites where data are collected. The classic research setting for qualitative design is one that is relevant for the research endeavour and easily accessible, and where cooperation with participants can be easily achieved, the researcher has freedom to move about freely and information can be easily obtained (De Vos et al., 2011:332). Creswell (2009:175) and Polit and Beck (2012:50) indicate that qualitative research is conducted in a naturalistic setting, which is an environment that is not controlled. Grove et al. (2013:37) are also of the opinion that natural settings are uncontrolled, real-life settings where studies are conducted.

The research study was conducted at Mpumalanga College of Nursing. Mpumalanga College of Nursing is situated in the eastern part of Mpumalanga, in the Ehlanzeni district, one of the three districts of Mpumalanga Province. This is the only nursing college in the province that provides education and training for both undergraduate and postgraduate nursing students. The chosen site is situated in a rural area,
approximately 500 m from Themba Hospital, one of the 19 hospitals that provides clinical exposure to the students. The students on training are allocated to the 19 hospitals and their feeder clinics within the Mpumalanga Province for clinical exposure.

The district where the nursing college is situated shares international borders with Swaziland and Mozambique on the eastern side and a national border with Limpopo on the northern side. Languages spoken in Mpumalanga include Tsonga, Pedi, Zulu, Swazi, Ndebele and Portuguese. The influx of people from neighbouring countries (Swaziland and Mozambique) influences the culture of the people in Ehlanzeni district regarding their understanding of the concept emancipation and freedom to make an informed decision about family planning.

The researcher chose to use the boardroom of the nursing college, as participants usually held meetings there and were therefore familiar with the venue. This venue was easily accessible, spacious, and far from classrooms and other distractions. It was equipped with an air conditioner. Refreshments were provided since eating together promotes conversation and communication within a group. The researcher further had a watch to keep track of the time, an audio recorder to capture information as well as an interview schedule to guide the discussion (De Vos et al., 2011:370-371).

2.4 STUDY POPULATION

A population is described as all elements that meet certain criteria for inclusion in a given universe (Grove et al., 2013:44). These elements include objects, individuals, events, artefacts, groups and substances. Polit and Beck (2012:738) refer to the study population as the target population. The accessible population is the population within the target population that is accessible to the researcher. The population for this study included all lecturers/preceptors (heads of subjects and of clinical facilities accredited for clinical placements of students included) and undergraduate nursing students working and enrolled, respectively, at Mpumalanga College of Nursing. A total of 54 lecturers/preceptors and 780 undergraduate nursing students were working and enrolled respectively at Mpumalanga College of Nursing at the time of data collection. Out of the 54 lecturers/preceptors 23 were directly involved in teaching undergraduate
nursing students reproductive health practice theory and clinical practice, whilst of the 780 undergraduate nursing students 360 were in third and fourth year level of study. Only 188 of the third and fourth year students were at the college at the time of data collection. All these participants provided rich information necessary for the study.

2.5 **SAMPLING**

Grove et al. (2013:44) describe a sample as a portion of a population sharing the same characteristics as the population. A sample is selected from the accessible population (Polit & Beck, 2012:738). Polit and Beck (2012:59) further explain that it is more practical to collect data from a specific sample than from a population. In this study a non-probability purposive sampling method was used to select the undergraduate nursing students and lecturers/preceptors that were participants.

Purposive sampling is defined by Brink (2011:102) as a deliberate selection of a particular element for a specific purpose. The author further states that those elements are hand-picked based on researcher’s knowledge of the population in terms of their contribution to the phenomenon at hand. By using this technique, the researcher thought that information elicited from participants would be rich to answer the research question. The participants were chosen on the basis of their knowledge and experience regarding the provision of family planning services.

2.5.1 **Sample size**

In qualitative research, sample size is not predetermined by conventional formulae. The sample size is achieved after data saturation or data adequacy has been achieved. Creswell (2013:157) states that it is thus not possible for the researcher to state how many participants will be sufficient for the study as the intent of qualitative research is not to generalise the information, but to elucidate the particular or specific phenomenon. Burns and Grove (2009:361) confirm the above notion by stating that saturation of data is achieved when no new information is obtained from participants who could increase the sample size and data obtained are rich and cover the anticipated dimensions of the phenomenon of interest. Holloway and Wheeler (2010:146) add that, in qualitative
research, sample size does not necessarily determine the quality of data. The goal is to understand the phenomenon as it occurs, not to represent the population.

Consequently, in the present study, two focus group discussions were conducted and data were considered saturated when redundancy of previously collected data commenced. The researcher adhered to ethical considerations relating to sampling. Thus, there was no discrimination in the selection of participants, unless the inclusion criteria were not met. In the present study, all the undergraduate nursing students and lecturers/preceptors were eligible to participate in the study. Burns and Grove (2009:361) mention that the sample size should be large enough to identify relationships amongst variables or to determine dissimilarities between groups. In the current study, focus group discussions were used to collect data from the participants. Brink, Van der Walt and Van Rensburg (2006:152) state that focus group interviews should consist of five to 15 participants whose views, opinions and experience are required simultaneously. According to De Vos et al. (2011:367), focus groups should consist of six to 10 participants to allow everyone to participate while a range of responses can still be elicited.

Table 2.1 below illustrates the manner in which the two focus groups that participated in this study were formed.

Table 2.1: How the two focus groups were constituted

<table>
<thead>
<tr>
<th>FOCUS GROUP</th>
<th>SAMPLE</th>
<th>SAMPLE SIZE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Undergraduate nursing students</td>
<td>12</td>
</tr>
<tr>
<td>2</td>
<td>Preceptors and lecturers</td>
<td>8</td>
</tr>
</tbody>
</table>

Thus, 12 undergraduate nursing students and eight lecturers/preceptors were included in the study. A total sample of 20 participants provided a rich information base.

2.5.2 Recruitment process

The sample was recruited from the Mpumalanga College of Nursing undergraduate nursing students and lecturers/preceptors. This was done after obtaining written
permission from the Mpumalanga Department of Health Research Committee (see Annexure C). All lecturers and preceptors hold provincial meetings tri-annually; thus the researcher, who was a manager of the nursing college where the study was conducted, used one of the meetings days to recruit prospective participants. Information on the study plan, aim, objectives and benefits of the study was explained to the prospective participants and those willing to participate signed consent forms (see Annexure A). Schedules for focus group discussions were secured with participants to arrange a convenient date, time and venue. Particulars of participants were requested to make follow-up contact as needed. Recruitment of undergraduate nursing students was done using their class timetable to identify one afternoon when they were given a half day. Thirty minutes were used to inform the undergraduate nursing students about the study plan. Students willing to participate signed consent forms (see Annexure A). Three proposed dates were given to them to identify the one that was most suitable to conduct the focus group discussions.

2.5.2.1 Inclusion criteria for study participants

This section discusses inclusion and exclusion criteria for the undergraduate nursing students and lecturers/preceptors.

(1) Inclusion criteria for undergraduate nursing students

Third- and fourth-year undergraduate nursing students studying towards a four-year nursing diploma were chosen because they were at the stage of their education and training where they were involved in learning reproductive health practice and had been to the wards and clinics. The undergraduate nursing students had to be on a theory block at the time of data collection. They had to be over 18 years of age and must have given informed consent. The focus group discussion was conducted in English, hence all participants were expected to speak English as is the medium of instruction.

(2) Exclusion criteria for undergraduate nursing students

First- and second-year students studying towards a four-year nursing diploma were excluded from the study because their course content dealt with introduction to family
planning and thus they lacked the experience and appropriate knowledge to benefit the objectives for this study. Undergraduate nursing students who were not on a theory block at the time of data collection and those who were under the age of 18 years at the time of data collection were also excluded from the study.

(3) Inclusion criteria for lecturers/preceptors

Lecturers/preceptors who were teaching theory and accompanying undergraduate nursing students in the clinical training facilities were included in the study. They had to have been working at the college as lecturers/preceptors for more than a year and to voluntarily consent to participate in the study. They could not have facilitation sessions at the time of data collection. Thus the researcher did not disturb the learning process and the selected sample was knowledgeable about the phenomenon and provided the desired information. All lecturers/preceptors were expected to speak English as the focus group discussion was conducted in English.

(4) Exclusion criteria for lecturers/preceptors

Lecturers/preceptors who had been teaching theory and accompanying undergraduate nursing students for less than one year teaching and following undergraduate nursing students in the clinical training facilities were excluded. Lecturers/preceptors who were scheduled to conduct facilitation sessions at the time of data collection and those who did not give their consent were excluded from the study.

2.6 DATA COLLECTION

Creswell (2013:146) describes data collection as a series of interrelated activities aimed at gathering good information to answer emerging research questions. Grove et al. (2013:45) emphasise that data collection is a process of identifying research participants, and collecting accurate data in a systematic way that is relevant to the purpose, objectives, questions and hypotheses of the study. Focus group discussions were used to collect data for this study. According to Burns and Grove (2009:513), focus groups refer to groups that are designed to gather participants’ perceptions in a focused area in a setting that is nonthreatening. Focus group study may incorporate six...
to 10 participants (Burns & Grove, 2009:513). Brink et al. (2006:152) state that focus group interviews should consist of five to 15 people whose experiences and opinions are requested at the same time.

To collect these data, the researcher used observational notes, interview schedules, the researcher, and field and reflective journal notes as data collection instruments (De Vos et al., 2011). The tables were arranged in a circle with comfortable chairs. This type of setting allowed face-to-face interaction with one another. De Vos et al. (2011:325) add that successful data collection and fieldwork depends on the initiative the researcher takes to establish rapport and relationships with the gatekeepers. Focus group discussions for the two groups of participants were conducted by the researcher. The researcher held a master’s degree, is experienced in facilitating focus group discussions and has knowledge of reproductive healthcare services. She was a manager of the nursing college where the study was conducted. The researcher was intensely involved in the supervision of research projects for fourth-year undergraduate nursing students, college lecturers/preceptors and postgraduate university students who utilized focus group discussion method of data collection for their research projects. The researcher was assisted in capturing field notes and non-verbal cues by two colleagues who held doctoral and master’s degrees and were experienced in focus group discussions and guidelines development. The discussions were also audiotaped.

To collect data, the researcher in this study used a semi-structured interview schedule to provide a clear set of questions with the aim of providing reliable, comparable qualitative data (see Annexure B). According to De Vos et al. (2011:352), an interview schedule is a written questionnaire used to guide interviews which provides the researcher with predetermined questions to encourage the participants in a narrative terrain. The interview schedule may be structured or unstructured, depending on the research design. In the current study, the interview schedule allowed the researcher to structure the questions according to the objectives of the study. This benefited the researcher because questions were predetermined and the researcher appeared to be prepared as well as competent during the focus groups. To understand the views and opinions of participants on support for women to make informed decisions about family
planning methods, the researcher followed the interview schedule, used open-ended guide questions and posed probing questions based on the information that emanated from the context of the participants (Cohen & Crabtree, 2006:1; Streubert & Carpenter, 2011:34).

2.6.1 Pilot study

The pilot study of the research instrument is a trial run used to test the effectiveness of the data collection instrument as well as to improve the success of the investigation (Polit & Beck, 2012:195). De Vos et al. (2011:395) are of the opinion that, as qualitative research does not require large sample size, it would be cumbersome to pilot the research instrument in exactly the same manner as this will be equivalent to repeating the main study. Contrary to this sentiment, the researcher piloted the research instrument by conducting one focus group interview consisting of five lecturers/preceptors with the aim of determining whether the instruments would be easily understood and administered within a reasonable time period of an hour.

During this session, ethical considerations were adhered to, which included, amongst others, seeking permission to use the venue to undertake the pilot study and obtaining informed consent from the participants. The researcher conducted a detailed tape-recorded, confidential focus group discussion. Field and reflective journal notes were taken and as a principle transcribed the interviews verbatim (Creswell, 2013:165). The pilot study enabled the researcher to determine:

- the suitability of the site for data collection;
- her competency of using a tape recorder;
- the duration of each interview;
- suitability of the interview methods used to elicit the required information;
- the willingness of the participants to participate, which was demonstrated by the way they responded and commented;
- an indication of what needed to be changed in order to ensure scientific study; and
- planning for follow-up prompts based on the initial response to generate further discussion in the focus group discussions to follow.
2.6.2 The role of the researcher in this study

Creswell (2013:45) states that qualitative researchers collect data themselves by means of instruments they developed. According to De Vos et al. (2011:325), successful accomplishment of qualitative research design and data gathering is determined by the accessibility of the setting and the researcher’s ability to establish and maintain relationships and agreements with gatekeepers and participants. In order to improve the quality of data and data collecting process, the researcher in this study was involved in the following roles:

2.6.2.1 Planning to conduct focus group discussions

The research planning phase involved reminding the participants who gave consent during the recruitment process of the date, time and venue for group discussions a week before the date of the focus group session. The researcher reiterated that participation is voluntary, but that their participation in the focus group discussions was considered valuable. The audiotape recorder was tested beforehand and participants were reminded that the session would be recorded to ascertain whether they were still in agreement with this. The interview schedule was made available and copies of the section on biographic data was duplicated according to the number of participants. The researcher further requested the permission from the facility authorities (Department of Health) to conduct the study (see Annexure D).

The researcher has, amongst others, determined how to gain access to the research field. In the current study, the researcher reviewed literature relevant to the study, familiarised herself with the research methods and design, developed interview schedule, specified the group of subjects, identified the research setting, and secured the date and the venue for the collection of data.

2.6.2.2 Gaining access to the field and establishment of rapport

According to Polit and Beck (2012:183), in order to collect data, researchers need to gain access to the field that is suitable for the enquiry. All fields are said to have gatekeepers. Cohen, Manion and Morrison (2011:168) agree with the above sentiment.
Therefore, the researcher needs to build good relationship with gatekeepers to access the field. This is only possible if the researcher has strong interpersonal skills and is familiar with the customs and language of the site. The researcher established rapport by spending a great deal of time with the prospective participants during the recruitment period, as well as 15 minutes before commencement of each focus group discussion, to explain the purpose of the research, who the beneficiaries would be, how the prospective participants would benefit from the study, how long the study would take, how ethical considerations would be adhered as well as how results would be published. All these were written down and formed the negotiation package which enable the gatekeepers and participants to make their decision about granting access to the field. The image of the researcher as the manager of the nursing college was a reputable one and she was familiar with the conversation patterns, culture, norms and values of the study setting. The researcher had strong interpersonal skills and blended well with the participants.

2.6.2.3 Focus group discussions

De Vos et al. (2011:361) state that focus group are planned group discussions aimed at obtaining participants’ perceptions about a phenomenon under study. The authors further state that focus group discussions occur on a defined area of interest in a permissive, non-threatening environment. Boswell and Cannon (2014:278) explain that, in focus group interviews, participants are guided in the discussion of a phenomenon of interest at the same time. Each participant is stimulated by the comments of others.

The focus group method was used in this study to explore the views and opinions of all participants about their ability to support women to make informed decisions about family planning methods. The central leading discussion question was based on the objectives of the study and the Wittmann-Price Theory of EDM in women’s health care (Wittmann-Price, 2008:440). The researcher had two assistants during focus group sessions. The assistants had experience in conducting focus group discussions and knowledge of the topic under study (Polit & Beck, 2008:387). Collection of data continued until there was no new information emerging from participants, which is when
the “principle of saturation” was reached (Burns & Grove, 2009:361). Focus group discussions with both categories of participants in this study lasted for about an hour to prevent exhaustion of the participants (Burns & Grove, 2009:514). To enhance the data collection process, the focus group discussions were audiotaped. Each participant’s biographical data were collected for the description of the participants.

The participants in this study were undergraduate nursing students and lecturers/preceptors whose responsibilities included providing reproductive health services. These participants discussed their views and perceptions within the context of reproductive health services as well as education. Furthermore, the data collected were rich and enabled the researcher to develop guidelines for undergraduate nursing students to support women to make informed decisions regarding family planning methods. Focus group discussions have flexibility. Although the interview guide was used, once the discussion was started, it brought a great deal of excitement over the topic and the participants expressed their views and opinions regarding the topic. Probes were used by the researcher on emerging issues from the discussion and further provided an investigation on a multitude of perceptions in a reproductive health service fraternity.

The participants in the study shared the same attributes and characteristics relevant to the topic, which made it easy and comfortable for them to express their views and opinions regarding reproductive health services. Because the discussion involved a group of participants, individuals’ comments triggered reactions from other participants regarding the topic, which elicited more views and opinions (De Vos et al., 2011:360).

The seating plan was in a manner that would enhance face-to-face communication. Before commencing with focus group interviews, the researcher made sure that the boardroom was ready. The researcher sat away from the door to avoid being distracted and to better focus on facilitating the discussion. The assistant researchers sat near the door to welcome those that arrived late. The assistants further tested two tape recorders for readiness and in working order to capture the proceedings and put the paper and pen ready so that field notes could be captured.
Although the participants knew the researcher and her assistants, an introduction was done to formalise the discussion, to make participants aware of the researcher’s role for the day and to clarify the assistants’ role. A small social discussion prior to the main discussion was held with the aim of creating a warm and friendly environment and to keep the participants at ease. Then, the ground rules were set for the discussion. The researcher kept the introduction very brief and stuck to the point of informing the participants of the purpose of the discussion. It was further mentioned that the participants should be free to make contributions as there would not be any criticisms attached to what they have said.

The researcher portrayed familiarity in good facilitation and listening skills. If participants did not understand the question asked, the researcher asked more specific and focused open-ended question based on the initial response as directed by the objective. All participants were given chance to participate.

The researcher noted the first few words every time a participant spoke in order to identify the participants and kept notes under the following categories:

**Field notes:** Field notes contain the insight events the researcher collected in a natural setting. They are created by the researcher immediately leaving the field site to produce an understanding of the phenomenon of interest (De Vos et al., 2011:359).

For this study, the researcher captured field notes which included aspects such as manner of speaking, the way of interacting, short quotations indicating language or tone of verbal communication in the research setting, description of interaction patterns, activities and events that occurred in the setting, themes that were striking and the description of the physical setting itself (De Vos et al., 2011:372; Stommel & Wills, 2004:286).

Babbie (2010:310) emphasises the significance of making full and accurate notes of what has transpired during an interview to prevent loss of data through depending on memory of what has happened during an interview, as remembering what happened might be impossible. Hence, in addition to the above, the researcher made field notes to
capture verbal and non-verbal cues which enabled the description of what has transpired during the focus group discussions.

**Observational notes:** Stommel and Wills (2004:286-287), and Polit and Beck (2012:548) describe observational notes as attempts to describe people and events in neutral language that adheres to observable details and state that these cannot be separated from interpretive inferences. Consequently, the researcher noted information pertaining to date, time and location, participants’ behaviour and the dialogue as fully as possible. These notes were captured in order to remind the researcher of the way the focus group discussions took place.

**Theoretical notes:** Polit and Beck (2012:549), and Stommel and Wills (2004:287) explain that theoretical notes are used to reflect the researcher’s efforts to attach meaning to observations in the field. The researcher attached meaning to her interpretive attempts and captured such meaning to serve as a starting point for subsequent analyses.

**Methodological notes:** Polit and Beck (2012:549) emphasise that methodological notes refer to the researcher’s reflections about the strategies used in the study to observe the phenomenon as it unfolds. These notes serve as reminders for the researcher to ensure that similar observations throughout the interviews are interpreted in a uniform manner. The researcher in this study kept notes on the process followed to conduct focus group sessions as reminders or instructions to be adhered to for subsequent sessions.

**Personal notes:** Comments about the researcher’s personal feelings during the research process were recorded (Polit & Beck, 2012:494).

**Reflective journal notes:** A reflective journal is used as a measure to keep a record of researchers’ thoughts, notes, reflections and questions regarding the phenomenon under study. Keeping reflective journals is a method that can facilitate reflexivity, whereby researchers through this journal examine personal assumptions that can have an influence on the phenomenon under study (Polit & Beck, 2012:495). The researcher
therefore kept a reflective journal to monitor her emotions and perceptions throughout the research process by writing down her emotions, preconceptions and prejudices so that they could be bracketed to prevent bias in the study.

**Data management:** The audio data were translated into text by transcription. The data were then typed for analysis.

2.6.2.4 *The researcher’s role during focus group discussions*

**Communication skills:** Paraphrasing was used to ensure that the information was captured accurately. Paraphrasing is a method of restating clearly and concisely the ideas of the author using one’s own words (Burns & Grove, 2009:110).

**Minimal verbal response:** The researcher used short verbal responses like “*um*” to encourage the participant to continue narrating. She also adopted a less active role to allow adequate time for participants to talk.

**Probing:** The researcher used probing phrases, such as “*anything more on that?*” within reasonable guidelines to ensure that participants had no feeling of being cross-examined. This was done to obtain more detailed information about questions where inadequate information was provided by participants. Probing questions were kept neutral to avoid biases (Burns & Grove, 2009:405).

**Bracketing:** The researcher identified and set aside any preconceived beliefs and opinions she might have had about the phenomenon under study. In other words, she identified what she expected to discover and deliberately set aside this idea so that she could consider every available prospect (Brink et al., 2006:113; Burns & Grove, 2009:546).

The researcher was regularly confronted with negative issues of reproductive health care during academic meetings, in the media and at the health care facilities where undergraduate students are allocated for their clinical exposure. It became necessary for the researcher to suspend this prior knowledge and her assumptions about the
phenomenon under study in order not influence a new understanding of support for women to make informed decisions from the perspective of the participants.

This position was attained through bracketing the researcher’s own preconceptions regarding support for women to make informed decisions about their reproductive health care issues. The researcher used bracketing deliberately to avoid misinterpreting the phenomenon as it was being experienced by the participants. The participants themselves had to form the direction of the study (Burns & Grove, 2009:545).

**Intuition:** This happens when the researcher attempt to develop an awareness of the lived experience. In this study, the researcher became immersed in the data collected during focus group discussions to get a sense of what support for women to make informed decisions meant. The researcher reviewed the transcribed data while at the same time listening to the audiotape (Burns & Grove, 2009:524). The data were reviewed repeatedly to get an understanding. The final data were contrasted and compared to determine emerged themes. This was made possible because the focus group discussions took place in a natural setting using a semi-structured interview schedule/guide. The researcher also captured field and reflective journal notes to capture data. All focus group discussions were recorded (Brink et al., 2006:113).

**Reflection:** Field and journal notes were captured by the researcher during focus group discussions to reflect back on the entire process in order to identify any need for improvement. After the session, the researcher and assistants reflected on the whole focus group discussion, discussed the interview, compared field notes and discussed limitations (Creswell & Plano Clark, 2011:372). During data analysis, the researcher was continuously involved in reflecting on her personal beliefs and feelings that could influence the phenomenon under study. This was made possible because the researcher identified her beliefs, assumptions and preconceptions about the phenomenon under study at the beginning of the study and wrote them in a diary for continuous self-reflection. This facilitated openness and internalisation of new insight on the part of the researcher as the participants were relating their views and opinions on the topic for the study during focus group discussion (Burns & Grove, 2009:546). Much
time was also spent by the researcher reflecting on the possible meaning and relationship of the data to the phenomenon under study (Brink et al., 2006:184).

**Non-verbal encouragement:** The researcher used herself to create a relaxed, non-judgemental atmosphere and sustained a pleasant face to set the tone for focus group discussions. She continually nodded her head to assure the participants that she was listening and that she understood and valued their contributions.

**Clarification:** The researcher kept verifying with the participants what was said throughout data collection process by utilising phrases such as, “let me ascertain whether I understood you well, you mentioned that…”, “may I verify if I heard you well…”, or “did you say that…”.

**Summarising:** To conclude the session, summarising was done and the researcher asked the participants whether there was anything else that needed to be discussed. She then thanked them for their valued contributions.

2.6.2.5 *Leaving the field*

This is the last phase of data collection process, during which data saturation is experienced. De Vos et al. (2011:336) warn researchers to be ethical and leave the field in a way that brings no negative consequences to any of the participants. In this study, the researcher made sure that she was ethical throughout the time of data collection and left the field when she was sure that the data collected answered the research question. The information collected had no negative consequences to any of the participants and it highlighted the views and opinions regarding reproductive health services provided to women.

2.7 **DATA ANALYSIS**

Data analysis refers to the entire process of bring order, structure and meaning to the collected data (De Vos et al., 2011:397). Analysis of qualitative data for this study was done using Tesch’s steps, as outlined in Creswell (2009:185). Data collected from the two group of participants were analysed concurrently according to the principle of
constant comparison to determine existence of similarities and dissimilarities. Much time and energy was spent by the researcher to read through field and journal notes, and to listen to the audiotapes repeatedly (De Vos et al., 2011:398). The aim of analysis of the data in this study was to enable the researcher to understand support for women to make informed decisions about family planning methods from the participants' perspective. Demographic data were analysed quantitatively and descriptively.

The voice-recorded focus group discussions were transferred to the researcher's personal computer and were password protected to prevent unauthorised persons from listening. The focus group discussions were transcribed, and transcripts and notes for the two focus groups were identified properly and grouped with an identification code per focus group.

2.7.1 Transcribing focus group discussion data

The researcher transcribed the interviews while they were still fresh in her mind. Four hours was taken to transcribe each focus group collected data because the researcher played and re-played the audiotape to understand what was said. Sandelowski (cited in Burns & Grove, 2009:521) points out that transcription takes about three to five hours for each hour of interview time. The researcher carefully listened to the voice tone, inflections and pauses of the researcher and the participants, as well as the context in which the responses were provided, as these features indicate that the topic is important or emotional. The written notes were also read while listening to the audiotapes and notations on observations were made on the transcript. The external coder also listened to the audiotapes from the two focus group discussion to enhance her understanding while coding the data. All data were entered more than once and repeated spot-checking was done to ensure that quality data were captured.

2.7.2 Development of themes, categories and sub-categories

According to De Vos et al. (2011:397), data analysis involves making sense of the collected data, as well as interpreting and data theorising. Following transcription of the data, Tesch’s steps of data analysis were utilised by the researcher.
The researcher read through all documents for the data collected in order to get a sense of the whole, concentrating on thoughts, issues, topics and feelings mentioned by participants. Similar aspect were grouped together to minimise categories as sensibly as possible. All data collected, including the recorded discussions, non-verbal information, and field and reflective journal notes, were transcribed verbatim by the researcher.

Looking for trends and patterns that reappeared amongst the two focus group discussions assisted the researcher in the development of the initial themes and categories prior to submission to the external coder. The transcribed data were submitted to the external coder, who was experienced in coding qualitative data. The researcher also worked with the supervisor and co-supervisor to code the transcripts to get the sense of the findings of the study. This activity assisted in ensuring credibility of the data analysis process (Polit & Beck, 2008:547). In addition to using the above steps, identified themes, categories and sub-categories were also synthesised.

2.8 RESEARCHER’S REASONING STRATEGIES

The researcher had to implement the techniques used to structure the study as well as gather and analyse information in a systematic fashion (Polit & Beck, 2012:13, 741). Various reasoning strategies to facilitate the research process and to formulate logical arguments about support for women to make informed decisions about family methods were utilised in this study. Polit and Beck (2008:13) explain logical reasoning as a problem-solving method where experience, intellectual faculties and a formal system of thought are combined. Burns and Grove (2009:16), on the other hand, describe logical reasoning as involving the processing and organising of ideas in order to arrive at conclusions. The above authors assert that deductive and inductive reasoning are useful strategies for understanding and organising phenomena (Polit & Beck, 2008:13). Walker and Avant (2011:65) outline analysis, synthesis and derivation as the three basic reasoning strategies. Four reasoning strategies described below were used in this study to arrive at a logical conclusion, namely, analysis, synthesis, induction and deduction.
2.8.1 Analysis

During data analysis, the researcher was able to examine the relationship of each emerging theme with the other themes, categories and sub-categories within the topic under study, namely, support for women to make informed decisions about contraceptive methods. According to Walker and Avant (2011:64), analysis is an approach that theorists utilise to dissect a whole into parts and that allows them to clarify, refine or sharpen concepts, statements or theories, especially where there is an existing body of knowledge, to enable better understanding. Existing knowledge about the phenomenon is examined and re-examined to improve the accuracy, relevance and/or currency of the knowledge (Walker & Avant, 2011:64). Analysis leads to identification, refinement, classification and sharpening of concepts. Using analysis as a research technique helped the researcher to identify and classify the themes and related relationships amongst concepts that emerged during focus group discussions with lecturers/preceptors and undergraduate nursing students.

2.8.2 Synthesis

Synthesis is said to be the process of bringing up or combining separate elements into a connected whole. Synthesis is particularly useful where a researcher undertakes interpreting data without an explicit theoretical framework (Walker & Avant, 2011:63). In this study, the researcher applied this strategy to identify relationships amongst concepts and categories to construct new concepts, categories and statements. Synthesis was also useful in drawing conclusions for this study, as well as making recommendations based on findings from the focus group discussions with the participants.

2.8.3 Inductive reasoning

According to De Vos et al. (2011:49), inductive reasoning is a process that starts with an observation of the empirical world. This form of reasoning is regarded as a logical thought process in which generalisation is developed from specific observations. It starts with details of experience from specific observations and moves to a more
general theoretical explanation of the phenomenon. Through inductive reasoning, people reflect on what is taking place in the empirical world, moving towards theoretical concepts and prepositions.

In this study, the researcher utilised inductive reasoning strategies to explore the views and opinions of lecturers/preceptors and undergraduate nursing students concerning support for women to make informed decisions about family planning methods. The concepts that emerged from focus group discussions were refined, elaborated and combined into more tentative generalised statements. This form of reasoning was important in guiding the researcher during the development of guidelines to support women in making decisions about family planning methods.

2.8.4 Deductive reasoning

Deductive reasoning is said to be a form of logical reasoning in which two premises are relevant and which moves from the general to the specific, using two or more variables (De Vos et al., 2011:48; Streubert & Carpenter, 2011:10). The researcher in this study used deductive reasoning when drawing conclusions from the data collected through the focus group discussions and field notes, during literature control, and in generating statements for the guidelines, describing the guidelines and identifying concepts based on research findings.

2.9 ETHICAL CONSIDERATIONS

The study had ethical implications as it involved human participants. Considering this, the principles that were adhered to are described in the sections below.

2.9.1 Protecting the rights of an institution

The researcher sought permission within the facility to schedule the focus group session on a day when the venue was not used. This was achieved with ease since the researcher was the manager of the nursing college where research was conducted. The research sessions were conducted during the participants’ free periods. In addition, the study was conducted after obtaining a written permission from MREC (see Annexure C)
and the Mpumalanga Department of Health Ethics Committee, following intense scrutiny of the research proposal. Following the satisfaction of the ethics committee that the research would not pose ethical risks to the participants or the institution, an ethical clearance certificate was issued to the researcher, allowing her to continue with the study. Based on the written requests by the researcher (see Annexure D), to which the request was the ethical clearance certificate, research proposal and research instruments were attached, further permission to conduct the study was granted following intense scrutiny of the research proposal by the Mpumalanga Department of Health Ethics Committee. Permission was obtained from the authorities of Mpumalanga College of Nursing after they were convinced that the researcher would uphold sound research ethical principles during the study (Polit & Beck 2012: 150; Creswell, 2013:57).

2.9.2 Right to self-determination

In research, the principle of self-determination refers to upholding the participants’ autonomy during the period of the study. This principle emphasises participants as human beings that have value in themselves, which informs the interaction between people. In recognising the participants’ self-determination, the researcher explained the purpose of the study to the participants and that participation was voluntary (Polit & Beck, 2012:154). In line with Grove et al. (2013:164), the researcher advised the participants on the following:

- The duration of the focus group interview session.
- That they could withdraw their participation at any time during the study if they no longer felt comfortable to participate, and that their withdrawal in participation would bear no penalty.
- The way confidentiality and anonymity would be ensured.
- That all their contributions are valuable and will contribute towards the improvement of reproductive health education.

The above information was recorded (Brink, 2011:36). After giving participants sufficient information about the study, the researcher requested the participants to ask questions for clarity and thereafter sign consent forms as a mutual understanding between the
researcher and participants (National Health and Medical Research Council, Australian Research Council & Australian Vice-Chancellors’ Committee, 2007).

2.9.3 Right to confidentiality and anonymity

Creswell (2013:60) refers to confidentiality as a process in which data collected from participants in a relationship of trust will not be disclosed to others without the participants’ permission. In recognising the principle of confidentiality, the following steps were taken:

- The researcher assured the participants that information elicited from the focus group discussion would not be discussed with any other people not involved in the study, except the research supervisor and co-supervisor.
- The research assistants were sworn to confidentiality.
- Data were collected in the boardroom of the nursing college, which was far from the classes and offices, to prevent other people from hearing the proceedings.
- A written sign was placed on the door of the boardroom, with the message: “Do not disturb, interviews in process”.
- At the end of focus group interviews, data were transcribed and the transcriptions were kept in a cupboard which the researcher kept locked.

The researcher also ensured that participants involved in data collected remained anonymous. According to Brink (2011:198), the process of anonymity refers to “the researcher’s act of keeping subjects’ identities a secret with regard to their participation in the research study”. To ensure anonymity, the researcher did the following:

- At the commencement of the focus group discussion, a request was made that the participants do not to mention their names or call other participants by their names.
- Numbers were assigned to the participants during data discussion (Brink, 2011:34).
- In case a name was mistakenly mentioned and captured, during member checking, recordings were edited with the aim of deleting names mentioned.
- Data were analysed in a way that the information mentioned could not be attached to the participants.
• Data were reported in a way that no other person would be able to link the deliberations to individual participants (Grove et al., 2013:172).
• Tapes and transcriptions are to be destroyed and erased after the publication of the report.

2.9.4 Right to fair treatment

The right to fair treatment is based on the ethical principle of justice and dictates that every participant should be treated fairly without an act of exploitation or vulnerability (Grove et al., 2013:173; National Health and Medical Research Council, Australian Research Council & Australian Vice-Chancellors’ Committee, 2007; Polit & Beck, 2012:155).

To adhere to the above principle, the researcher ensured the following:

• Data collected were within the scope and objectives of her research.
• Participants were selected as per inclusion criteria.
• All participants were treated equally during data collection.
• Participants were all regarded as valuable contributors of information and no judgement was made following their contribution.

2.9.5 Right to protection from discomfort or harm

The right to protection from discomfort or harm is based on the principle of beneficence, which states that the researcher should do good and not harm the participants (Brink, 2011:32; Grove et al., 2013:174; National Health and Medical Research Council, Australian Research Council & Australian Vice-Chancellors’ Committee, 2007). In recognising the above principle, the researcher made sure of the following:

• The study did not have the potential to harm the participants.
• Questions for interviews were phrased carefully.
• Interviews were conducted in a respectable manner, free from harassment or discomfort.
• The researcher asked probing questions in an acceptable manner.
• The researcher protected the participants from financial harm as focus group interviews were conducted in the boardroom where the lecturers and preceptors worked and that was walking distance from where the undergraduate nursing students attended classes.

• Although the participants would not benefit from the study immediately, the education of undergraduate nursing students will benefit them in future when the guidelines are developed to assist them to support women to make informed decision about family planning methods.

• The process of consent was done to allow participants to decide whether to proceed with the study or not.

• The researcher continued to be non-judgemental during the focus group discussions.

2.10 TRUSTWORTHINESS OF DATA COLLECTION

A research study is believed to be authentic or trustworthy when it reflects the reality of the viewpoints of people living in the area where the phenomenon of interest is embedded. Shenton (2004:63) states that trustworthiness of qualitative research is criticised by many people as the concepts of validity and reliability cannot be addressed in the same way as in quantitative research. To deal with the above notion, strategies of trustworthiness, namely, credibility, dependability, transferability, confirmability and data triangulation, were taken into consideration (De Vos et al., 2011:419; Polit & Beck, 2012:745).

2.10.1 Credibility

De Vos et al. (2011:419-420) state that credibility seeks to demonstrate that the research was conducted in a way that the participants were identified and described accurately so that the results of the research are believable. Polit and Beck (2012:585, 724) are also of the opinion that credibility relates to the truth of data collection and interpretation thereof. The techniques that were adhered to in the study in order to ensure increased credibility, as outlined in De Vos et al. (2011:420), are discussed below.
2.10.1.1 Research credibility

According to Patton (as cited in Shenton, 2004:68), the credibility of the researcher is of crucial importance in research as the researcher is the person that is the major instrument of data collection and analysis. The credentials of the researcher contribute to the success of the study and, for research results to be credible, it is vital to explain who the researcher is.

In the present study, the researcher held a Master Curationis degree and was the manager of the nursing education institution (NEI) where the research was conducted. Included in the key performance areas of the researcher’s job was being expected to conduct research on a continual basis to improve the provision of education and training in the college. During the time when she was a lecturer, the researcher facilitated a research module for the undergraduate nursing students and still continued to supervise their research projects at the time of writing. She also supervised research projects for post-basic studies university students. The abovementioned parameters prove that the researcher was knowledgeable in the field of research.

To avoid biases, the researcher remained objective throughout the study and bracketed her experiences and knowledge regarding reproductive health services. The research supervisor and co-supervisor were also experienced researchers who have published numerous research articles, and their research knowledge enhanced credibility of the study (Polit & Beck, 2012:596).

2.10.1.2 Peer examination

To achieve peer examination in this study, the researcher presented and discussed the data with two colleagues who were experienced in research, the supervisor and co-supervisor. Additionally, the data were analysed with the assistance of an external coder who was experienced and knowledgeable in qualitative research methods.
2.10.1.3 Member checking

In qualitative research, member checking is a technique used by researchers to bolster the accuracy, validity, credibility and transferability of the study, and to eliminate researcher bias when analysing and interpreting data. Researchers compare their understanding of what the participant said with the participant to ensure accuracy as well as what is salient in the study (Creswell, 2013:251; Shenton, 2004:68; Vincent, 2014:277). Member checking takes place at the end of data collection dialogues.

In this study, the researcher played back the recorded session to the participants to ensure that the articulations had been accurately captured. The participants were also requested to read the transcribed data, with the field notes included, with the emphasis that participants should consider whether the non-verbal cues portrayed matched with what they intended or not. The results of the data analysis were also discussed with the participants.

2.10.1.4 Establishment of referral adequacy

The researcher established referral adequacy through utilising information obtained from different authors through literature regarding support for women in decision-making to refine core areas in the study which were used as basis for the development of the guidelines.

2.10.1.5 Prolonged engagement with the data

Prolonged engagement refers to sufficient time spent by the researcher in the research setting to enhance establishing rapport, build trust with participants and increase understanding of the phenomenon of interest within a specific context, which will in turn result to rich information being obtained (Creswell, 2013:250; Polit & Beck, 2012:589; Shenton, 2004:65; Vincent, 2014:276). In this study, the researcher did the following to ensure prolonged engagement with the data:

- Developed the research instrument.
- Tested the instrument for validity and reliability.
• Oriented the research assistants and participants regarding the study and research instrument. Notably, she spent 30 minutes explaining the aim, objectives and benefits of the study, as well as ethical considerations for the study.
• Conducted focus group interviews with the participants, spending one hour with participants. She further clarified the participants’ questions.
• Transcribed data verbatim and reread the transcripts.
• Did thematic analysis of data.

2.10.1.6 Multiple investigators

Niglas (2000:1) refers to the use of multiple investigators as investigator triangulation which is implemented to bring different perspectives of the phenomenon under study. In the present study, the researcher engaged research assistants, research supervisor and research co-supervisor from the beginning to the end of the study. The incorporation of the abovementioned enhanced the trustworthiness of the study. The researcher furthermore allowed the participants to read the transcribed data in order to ensure credibility of the study.

2.10.1.7 Data from multiple sources

Denzin (1978) and Patton (1999) (both cited by Cohen & Crabtree, 2006:1), as well as Creswell (2013:251), refer to the use of multiple methods in qualitative research as methods triangulation to elucidate complementary aspects of the same phenomenon as well as enhancing confidence in the ensuing findings and to provide corroborating evidence. The notion referred to in this regard is used to determine the validity of qualitative research. Triangulation helps the researcher to reduce bias and cross-examine the integrity of participants (Vincent, 2014:277). Meijer, Verloop and Beljaard (2002:145) are of the opinion that triangulating methods of data collection will tell whether the findings of the study make sense or are credible to the participants, and will further indicate whether they give an authentic portrait of what the researcher is looking at. To add to the above, quantitative data were collected to enable the researcher to gain insight and understanding of the participants.
Building on these notions, the researcher in the present study collected information regarding reproductive health from the undergraduate nursing students, who went through theoretical and practical education and training on reproductive health, with the aim of eliciting rich information that would assist in the development of guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods. To compare the information received from the undergraduate nursing students, the researcher also collected data from the lecturers/preceptors of the course. Thus, the researcher gained insight from different sources.

The researcher further collected data from lecturers/preceptors to understand their views and opinions regarding reproductive health content of education given to the students. To capture information, focus group discussions were conducted by the researcher using a semi-structured interview schedule. A tape recorder was used to capture all the information during the focus group discussions. To supplement this method, the researcher also compiled field notes which stipulated non-verbal cues that could not be captured by the tape recorder. This enabled the researcher to draw inferences about the topic (De Vos et al., 2011:442).

2.10.1.8 Establishment of structural coherence

The Wittmann-Price Theory of EDM (Wittmann-Price, 2004:441) was used as theoretical framework in the development of the guidelines for this study.

2.10.2 Dependability

Shenton (2004:71) and Babbie and Mouton (2001:278) describe dependability as consistency and accuracy of the research findings following the study being repeated with the same participants and in the same context using the same research instrument and method. Botma, Greeff, Mulaudzi and Wright (2010:234) further state that, to address the dependability issue directly, the way the study was conducted should be reported in detail so that the same processes that were followed during the initial study can be followed if the same study needs to be repeated in future.
Dependability was ensured in this study through co-facilitator triangulation and a dependability audit.

2.10.2.1 Co-facilitator triangulation

The researcher was assisted by two colleagues who captured field and observational notes during focus group discussions. Field and reflective journal notes, including all detailed information collected on all focus group discussions, as well as audiotape recordings, will be kept for audit use.

2.10.2.2 Dependability audit

The supervisor and co-supervisor, who were experienced researchers in qualitative methods, followed the research progress events to establish whether comparable conclusions could be arrived at given the same data and research context. The research instruments used during the focus group discussion with undergraduate nursing students were also used with lecturers and preceptors, and the same results were elicited.

To further enhance dependability of this study, the focus group discussions were tape recorded and verbatim transcripts were made for each discussion session. The researcher coded the transcribed data and the external analyst came up with same codes. The supervisor and co-supervisor scrutinised the data interpretations to further enhance dependability.

The researcher established an audit trail to enable other researchers to scrutinise the research design used and how it was implemented, the operational details of data gathering, as well as the reflective appraisal of the project (Shenton, 2004:71-72). The researcher was assisted by co-researchers.

2.10.3 Confirmability

Confirmability refers to the way the results of a study can be confirmed and corroborated by other researchers (Vincent, 2014:279). Confirmability is further described by Vincent (2014:279) as a true reflection of data emanating from the study,
not from the preconceived ideas of the researcher regarding the phenomenon. Streubert and Carpenter (2011: 49) add to this by stating that the purpose of confirmability is to elucidate the evidence and thoughts that led to conclusions by ensuring that data are free from the researcher's preconceptions about the study topic.

2.10.3.1 Confirmability audit

Bracketing was used to achieve confirmability in this study. Assistance of an external coder, conducting a pilot study and an audit trail further helped the researcher to achieve this. The data collected during focus group discussions were audiotaped, transcribed and subjected to the participants for confirmation. Furthermore, the external coder examined both the process and the product of the account, assessing their accuracy. The findings, themes and categories were compared with transcribed data from tape recorders and field notes. The supervisor and co-supervisor ascertained that conclusions of the findings were supported by literature (Creswell, 2013:252).

2.10.3.2 Reflexivity

Shenton (2004:68) and Vincent (2014:279) state that the researcher's reflective commentary serves to confirm the value of the data collected and findings from data. The researcher achieved this by identifying and documenting her personal feelings and experiences that might influence the study at the beginning of the study. The understanding of these was integrated into the study. Reflective thinking was also utilised by the researcher during data analysis.

2.10.4 Transferability

Transferability in qualitative research refers to the degree to which the results of the study can be applied beyond the boundaries of the study.

2.10.4.1 Recruitment sample

To facilitate transferability in the present study, the researcher used purposive sampling of the facility and participants and provided a detailed description of the study to enable
the readers of the research report to apply the same method in the other situations (Polit & Beck, 2012:525-526; Vincent, 2014:277).

2.10.4.2 Dense description

A detailed description of the methodology, literature control and development of guidelines was provided by the researcher in order for other researchers to transfer the findings to similar situations.

The strategies for establishing trustworthiness of data collection with criteria and applicability to this study are depicted in Table 2.2 below.
Table 2.2: Strategies for trustworthiness in data collection

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>CRITERIA</th>
<th>APPLICATION</th>
</tr>
</thead>
</table>
| Researcher credibility       | • The researcher had 10 years’ experience as manager of a nursing college, and was involved in research project supervision of undergraduate nursing students and post-basic university students who did practicals at the college.  
|                              | • The researcher held a Master Curationis degree (specialising in Nursing Education). She developed investigative skills and literature review experience during the master’s programme.  
|                              | • Five months were spent on preparatory work for this study  
|                              | • A pilot study was conducted.  
|                              | • Two assistants, who held a PhD and master’s degree respectively and who were experienced with qualitative data collection and guideline development, provided technical support throughout the study period.  
|                              | • The researcher implemented bracketing to avoid biases.  
|                              | • The research supervisor and co-supervisor were experienced researchers and they had been involved in research for a long time.  
| Peer examination             | • Data were presented to the external coder, who held a PhD and who had experience and knowledge of qualitative research methodologies.  
|                              | • The supervisor and co-supervisor were experts in qualitative research methods. They both held doctorates and were advanced practitioners in midwifery, where aspects of the study topic is handled.  
| Member checking              | • Follow-up interviews were done with some of the participants after data collection to confirm that what was said was reflected in the researcher’s notes.  
|                              | • The audiotape was played back to the participants to check their reaction after focus group discussions.  
|                              | • Participants who were involved in the formulation and evaluation of the guidelines were provided with a copy to confirm that the captured data were a true reflection of their comments and suggestions.  
<p>| Establishment of referral adequacy | • Information obtained from different authors through literature regarding support for women in decision-making was utilised to refine core areas in the study.  |</p>
<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>CRITERIA</th>
<th>APPLICATION</th>
</tr>
</thead>
</table>
| Credibility| Prolonged engagement with the data | • The researcher designed the instrument, conducted focus group discussions and analysed the data. Prolonged engagement with data was therefore ensured (Creswell, 2013:53) through the following:  
  o Prior to conducting focus group discussions (FGD), the researcher made courtesy calls to all participants, and spent 15 to 20 minutes with each of the participants to: build rapport, remind them of the date of the FGD sessions, explain again the topic and purpose of the study  
  o The researcher applied persistent observation during focus group discussions to identify those characteristics and elements that are most relevant to the study problem and focused on them in detail by using probes where necessary  
  o The researcher spent three months immersed in the data.  
  o The researcher spent a further four months during data analysis (data were analysed manually using Tesch’s guidelines and the assistance of an independent coder was requested).  
  o A pilot study was conducted.  
  o During data collection, the researcher spent approximately an hour during focus group discussions and 20 minutes during follow-up discussions with participants who confirmed the true reflection of data captured.  
  o The researcher further established rapport with participants during the recruitment process.  
  o The researcher took notes during the process of data collection as recommended by Burns and Grove (2009:522). |
|            | Multiple investigators    | • The whole research process was guided, monitored and evaluated by supervisor and co-supervisor, from the inception of the study until the final report was produced. |
|            | Data from multiple sources| • Focus group discussions were conducted with two population categories (undergraduate nursing students and lecturers/preceptors) |
|            | Persistent observation    | • Non-verbal communication of the participants was consistently observed and recorded. Other elements in the context of the discussions that took place were captured as well.  
  • The researcher sought out clarification where necessary. |
|            | Establishment of structural coherence | • The Wittmann-Price Theory of EDM was used as a theoretical framework in the development of the guidelines. |
| Dependability| Co-facilitator triangulation | • The researcher collected data assisted by a co-facilitator who had experience with the data collection methods used for this study. Field notes, all detailed information collected on all focus group discussions and audiotape recordings will be kept for audit use. |
|            | Dependability audit       | • The supervisor and co-supervisor, who were experienced researchers in qualitative methods, followed the research progress events in this study to establish if comparable conclusions can be derived at, given same data and research context. |
2.11 GUIDELINE DEVELOPMENT PROCESS

The National Institute for Health and Clinical Excellence (NICE) and Evidence-Based Guidelines Development (EBGD) processes were adapted and followed in the development of the guidelines for this study. Preparing for development of guidelines, evidence retrieval, formulating draft guidelines and compilation of guidelines were the main steps or phases followed in the process of guidelines development for this study. The researcher developed the draft guidelines which were presented for validation to the participants described below. The guidelines were amended based on participants’ inputs and evaluated by five participants.

2.11.1 Selection of participants

The researcher selected a minimum of 12 participants who formed part of the main study to validate the guidelines as follows: three head of subjects/components, for PHC, Midwifery, Community Nursing Science, two heads of clinical facilities accredited for placement of undergraduate nursing students, four senior lecturer/preceptors and three (undergraduate nursing students). It was a purposive sample which was selected based
on availability and work experience with regard to teaching undergraduate nursing students in class and accompanying undergraduate nursing students in clinical practice, as well as level of involvement with regard to provision of reproductive health care to women/clients. Recruitment for participants was through meetings, as explained in Chapter 1 of this study. Telephonic conversations were followed by one-on-one discussions with heads of components, senior lecturers/preceptors and undergraduate nursing students.

2.11.2 Evaluation of guidelines

Guideline evaluation was carried out following the adapted NICE and EBGD guidelines process. The five participants who participated in the pilot study were also requested to evaluate the guidelines. The draft guidelines were developed by the researcher based on the results of phase one of the study, field and reflective journal notes, findings from literature review, and literature used to control the findings of the study. Initial recruitment communication with the participants was done through regular nursing college meetings. This was followed by telephone communication to remind participants that the draft guidelines would be sent to them electronically for evaluation. Three participants were in close proximity to the researcher, hence hard copies of the guidelines were delivered to them. The evaluation of guidelines for the study is discussed in detail in Chapter 5.

2.12 SUMMARY

This chapter provided a detailed description of the research design and methodology followed in this study. The qualitative, descriptive, explorative and contextual approach utilised for this study was discussed and the study population and sampling were presented in detail. Data collection and analysis, strategies to ensure trustworthiness of data collection, study setting and ethical considerations were also described. A brief description of the guideline development process was outlined as well. Chapter 3 presents the findings of this study.
CHAPTER 3: FINDINGS OF THE STUDY

3.1 INTRODUCTION

Chapter 2 described the research design and methodology of this study. This chapter presents the findings of data collected through focus group discussions from undergraduate nursing students and lecturers/preceptors. The aim of the study was to develop guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods using a NEI in Mpumalanga Province as a focal area. The findings are presented in two sections: section one comprises the findings from lecturers/preceptors, section two comprises findings obtained from undergraduate nursing students.

3.2 SECTION ONE: FINDINGS FROM FOCUS GROUP DISCUSSION WITH LECTURERS/PRECEPTORS

This section comprises the findings obtained from focus group discussions held with lecturers/preceptors from a NEI in Mpumalanga Province. First, the demographic profile of the participants is discussed, followed by the findings from the focus group discussions.

3.2.1 Demographic profile of the participants: lecturers/preceptors

Eight lecturers/preceptors were identified to participate in this study. These participants were all willing to participate and to share their views and experiences with the researcher about RHS offered to women/clients by nurses, focusing on support for women/clients to make decisions about family planning methods.

**Age:** The ages of the participants ranged from 31 to 65, with the majority (75%; n=6) being aged between 51 and 65 years. The age ranges of the other two participants were 31 to 40 and 41 to 50 respectively.

**Gender:** Seven participants were female and one was male.
**Marital status:** The majority of the participants (75%; n=6) indicated that they were married at the time of data collection, while two indicated that they were single and widowed respectively.

**Occupation:** All eight participants were employed as lecturers/preceptors at the time of conducting the study. The majority of the lecturers/preceptors (62.5%; n=5) who participated in this study were preceptors involved in the training of undergraduate nursing students in the midwifery units and reproductive health care in the clinical facilities, whereby family planning methods, included as part of the undergraduate nursing students’ curriculum, are emphasised and practically implemented post-delivery. Two participants were involved with Community Nursing Science 11 practical, whereby family planning methods are taught as part of the curriculum. Three participants were teaching theory to the undergraduate nursing students – two were teaching midwifery and reproductive health care content and one participant was teaching Community Nursing Science 11 theory, forming part of the undergraduate nursing students’ curriculum which has a module on family planning methods.

According to the researcher, lecturers/preceptors teaching undergraduate nursing students theory and clinical aspects at third- and fourth-year levels of training would have adequate experience to respond to the questions on the phenomenon under study. Hence, level and area of involvement with undergraduate nursing students during their education and training were used as criteria for exclusion or inclusion for this category of participants.

All eight participants indicated that they were Christians. Table 3.1 depicts the biographical data of the participants for the present study.
Table 3.1: Demographic profile of the participants

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>CHARACTERISTICS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>31-40 years</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td></td>
<td>41-50 years</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td></td>
<td>51-65 years</td>
<td>6</td>
<td>75%</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>7</td>
<td>87%</td>
</tr>
<tr>
<td>Marital status</td>
<td>Single</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>6</td>
<td>75%</td>
</tr>
<tr>
<td>Occupation</td>
<td>Lecturers/preceptors</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>Religion</td>
<td>Christian</td>
<td>8</td>
<td>100%</td>
</tr>
</tbody>
</table>

3.2.2 Analysis of findings from focus group discussion: lecturers/preceptors

Three themes, seven categories and 16 sub-categories were identified from the focus group discussions with lecturers/preceptors. These are discussed and summarised in Table 3.2 below.

The first theme that emerged was RHS offered to women by nurses. From this theme, three categories were identified, namely: nurses’ responsibilities in the provision of reproductive health care, characteristics displayed by nurses during provision of reproductive health care, and challenges experienced by nurses and women at the reproductive health care facilities. The second theme pertained to measures to assist women/clients to make decisions about family planning methods. Categories that emerged under this theme pertained to upgrading nurses’ knowledge and skills on RHS and accessibility of RHS. The undergraduate nursing programme was the third theme that emerged from the data collected from the lecturers/preceptors. From this theme, two categories emerged, namely, teaching undergraduate nursing students reproductive health care practice and teaching strategies or methods.
### Table 3.2: Themes, categories and sub-categories from lecturers/preceptors

<table>
<thead>
<tr>
<th>THEMES</th>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. RHS offered to women/clients</td>
<td>• Nurses’ responsibilities</td>
<td>• Provision of health education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Advocating for women/clients</td>
</tr>
<tr>
<td></td>
<td>• Characteristics displayed by nurses</td>
<td>• Women empowerment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nurses display negative attitudes</td>
</tr>
<tr>
<td></td>
<td>• Challenges experienced by women</td>
<td>• Challenges faced by nurses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Challenges faced by women/clients</td>
</tr>
<tr>
<td>2. Measures to support women to make decisions on RHS</td>
<td>• Upgrading nurses knowledge and skills on RHS</td>
<td>• Provision of in-service education and training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Supermarket approach to reproductive health care service delivery</td>
</tr>
<tr>
<td></td>
<td>• Accessibility of RHS</td>
<td>• Conducting RHS impact analysis/evaluation</td>
</tr>
<tr>
<td>3. Undergraduate nursing programme</td>
<td>• Teaching third and fourth year undergraduate nursing students reproductive health care practice</td>
<td>• Reproductive health care content covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Year level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Module types</td>
</tr>
<tr>
<td></td>
<td>• Teaching practices/methods</td>
<td>• Responsible person for teaching reproductive health care content</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Teaching methods and activities used</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Teaching materials used</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assessment methods used</td>
</tr>
</tbody>
</table>

### 3.3 THEME 1: REPRODUCTIVE HEALTH CARE SERVICES OFFERED TO WOMEN/CLIENTS

Three **categories** and six **sub-categories** were identified under this theme and these are discussed below.

#### 3.3.1 Category 1: Nurses’ responsibilities

During the focus group discussion, participants strongly viewed nurses’ responsibilities during provision of RHS as being that of giving health education to women/clients about the whole contraceptive concept, being women’s advocates and women empowerment. The three sub-categories that emerged from this category are discussed below.
3.3.1.1 Provision of health education

The participants echoed that it is the role and responsibility of lecturers/preceptors to educate undergraduate nursing students about reproductive health care to prepare them for their role in the provision of health promotion and disease prevention. Health information on various available types of family planning methods, benefits, adverse and side effects, myths, indications and contraindications of contraceptives (whole contraceptive concept) was seen as having the potential to create awareness for women/clients on RHS available to enable them to make informed decisions regarding which contraception to choose. They further indicated that facilitation of awareness of contraceptive side effects, indications and contraindications, and various available family planning methods should be part of content of health education on RHS to allow undergraduate nursing students to transfer this information to women/clients in need of contraceptive services. This was expressed as follows:

P1/FGD 1: Nursing services has the responsibility to provide information to women about the whole contraceptive concept; ... as educators we teach the student nurses about educating the women... to administering the very contraceptive services.

P1/FGD1: ... they have to monitor their clients; follow them up; check adherence; they need to know how the method is treating the women… are they comfortable.

P1/FGD1: ... and to finally check such a method whether the women are experiencing side effects. If the monitoring is not given the women will stop at any time if the side effects are not bearable to them.

3.3.1.2 Advocating for women/clients

Participants cautioned that nurses, by nature of their profession, are involved daily in helping patients with their health needs, resolving their concerns about care they need as well as ensuring that their voice is heard by their spouses, communities and health professionals and that they are included in making decisions about their health care; however, this is not done properly. The need to provide undergraduate nursing students
with knowledge and skills on provision of effective women (client) advocacy was also emphasised by participants, stating that it will prepare the students to advocate for quality reproductive health care delivery on behalf of women/clients. The participants further added that women's/clients' information should be regarded as privileged and confidential in order to assist them to make informed decisions about their reproductive health care. The participants also indicated that privacy for women/clients who consult should be maintained and that confidential matters should be entrusted in the health professionals.

One participant added that, in essence, advocacy should be viewed by all who are involved in the teaching of pre-service health professionals (undergraduate nursing students undergoing education and training to become health professionals) as a requisite competence to be acquired without failure. The following was expressed by participants regarding provision of advocacy:

**P7/FGD1:** … the nurse must advocate for availability of contraceptives at the same time… listening skill should be applied …remember the nurses’ nature is that of helping patients daily…

**P3/FGD1:** I want to add that advocating is our role as nurses…we must ask what services the client want or we will mislead the people…keeping their information confidential also important…

**P4/FGD1:** … eh yeah, I think lecturers must assist undergraduate nursing students to be competent so that they can advocate for their patients, you know, yes…it is important…

**P3/FGD1:** There is also a need for supportive policies with resources allocated for implementation of client advocacy…

3.3.1.3 Women’s empowerment

The participants suggested that, in order to assist women/clients to make informed decisions about their reproductive health care, lecturers/preceptors must empower
undergraduate nursing students with knowledge and skills about contraceptives. They expounded that, through empowerment, undergraduate nursing students will be able to engage communities on health matters, prepare women/clients to make informed decisions regarding their reproductive needs and enable them to practise their reproductive rights.

The majority of the participants focused on women's/clients’ empowerment, stating that the purpose of women's/clients’ empowerment in the context of RHS is to facilitate awareness for human rights and rights to freedom of choice. The following statements were the participants’ expressions:

**P1/FGD1:** I believe in empowering women about reproductive health… we need media and all other strategies to make women aware of the rights… we know partners… eh! may be unapproachable… students must be prepared to educate women.

**P7/FGD1:** I agree in empowering women… we need to extend the service to men, talk about vasectomy… cut the barrier, extend the service to male…. We need to discuss this broadly as RHS rather than focus on the name/concept family planning…

**F5/FGD1:** More campaigns…. Providing health education to the women so as to empower them to exercise their rights in making choices and…. yah! that is it.

### 3.3.2 Category 2: Characteristics displayed by nurses

One sub-category emerged under this category, namely, nurses’ negative attitudes displayed during provision of RHS. The participants reiterated that nurses’ negative attitudes at RHS facilities need to be addressed as they impact on quality reproductive health care delivery and further violate human rights.

#### 3.3.2.1 Nurses display bad attitude at reproductive health care facilities

The participants expressed disappointment about attitudes displayed by nurses at reproductive health facilities. They stated that nurses are unapproachable and
judgemental, and do not allow women to make decisions about the family planning methods they prefer to use. According to participants, nurses’ attitudes at the health care facilities are bad and as such affect clients’ decision-making. They further alluded that nurses’ welcoming attitude is critical in creating a positive environment that is supportive of patients to have free expression of their reproductive health care needs. The following statements were expressed to support this view:

**P4/FGD1:** In my opinion I think we are judgemental, we do not allow women to exercise their intellectual abilities in making choices, we impose methods.

**P4/FGD1:** Um… this person must be sensitive and show respect… she must not be coercing the patient… not imposing her values as well.

**P5/FGD1:** I will add by saying that positive attitude… non-judgemental… respect the autonomy of making own choices… nurses should have that mind-set and allow women a chance to choose a method…

### 3.3.3 Category 3: Challenges experienced by nurses

From this category, one sub-category emerged, which pertained to challenges faced by nurses. According to participants, a number of challenges are encountered in RHS and these are discussed below.

#### 3.3.3.1 Nurses’ challenges

Participants cited various factors, such as staff shortage, overcrowded facilities, time constraints, limited contraceptive methods, nurses not being up to date about current contraceptives methods, and women’s education level, as interfering with attempts to assist women/clients to make informed decisions about family planning methods. Some participants mentioned that women/clients with low levels of education usually do not ask questions about preferred family planning methods, leaving nurses with no choice but to administer services convenient to them. Participants said the following:
P2/FGD1: The issue of not making informed choice is because the nurses who provide these they do these as a routine they do not have time to give patient information.

P2/FGD1: The pressure… of having a huge number of patients… you not able to spend time to each and listen to what they really want, there is paperwork on the other side. … the nurses end up taking short cuts when providing RHS.

P4/FGD1: There are also limited methods of contraceptives in our practice there are oral or injectable… unlike in the private sector where women we are exposing to other methods…

P5/FGD1: There is always a challenge with resources, the very different contraceptive methods that you want to educate the client on… but you don’t have them such as… condom and you don’t have a “dildo”…

P4/FGD1: Another challenge is that as lecturers we are not informed of new developments, such new guidelines, new contraceptive methods, etc.

3.3.3.2 Challenges faced by women/clients

The participants mentioned that, in addition to challenges faced by nurses, there are also challenges experienced by women/clients. They expressed that women/clients are probably not able to distinguish side effects from adverse effects, assuming that health professionals do not give information on these aspects. The lack of information on these may contribute to non-compliance to contraception and limiting women's/clients' decision-making. The participants also disclosed that nurses do not give full information about contraceptives to women/clients. This is what they had to say:

P5/FGD1: Nurses are to give the information to their clients though this is not happening, clients… are not given the information of side effects…. Not told they will get amenorrhea….
3.4 THEME 2: MEASURES TO SUPPORT WOMEN/CLIENTS TO MAKE DECISIONS ON RHS

Two categories and three sub-categories were identified under this theme and these are presented below.

3.4.1 Category 1: Upgrading nurses’ knowledge and skills on contraception practices

One sub-category emerged under this category, namely, provision of in-service education and training.

3.4.1.1 Provision of in-service education and training

The participants mentioned that they lacked knowledge and skills about new contraceptive methods and needed regular in-service and training, as health professionals with appropriate knowledge and skills on reproductive health care would improve the quality of care for women/clients in the RHS facilities. They further mentioned that health institutions need to intensify nurse training and in-service education on reproductive health care, new developments and the provision of these to keep providers up to date with current and evidence-based contraception practices. They said the following:

P5/FGD1: ... I think knowledge is power, most of us nurses we lack knowledge of new RHS development... this is not correct... nurses and students included must be educated on a new thing to can lead the health care for who need it... you see all these things.

P4/FGD1: ... You know like the implant, you find such implement in the health facilities when you have not been skilled and be able to updates the undergraduate nursing students learning guides. There is no streamlining of professional nurses in service with the college/nursing college lecturers. This practice/attitude should change... we are left behind .... It goes with our attitude.
P3/FGD1: To sum it up intensify nurse training… eh! We want nurses to be empowered on new developments and be included in all patient care matters because they are always close to the patient. Nurses’ empowerment will build their confidence in providing services teaching of the undergraduate nursing students…

3.4.2 Category 2: Accessibility of RHS

Two sub-categories were identified under this category and these are discussed below.

3.4.2.1 Supermarket approach to health care service delivery

According to participants, there are times stipulated for accessing RHS at facilities. This makes it difficult for women to visit facilities because the scheduled times do not suit some of the working women. As one of the participants put it:

P6/FGD1: … if there was a supermarket approach it would be easy… they should know that they can come at any time.

3.4.2.2 Conducting RHS impact analysis/evaluation

Apart from a supermarket approach to health care service delivery, participants also mentioned that nurses should do follow-up and analysis of contraceptive usage by women to check for adherence and how women are experiencing the contraceptives. The objective for conducting analysis of contraceptive usage, according to the participants, is to inform RHS improvements and to identify areas of concern as raised by women/clients. They further expressed that the results of analysis could be used by health professionals to assist women/clients to better deal with untoward effects of contraceptives and in making decisions about the contraceptive methods they would like to use, to plan health education activities pertaining to contraception, and to track indicators of success for implementation of RHS to women/clients. The participants were also asked about the indicators of women’s/clients’ ability to make informed decisions, whereby they explained that the statistics will reveal a drop in the number of
unintended pregnancies, number of pregnancies, abortions, and maternal and neonatal mortality rates, while visits to the clinics will increase. This was stated in the excerpts that follow:

**P1/FGD1:** Nursing services has the responsibility… they have to monitor their clients; follow them up; check adherence; they need to know how the method is treating the women, are they comfortable… and to finally check such a method whether the women is experiencing side effects. If the monitoring is not given the women will stop at any time if the side effects are not bearable to them.

**P1/FGD1:** We can refer to the number of women that using our contraception…. If the number increasing… mmmm, the number if unwanted pregnancies…. If this is increasing.

**P4/FGD1:** … and just to add that there are other indications…. Illegal abortion will drop mmmmmm, as an indicator of women making informed decisions without being pushed to do so.

**P8/FGD1:** It is good to do research (analysis) on what works for women… so research should be done to find out what is best.

### 3.5 THEME 3: UNDERGRADUATE NURSING PROGRAMME

Two categories and seven sub-categories were identified from this theme and these are presented below.

#### 3.5.1 Category 1: Teaching undergraduate nursing students reproductive health care practices

Three sub-categories, as discussed below, emerged under this category.

##### 3.5.1.1 Reproductive health care content

The participants alluded to the fact that undergraduate nursing students are taught reproductive health as part of the curriculum that they follow. They mentioned that
family planning is mostly taught in Community Nursing Science, where the concept of contraceptives and the benefits of child spacing are emphasised in further educating women/clients who seek RHS. This was expressed as follows:

**P3/FGD1:** *In their curriculum there is training as part of their community health… They are taught of all women’s health… general health (emphasise with hands) students should be aware that before the women can engage in sexuality she should be informed… without fear of pregnancy. They are taught of all the methods of family planning and there is a whole module for teaching student on RHS.*

3.5.1.2  **Suitable year level for introduction of reproductive health care**

When asked at what level undergraduate nursing students should be introduced to reproductive health care content, the participants suggested that reproductive health care should be introduced and be taught at second year level because the students are introduced to community nursing science subject; thus, students will be able to have contact with women who seek RHS. They also indicated that the content received in second year would further be integrated in midwifery content at third- and fourth-year levels of study. The suggestion was expressed as follows:

**P5/FGD1:** *Second year level is appropriate… they talk about physiology… they move on to partake in midwifery… they need to know the anatomy, the anatomy of the very uterus where IUCD is inserted.*

3.5.1.3  **Types of module in which reproductive health care content is commonly integrated**

In response to a question on how undergraduate nursing students are prepared for their role of provision of RHS, the participants mentioned that there is module integration during teaching of reproductive health. They further indicated that aspects of reproductive health care are taught in General Nursing Science and Community Nursing Science, and reinforced in midwifery, postpartum and contraceptive modules.
**P6/FGD1:** As part of their curriculum students are expected to complete a Community Nursing Science module on family planning there are also other family planning modules which form part of the students curriculum for which they are required to complete during their education and training and these modules are integrated in subjects such as midwifery for reinforcement of reproductive health.

### 3.5.2 Category 2: Teaching practices/methods

Four **sub-categories** emerged from this category and these are presented below.

#### 3.5.2.1 Responsible persons for teaching reproductive health care content

The participants responded that teaching of undergraduate nursing students is primarily the lecturers’ responsibility; however, peer group, professional nurses and members of the multi-disciplinary health team at the health facilities also teach students. This was expressed in the following quotations:

**P1/FGD1:** At college the lecturers that are teaching Community Nursing Science are involved in teaching of reproductive health which in third and fourth year are enforced by midwifery lecturers.

**P4/FGD1:** … (nodding) lecturers are teaching the students. It is true they are doing it … teaching the students; however most of the time expert nurses like PHC nurses are requested to teach the students.

#### 3.5.2.2 Teaching methods and activities used

The participants indicated that a variety of teaching strategies are used in the teaching of reproductive health content. They cited that lectures and demonstrations are the most commonly used methods to teach reproductive content, while campaigns, seminars and pictures are used to disseminate RHS information. These methods and activities were expressed in the following excerpts:
**P6/FGD1**: We use demonstration, formal lecture, in service training, campaigns, awareness programmes, and seminars as methods of educating students regarding reproductive health…

**P5/FGD1**: … also modules are given to students and discussions for correlation to theory when they go to practice… they are given time frames whereby they go to real patients and give the feedback. Identify the women’s real needs… although it is not easy… time is the issue but we try to give more…. I think is high time that the curriculum is reviewed to incorporate modern and creative ways of increasing student learning time in the reproductive health care. Family planning time intensified in the facilities.

3.5.2.3 Teaching materials used

In addition to methods of teaching and activities involved in the teaching of undergraduate nursing students, participants also stated that posters, simulated and live models, as well as pictures are the most commonly used materials. This is what they said:

**P1/FGD1**: Posters take different form… shows different methods for mothers with indication and contraindications…. Even live methods… they show them.

… clinics have nice pictures.

**P3/FGD1**: What I have seen is that in other clinics and some wards where women stay after delivery… health education is given; there are models that show how to help the partner on how to use the methods such as condoms.

3.5.2.4 Assessment methods used

The participants mentioned that written assessments and direct observations during performance of clinical nursing skills on clients were commonly used to evaluate undergraduate nursing students for competencies achieved. This aspect was expressed as follows:
**P8/FGD1**: How the students are assessed, firstly through the written assessment for testing knowledge. When at the clinic they are tested hands-on…

**P7/FGD1**: And also we advise the learners to prepare a script where they address the women with family planning… like giving health education. We also follow up to see how they administer the contraceptives like the injectable.

### 3.6 SECTION TWO: FINDINGS FROM QUALITATIVE DATA COLLECTED FROM UNDERGRADUATE NURSING STUDENTS

This section comprises the findings obtained from a focus group discussion held with undergraduate nursing students from a NEI in Mpumalanga. The demographic profile of participants is discussed first, followed by the findings from the focus group discussions.

#### 3.6.1 Demographic profile of participants: undergraduate nursing students

Twelve undergraduate nursing students were identified to participate in this study. These participants were all willing to participate and to share their views and experiences with the researcher about reproductive health services offered to women/clients by nurses, focusing on support for women/clients to make decisions about family planning methods.

**Age**: The ages of the participants (n=12) ranged from 20 to 50 years. Ten (n=10) participants were aged between 20 and 30 years, while one (n=1) was between 31 and 40 and another (n=1) was between 41 and 50.

**Gender**: Six (n=6) of the participants were male and six (n=6) were female. Gender equity indicated that, presently, men are also interested in the nursing profession and the recruitment of undergraduate nursing students also took cognisance of balancing the gender factor.

**Marital status**: All participants (n=12) indicated that they were single at the time of data collection. The researcher assumed that the participants would provide valuable information that would not be influenced by their marital status.
Occupation: All participants (n=12) were student nurses at the time of conducting the study. They did not have difficulty in providing answers on all questions relating to reproductive health services offered to women/clients, as assumed by the researcher. The students were at third- and fourth-year level of study, where RHS modules are provided and where students have also been in the practice. They were able to answer questions based on their knowledge and experience. Hence, first- and second-year students did not participate in the study because they have not been taught about reproductive health.

Religion: All participants (n=12) indicated that they were Christians. As such, making contributions in the discussion was free from influence of different religious denominations.

Table 3.3: Demographic profile of the participants

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>CHARACTERISTICS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
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</thead>
<tbody>
<tr>
<td>Age</td>
<td>20-30 years</td>
<td>10</td>
<td>83.33%</td>
</tr>
<tr>
<td></td>
<td>31-40 years</td>
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<td>8.33%</td>
</tr>
<tr>
<td></td>
<td>41-50 years</td>
<td>1</td>
<td>8.33%</td>
</tr>
<tr>
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<td>50%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>6</td>
<td>50%</td>
</tr>
<tr>
<td>Marital status</td>
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<td>100%</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
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<td>12</td>
<td>100%</td>
</tr>
<tr>
<td>Religion</td>
<td>Christian</td>
<td>12</td>
<td>100%</td>
</tr>
</tbody>
</table>

3.6.2 Themes and categories derived from findings of undergraduate nursing students

Three themes and eight categories were identified from the focus group discussions with undergraduate nursing students. Each of the eight categories are described in Table 3.4, using the three themes as headings:
Table 3.4: Themes, categories and sub-categories from undergraduate nursing students

<table>
<thead>
<tr>
<th>THEMES</th>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
</tr>
</thead>
</table>
| 1. Reproductive health services offered to women by nurses | Nurses’ responsibilities | • Provision of health education  
• Advocating for women/clients  
• Women’s empowerment  
• Evident leadership |
| | Characteristics displayed by nurses | • Lack of appropriate/required knowledge and skills  
• Nurses displaying negative attitudes  
• Lack of professionalism |
| | Challenges experienced by nurses | Nurses’ challenges |
| | Challenges experienced by women/clients | Women’s/clients’ challenges |
| 2. Measures to support women/clients to make informed decisions on RHS | Upgrading nurses knowledge and skills on RHS | Mandatory in-service education and training on current RHS practices |
| | Provision of support needed | • Partner, group and political support  
• Conducting home visits |
| | Accessibility of RHS | • Supermarket approach to reproductive health care service delivery  
• Research on whole contraception concept |
| 3. Undergraduate programme | Teaching third and fourth year undergraduate nursing students reproductive health care practices | Reproductive health care content covered  
• Suitable year level for introduction of reproductive health  
• Types of module in which reproductive health content is commonly integrated |
| | Teaching practices/methods | Responsible persons for teaching reproductive health care content  
• Teaching methods and activities used  
• Teaching materials  
• Assessments methods used |

### 3.7 THEME 1: REPRODUCTIVE HEALTH CARE SERVICES OFFERED TO WOMEN

Three **themes**, nine **categories** and 21 **sub-categories** were identified in this theme and are described.
3.7.1 Category 1: Role and responsibilities of nurses

Four sub-categories were identified under this category, namely, provision of health education, being women’s advocates, women’s/clients’ empowerment and evident leadership. They are discussed below.

3.7.1.1 Provision of health education

The participants expounded that one role and responsibility of nurses is giving advice to women/clients of childbearing age about available RHS options, family planning methods to choose from, prevention of mother-to-child transmission, HIV/AIDS and dual protection. The participants in this study expressed the need to educate women/clients on other aspects of sex and gender issues, citing that communicable diseases are given more attention at the disadvantage of contraception. They furthermore mentioned that the public must be made aware that contraception does not prevent sexually transmitted diseases. The participants also indicated that information about all aspects of reproductive health require publishing in teen magazines to educate parents, who in turn will educate their children at various places, such as churches, schools and whenever opportunity presents itself. The following statements were expressed to support this view:

P9/FGD2: Nurses must provide health education and explain better.

P4/FGD2: Giving advice about available RHS options; explain effects and side effects of contraceptives… Eh! giving information on HIV/AIDS, dual protection and PMTCT.

P4/FGD2: And I think as well as when it comes to identifying and educating women that are of child bearing age and giving advice with regard to available resources… so giving information with regard to PMTCT services, available options and resources with regard to their reproductive system and everything is important.
**P11/FGD2:** … teenagers are very young people and can be influenced by media so you can get an article on this teen magazine so I think if they can get an article on contraceptives because they will know that magazine is cool, there are hip things I think eh! actually if it is communicated in the language that they understand in that way it will entertain them.

### 3.7.1.2 Advocating for women/clients

The participants indicated that, besides provision of health education, it is critical that health professionals recognise the need to play an advocacy role with regard to sexual and reproductive health, activism in attaining change and social justice, and ensuring that different types of contraceptive methods are available at the health facilities. They explained that nurses should treat clients equally, prevent human suffering and act on behalf of their clients for quality care. The participants alluded that it is also the nurses’ responsibility to liaise between clients, family, other team members and organisations to deliver quality care in the clients’ best interests. They further described that nurses should also be made aware that, in the performance of the advocacy role, they must be knowledgeable and skilled in order to effectively take up this role with confidence in the care of individuals, families, communities and populations. This was expressed as follows:

**P1/FGD2:** … advocate because our clients cannot go all the way to the province level to advocate for availability of these contraceptives so the nurse at the clinic or at the hospital level do advocate for the patient so that these things… contraceptives can be available.

**P1/FGD2:** I want to add that advocating is our role as nurses… advocate for partner involvement and for community support… for better services according to what clients need.

**P5/FGD2:** Umhhh, okay, the nursing profession is actually one profession that is not biased in any way such that we are expected to communicate or to liaise with the lowest category with regard to social status standing… nurses’ responsibility
is to ensure that not only does she research on the most recent available methods of contraceptives to inform clients about, but also on checking the level of literacy of women, that okay! how can it best suit the women, looking as well into the socio-economic status of that particular community or group when advising on a contraceptive method that is not available in the public health facilities as is common not to find all methods… you understand you cannot come with a method that is costly to a lower class group…

**P12/FGD2:** … actually the nurse should have knowledge and skills on contraceptive aspects to know what to advocate for. The nurses should actually portray and apply skills acquired academically, scientifically with regard to ethics and scientific knowledge and with regard to knowing the drugs they are administering, the effects of the drugs, how to administer that drug all that information collaboratively should be put to practice, eh!… nurses should consider their clients’ spiritual aspect, their social aspect, respecting that particular person… that is ethically correct…

### 3.7.1.3 Women’s empowerment

Besides providing client advocacy, the participants indicated that it is the duty of health professionals to empower undergraduate nursing students, stating that empowerment will continue as a cycle – undergraduate nursing students will in turn empower women/clients and their significant others, as well as their families about RHS to afford them opportunities to make informed choices, and the information will eventually reach the community at large. They elaborated that undergraduate nursing students and health care professionals need to be empowered with knowledge and skills about reproductive health care. The participants’ sentiments are indicated in the excerpts below:

**P7/FGD2:** Any member of a multidisciplinary health team; it is a kind of a cycle because lecturers teach students, students teach patients and their families and communities, patients teach their children and even the other practitioners do the
teaching to members of the community. It is also intertwined meaning that if something does not go right the nurse is a primary source of information.

**P2/FGD2:** Health education is key to empower women on their rights and RHS because well-educated individuals I believe can be confident to make choices. There is a need for a conversation with these women on pregnancy spacing… I believe in empowering women about reproductive health to can make choices with knowledge…

**P4/FGD2:** I think it is important to give full information about available services and let anyone choose what they want… eh! that is women empowerment.

(a) **Evident leadership**

In addition to women’s/clients’ empowerment, participants suggested the need for allocating professional nurses to RHS because they can provide a leadership role in assisting women/clients to make informed decisions. One participant added that empowering undergraduate nursing students on aspects of reproductive health care and rights aims at preparing them to become change agents and leaders in providing quality reproductive health to communities. This group of participants expressed their wish to have professional nurses be the ones to provide RHS because they could provide leadership for women/clients by assisting and solving their problems related to contraceptive methods. This was expressed as follows:

**P3/FGD2:** When nurses are providing services they must explain what is happening… the leadership role of the nurse is very important, you find that lower categories of nurses are giving contraception while professional nurses are not there to provide leadership role of motivating and guiding clients in making their own choices of contraceptive methods.

3.7.2 **Category 2: Characteristics displayed by nurses in RHS facilities**

The participants stated that health professionals at RHS facilities should display warm, friendly and pleasant welcoming attitudes to all women/clients, irrespective of social
standing. They further mentioned that nurses need to have appropriate/required knowledge and skills on the whole contraceptive concept to enable them to assist women/clients to make informed decisions about family planning methods, which is currently not the case. In addition to nurses’ lack of appropriate knowledge and skills, their bad attitude at RHS facilities was strongly cited as needing to be addressed as it impacts on quality reproductive health care delivery and further violates human rights. In this category, three sub-categories, relating to lack of appropriate/required knowledge and skills on RHS, nurses’ bad attitudes during provision of reproductive health care and nurses’ lack of professionalism, emerged. The sub-categories are discussed below.

3.7.2.1 Lack of appropriate/required knowledge and skills

The findings from this study confirm admission of a knowledge and skills gap by some health professionals regarding provision of RHS. The participants affirmed that there is a knowledge and skills gap on the part of some health professionals with regard to provision of reproductive health care. Training of nurses to have required/relevant knowledge and skills to provide reproductive services to clients was described by participants in this study. The following excerpts from the focus group discussions demonstrate this:

**P11/FGD2:** The nurse must show that she/he does have a required skill and can even have the expertise role and display it in the provision of RHS.

**P10/FGD2:** I think another thing is that we, nurses do not have knowledge about these services, RHS… I think knowledge is power. Most of us nurses lack knowledge on new developments on RHS. This is not correct.

**P4/FGD2:** What the colleagues are saying is true look at the new contraceptive that just came in the implant in family planning, they don’t even show us how it is done, its functioning, side effects… to sum it up we want nurses to be empowered on new developments as they are always close to patients… nurse empowerment will build their confidence in providing services.
3.7.2.2 Nurses display a bad attitude

The participants indicated that nurses should display a welcoming attitude at the RHS to encourage women/clients to make free choices about family planning methods. Nurses who are frontline contact with clients should display pleasant non-verbal communication, facial expression and tone of voice to create a welcoming atmosphere at health care facilities. The participants asserted that nurses are judgemental and do not allow women/clients to exercise their intellectual abilities in making choices – contraceptive methods are imposed on them without considering what they prefer. The participants stated that a positive, non-judgemental attitude and respect for the autonomy of clients to make own choices is needed. The participants also claimed that nurses should have a mind-set that will allow women/clients a chance to choose a contraception method they prefer. The participants expressed the following with regard to nurses’ attitude:

P12/FGD2: Our attitude is not good… when we are about to knock off the person/nurse will tell the patient I cannot listen to you now, I am going off.

P9/FGD2: Nurses attitudes need to be checked really… eh! In another incidence the other lady refused Nur-Isterate as a method, saying it makes her to bleed and that she prefers female condoms and nurses were swearing at her saying that you will be here tomorrow pregnant, said this and that to her and it was not nice.

3.7.2.3 Lack of professionalism

Participants stated that nurses tend not to adhere to their code of ethics in their line of duty, and that there are instances where confidential information entrusted to them may be divulged. They added that the public expects health professionals to display professionalism as judged by their behaviour, such as respecting the rights of women/clients, and their conduct. Further to this, one participant added that the public expects health professionals to be presentable, although currently this is not the case. The participants expressed themselves as follows:
P9/FGD2: Professional secrecy should be observed… keeping women’s confidential matters within the consultation room, eh, creating privacy during consultations as well.

P9/FGD2: Sometimes it helps the way the nurse dresses they must not dress like a “magogo” (meaning grannies)… they must be presentable and well identified with name tags and epaulettes with uniform, they should look nice.

P8/FGD2: Professional secrecy should be observed; I remember… in a clinic I was allocated to, there was an incidence whereby a nurse working in a gynaec ward reported a friend’s child who came to perform a termination of pregnancy, so you know that is lack of practising ethical principles as a professional.

3.7.3 Category 3: Challenges experienced by nurses

One sub-category emerged under this category, namely, nurses’ challenges, and this is discussed below.

3.7.3.1 Nurses’ challenges

The participants indicated that shortage of staff, overcrowded reproductive health facilities, time constraints, shortage of family planning methods in public health institutions, non-prioritisation of RHS, lack of knowledge and skills of some health care professionals on reproductive health care methods, and women’s literacy levels are challenges affecting nurses’ ability to assist women to make informed decisions about family planning methods. This is what they stated:

P12/FGD2: As nurses we work under difficult conditions because of shortage of staff and resources against many clients seeking health services and these results in less time spend with women and listen to what they have to say… women are not able to make decision because nurses do not have enough time to assist them in making decisions for services they require due to pressure of work… contraceptive methods are also not available. We know nurses should
give information to clients on these services but they themselves lack knowledge and skills on family planning new developments.

P7/FGD2: And also the shortage of the drugs can also be a problem, non-availability of infrastructure such as if there are no proper consultation rooms.

P2/FGD2: It does not help to encourage women to make choices sometimes when there are only two methods available in the public health institutions.... In the private institutions there are many methods but they are expensive, women cannot afford them, you see! It is discouraging.

P1/FGD2: The Community Nurse (CN) should do as they do with immunisation, an emphasis on RHS should be the same like the other programmes, and the CN must go to schools and crèches and spread the importance of contraceptives in choosing a method of comfort and spacing childbirth.

3.7.4  Category 4: Challenges experienced by women/clients

Women’s/clients’ challenges was the only sub-category that emerged under this category, as discussed below.

3.7.4.1  Women’s challenges

The participants alluded that nurses do not explain contraceptive effects or side effects. Most women are therefore found to be unaware of side effects or adverse effects, leading to non-compliance to contraceptive use. The participants’ opinion was that women/clients have low levels of self-confidence, are still subordinate to their husbands and their decisions are also influenced by their spouses, myths, perceptions, culture and religious beliefs.

P6/FGD2: The women suffer from side effects that lead them to be non-compliant because they were/are not given enough information about what to expect when they are on contraceptives.
**P1/FGD2:** There are some women who are actually unable to choose contraceptive methods because of their spouses you understand… the spouses refuse, saying you cannot tell me or do not tell me that you are stopping to have kids… I want my kids, the husband becomes the constraint.

**P8/FGD2:** I think eh… culture and religion at some stage will prohibit women to take contraceptives, yeah! that might be a hindering factor for women to exercise their choice because of religious or cultural belief.

**P3/FGD2:** I believe there is a lot of myths and perceptions about family planning, for example girls believe that they might gain weight from using contraception, their bodies might fill up with water, there is a lot of myths and perceptions about contraception I think this causes a lot of problem.

### 3.8 THEME 2: MEASURES TO SUPPORT WOMEN TO MAKE INFORMED ON FAMILY PLANNING METHODS

Three categories and five sub-categories emerged from this theme and these are discussed below.

#### 3.8.1 Category 1: Upgrading nurses’ knowledge and skills on RHS

One sub-category was identified from this category, as presented below.

#### 3.8.1.1 Mandatory in-service education and training on current RHS practices

Irrespective of a variety of challenges experienced with regard to assisting women/clients to make informed decisions about family planning methods, the participants indicated that there is a need for nurses to have appropriate/required knowledge and skills on reproductive health methods, including family planning methods. They mentioned that nurses need to be given regular in-service training on reproductive health care practices. This was expressed in the following manner:

**P10/FGD2:** I think another thing is that we nurses do not have knowledge, we do not know about these services (RHS)…. I think knowledge is power. Most of us
nurses we lack knowledge on new developments regarding RHS, we should be in a position or be in a manner that we provide information with dignity and respect.... and establish good nurse patient relationship to open up to information seeking clients without reproach by nurses.

P5/FGD2: In-service training on reproductive services are not so often.... If they ask me what the new contraceptives available are, I haven’t seen one of those things. Nurses must be educated on a new thing like the implant... eh! (yes) it is a challenge, around here we do not find it.

3.8.2 Category 2: Provision of support needed by women/clients

Two sub-categories were identified from this category, namely, partner, group and political support, and conducting home visits. These sub-categories are discussed below.

3.8.2.1 Partner, group and political support

The participants shared sentiments indicating that partners, groups and politicians should be brought on board on issues of reproductive health, especially to support women on the use of contraception. They also added that women/clients still fear spousal retaliation and disagreements about use of contraception, which urgently needs to be addressed in order to improve women’s decisions with regard to family planning methods. The sentiments were expressed as follows:

P12/FGD2: Not enough support from their partners, as others hide that they are on contraceptives and when they experience side effects there is no one to talk to about it.

P1/FGD2: Members of the family especially the partners must be brought on board on matters of contraceptives because when there is open discussion about this women will be supported in making choices.

P8/FGD2: Encourage women to engage in group discussion to support one another.
**P2/FGD:** People in the deep rural areas do not have access to services, they take a back seat, politics play a role here… people in the farms living with whites, need political interventions for them to access RHS by enforcing access policies.

**P12/FGD2:** Health professionals should collaborate with our culture and try integrating contraceptives practices in a manner that it does not clash with people’s cultures, get to know what is culturally accepted and take it from there in support of women.

3.8.2.2 Conducting home visits

The participants mentioned that it is crucial for nurses to conduct home visits, especially where there are difficulties to access RHS, in order to assist women/clients in making informed decisions about their reproductive health care. They also mentioned that there is a need to take services to where they are mostly needed. This need was expressed as follows:

**P7/FGD2:** One of the responsibility of community health nurses is to do home visits. If a woman has come to the clinic they have to understand everything about family planning, and if there is a problem with the spouse, the nurse can go as far as doing home visit in order to explain to the spouse the relevance and the importance of such, more or less.

**P8/FGD2:** Do house visits for such cases where it is difficult to access the RHS, some women leave the hospital without being attended to due to distances and overcrowded health facilities.

**P/4FGD2:** Yeah! Do home visits to educate the household on the relevance and importance of RHS… Introduce different methods of contraceptives… encourage good parent-child relationships to have open communication on issues of contraceptives and so forth.
3.8.3 Category 3: Accessibility of RHS

The participants indicated that it is important for health services to be accessible, supportive and resourced with a variety of family planning methods. A supermarket approach to health care service delivery and conducting research on the whole contraception concept were the two sub-categories identified under this category and these are discussed below.

3.8.3.1 Supermarket approach health care service delivery

The participants suggested that a supermarket approach to health service delivery should be used since some health facilities are not able to provide accessible RHS due to current scheduled times. This is how they stated their suggestions:

**P12/FGD2:** The timing of providing contraceptives services in some other primary health care facilities is a challenge because such services are provided in the afternoon when the nurses are already tired because it is hectic... at that time nurses are tired and play no advocacy at all.

**P3/FGD2:** There should not be stipulated date for family planning it should be from day to day visits, if is a CHC it should be on going on all the whole seven days, if PHC must be provided from 7-4 then the community would be able to access the services with no pressure such that the person is not confined to say eish! I am working shifts yeah! and I won’t be able to make it but they should know that they can come at any time.

3.8.3.2 Conduct research on whole contraception concept

The participants alluded that there is a need to conduct further research on usage of contraceptive methods by women/clients to identify what works, assess promising practices and track indicators of success and/or unmet contraceptive needs. This is demonstrated in the following excerpts:

**P4/FGD2:** The nursing profession has a role of research that is a nurse’s responsibility.
P10/FGD2: It is good to do research on what works for women, I agree on research especially research on the whole issues around contraceptives, so research should be done to find out what is best.

3.9 THEME 3: UNDERGRADUATE NURSING PROGRAMME

The two categories and seven sub-categories that emerged from this theme are discussed below:

3.9.1 Category 1: Teaching undergraduate nursing students reproductive health care practice

Three sub-categories were identified under this category, as explained below.

3.9.1.1 Reproductive health care content covered

The participants acknowledged that it is critical to teach nurses reproductive health care content prior to providing RHS. They mentioned that anatomy, physiology and pharmacology regarding reproduction and family planning are taught. They further mentioned that workbooks for Community Nursing Science and Midwifery have aspects of reproductive health care content which undergraduate nursing students are required to complete as part of their learning requirements. The participants indicated that they believe that nurses who are providing RHS should specialise in this field in order to assist women/clients to make choices about the family planning methods they would prefer to use and for nurses to give proper care in the area of their practice. This is what they said:

P11/FGD2: Nurses should be adequately prepared on the whole reproductive content and background of giving contraceptives; definition of contraception; different methods; scientific knowledge on contraceptives; administration of drugs; its effects and side effects.

P6/FGD2: Oh! there are a lot of subjects included in the curriculum which include methods of contraception.
P2/FGD2: The definition of family planning, contraceptives and its effect to the community, to the immediate family concerned and the impact on the socio-economic status if members of the community do not practice family planning are also included in the curriculum. We also learn about information which clients need to know such as the need to know that family planning assist individuals and families in maintaining a good lifestyle.

P5/FGD2: Given ahhh! The integration of the subjects that we are studying in class they play a very important role because as you know the contraceptives fall under medication… medication is treated under Pharmacology subject in our second year and we apply it in General Nursing Science and in Midwifery and in Community Nursing Science.

3.9.1.2 Suitable year level for introduction of reproductive health care

Some of the participants mentioned that the second-year level is suitable to introduce and teach reproductive health care content as students have already mastered first-year foundational content. However, one participant suggested that reproductive health care content should be introduced early in the first year to prepare undergraduate nursing students to respond to community members’ questions. The statements below demonstrate what was said:

P1/FGD2: At the second year level of study you get to be delegated to do this family planning in the clinic you are expected to prepare a script on giving health education to the public on family planning, its effects, side effects, etc. and you are expected as well to actually to perform the family planning if is oral contraceptives you show them and educate them if is injectable.

P6/FGD2: I think the second year level is fine because when you get to the third level where you are doing midwifery you need that background of giving contraceptives and you need to advice the women so you cannot still be learning about them, so it helps because midwifery on its own has a lot of theory
information that you still need to acquire or learn thus it is better to have background to inject, that is how we are prepared.

**P9/FGD2:** And I also agree with him I think second year is the best year because that is where you are exposed to the pharmacology part of it?

**P11/FGD2:** RHS should be introduced as early as in first year because clients once they see a nurse they want information irrespective of the level of study. The information will also empower students and reduce high level of pregnancy seen around the college.

3.9.1.3 Types of module in which reproductive health care content is commonly integrated

The participants alluded that reproductive health care content is part of Community Nursing Science modules. They further mentioned that integration of modules with other subjects is important in the preparation of undergraduate nursing students who will be able to assist women/clients in the reproductive health care. One participant stated the following:

**P4/FGD2:** Firstly we are prepared theoretically and practically so and theoretically in the lecture or classroom setting whereby we are given information and education under the Community Nursing Science subject.

3.9.2 Category 2: Teaching practices/methods

Four sub-categories were identified under this category and are discussed below.

3.9.2.1 Responsible persons for teaching reproductive health care content

The participants cited that lecturers, peer group, members of the multidisciplinary team, students and patients all are involved in teaching reproductive health care content. This is what they said:
P7/FGD2: Any member of a multidisciplinary health team; it is a kind of a cycle because lecturers teach students, students teaches patients, patients teaches their children and even the other practitioners also teach. It is also intertwined it also means if something does not go right the nurse is a primary source of information.

P1/FGD2: The lecturers are teaching us, we had it last year done by the Community Nursing Science 1 lecturer, she is teaching us; the anatomy and physiology lecturers, and pharmacology does the teaching as well.

P6/FGD2: The nurses in the clinic play a major role in teaching… eh the reproductive services provided and demonstrate as well how they are administered to the patients.

3.9.2.2 Teaching methods and activities used

The participants indicated that various teaching strategies were being used in teaching reproductive health content. They mentioned that lectures, role plays and demonstrations are the commonly used methods to teach reproductive content while campaigns, seminars and pictures are used to disseminate RHS information. In the focus group discussion, the participants alluded as follows:

P1/FGD2: Lecture, self –study, group work, placement at the RHS facilities, demonstrations, video watching and role- play

Teaching materials used

In addition to methods of teaching and activities involved in teaching of undergraduate nursing students, participants also stated that posters, simulated and live models, and pictures were the most commonly used materials. They added that pamphlets, workbooks and learner guides are also used. The following was expressed by the participants:

P6/FGD2: Pamphlets are issued… things like teen magazine, the school health nurse can also use these when doing school health services, the youth can benefit from this as well as use of magazines on RHS.
**P12/FGD2:** The workbooks for Community Nursing Science and Midwifery have aspects of RHS and students are to do practical and complete such as placement at the RHS facilities to use live patients to do demonstrations.

**P9/FGD2:** We have guides from the department and these are also used as teaching materials and the lecturers provide us with such to read relevant information about family planning matters…

3.9.2.3 Assessment methods used

The participants’ response on the question of strategies used to assess students’ learning indicated that questionnaires are most commonly used and that students are requested to prepare a presentation and present this to peers and lecturers, who provide comments based on the presentation. They added that lecturers/preceptors sometimes require the students to do feedback demonstrations and be critiqued by peer or lecturers/preceptors. The following statements indicate what the students mentioned in this regard:

**P3/FGD2:** Sometimes… after eh! presentation you can have a questionnaire to see if there was understanding of what you were teaching just ask questions random questions about what you were teaching then the client will tell you what they heard or understood.

**P7/FGD2:** And also the preparation of that presentation is important that is why you must have a handwritten copy because the professional nurse that is evaluating you can see if you are able to present and know where you got the information from and whether that information is correct and important.

3.10 CONCLUSION

In this chapter, the findings of the study were outlined. Common themes, categories and sub-categories that emerged out of the data collected from the lecturers/preceptors and undergraduate nursing students were described. Chapter 4 consists of the discussion of the findings, supported by literature control.
CHAPTER 4: DISCUSSION OF FINDINGS OF THE STUDY

4.1 INTRODUCTION

Chapter 3 presented the findings of this study. This chapter focuses on the discussion of the findings of the study and includes the relationship of the findings to literature through a literature control.

The three themes identified in the findings were as follows:

4.1.1. RHS offered to women by nurses, which consisted of the following categories: nurses’ responsibilities, characteristics displayed by nurses; and challenges experienced by nurses and women/clients.

4.1.2. Measures to support women/clients to make informed decisions about contraceptive methods, which included the following categories: upgrading nurses’ knowledge and skills on contraception methods; and accessibility of RHS.

4.1.3. The undergraduate nursing programme, consisting of the following categories: teaching undergraduate nursing students reproductive health care to support women on choice of contraceptive methods; and teaching practices/methods.

The categories to be discussed that emanated from the findings of the lecturers/preceptors are discussed under section one, while those from the undergraduate nursing students are discussed under section two.

4.2 SECTION ONE: DISCUSSION OF FINDINGS FROM THE LECTURERS/PRECEPTORS

4.2.1 Theme 1: Reproductive health care services offered to women/clients

4.2.1.1 Category 1: Nurses’ responsibilities

The lecturers/preceptors expressed that nurses have a responsibility to practise within the profession’s ethical rules and their scope of practice. They also mentioned that
nurses should encourage their colleagues to uphold positive attitude at all times during health care delivery. **Providing health education to women/clients** about available reproductive health services was viewed as an essential tool in support for women to enable them to make informed decision about family planning methods. Health education includes a well-constructed opportunity for learning involving some form of advocacy and empowerment. It is designed to assist individuals and communities to improve their health by increasing their knowledge base or influence their attitude (WHO, 2012:25). The participants expressed that, currently, women/clients are not empowered to make decisions around contraceptive methods. This was attributed to a shortage of resources, amongst others.

The findings of this study show that it is critical that lecturers/preceptors should ensure that undergraduate nursing students become competent with regard to provision of health education to women/clients who require family planning services. Participants in this study resonated that health education can be facilitated by using posters, fliers and different models to demonstrate how different methods, such as male condoms, are used. The use of any other media to create awareness to the larger communities was also emphasised by the participants. This group of participants expressed the need to give health education about RHS prior conception at schools and teach adolescents the importance of contraceptives as a health promotion strategy.

The participants’ view is supported by the South African Nursing Council (SANC), who state that the nurse shall prevent diseases, and promote health and family planning through teaching and providing counselling to individuals and groups (South Africa, 1984:2).

The above findings are also consistent with the assertions of Bitzer, Gemzell-Danielsson, Roumen, Marintcheva-Petrova, Van Bakel and Oddens (2012:66), who cite the need for health professionals to provide information to women about contraception in the limited time of consultation. These authors further mention that the information provided and shared during counselling must be in a manner that contributes to the selection of contraceptive methods preferred and according to individual needs.
Within the Nurses’ Code of Ethics, nurses have an obligation to provide their patients with high-quality care, protect, promote and restore health, prevent illness, preserve life, and alleviate suffering. One of the strategies to achieve this is provision of health education (SANC, 2013:4; Zahedi, Sanjari, Aala, Peymani, Aramesh, Parsapour, Maddah, Cheraghi, Mirzabeigi, Larijani & Dastgerdi, 2013:2). According to the researcher, compliance to the Code of Ethics by nurses would increase the chances that women/clients are supported to make informed decisions about contraceptive methods.

Kemppainen, Tossavainen and Turunen (2013:490) support the above assertions by stating that nurses have certain obligations towards their patients, namely, provision of clinical nursing practice, consultation, being care givers, communication, execution of medical treatment, provision of follow-up treatment, evaluation of care given, being patient advocates, provision of patient education, counselling, illness prevention, as well as being accountable for provision of quality health care. Health promotion by nurses is vital and could lead to positive outcomes such as patients’ knowledge and self-management of their illness.

With regard to health care providers being women’s advocates, the Wittmann-Price Theory of EDM (Wittmann-Price & Battacharya, 2008:230) posits that health care professionals are ethically obliged by standards of practice to help the patient and the family to make decisions without imposing their own values and preferences. The study also revealed that some nurses do not advocate for women/clients. They fail to defend the rights of women/clients and they do not speak out against nurses’ practices that might endanger women’s/clients’ well-being or that conflict with their rights. This statement supports the participants’ narrative regarding the malpractice committed by some nurses who withdrew a number of injectable contraceptives from vials into syringes prior to any consultations and without knowing the number of clients who would visit the facility for injectable contraceptives. This is evidenced by the following quotation:
**P4/FGD1:** I think this is because nursing is no longer a calling but a poverty alleviation, hence no advocacy is practised. It is presumed that all women are to get petogen injection. We look at the number of babies and decide on a method for these women.

The above-stated practice as narrated by the participants is in contrast to the stipulation of the Wittmann-Price Theory of EDM (Wittmann-Price, 2004:440, 2006:378) that a flexible environment is an internal and external environment that is responsive and ought to increased choices, thus enhancing self-esteem and satisfaction of individuals. This flexible environment is one of the sub-concepts that are necessary for emancipation to occur. Choice is emancipating when people are not only free to choose what is right for them but when that decision can be taken without consequences. Wittmann-Price (2004:442); Osamor and Grady (2016:191) assert that the oppression of women (as a result of strong social structures that rigidly define the roles of man and women, that are encoded in religious, tribal and social traditions that limit women autonomy) is a negative and emotional experience and thus encourage replacing it with emancipation, which is a positive state of being. Women were oppressed by nurses who did not offer them an opportunity to choose the contraception method that they prefer but were given injections that were already drawn in syringes.

Based on the above study findings with regard to nurses’ failure to provide client advocacy, the participants in this study reiterated that it is crucial for undergraduate nursing students to be provided with knowledge and skills on the provision of effective advocacy for women/clients to enable the students to play this role with confidence while simultaneously providing quality health care services.

The participants indicated that patient advocacy and creation of positive health care environments should be regarded as a critical aspect in the nursing profession. Sadly pressure of work and resource constraints deter nurses from providing advocacy for women/clients. The participants further disclosed that no additional information is given to assist women/clients who are trying to decide whether to accept or decline one contraceptive method against another. This was expressed as follows:
**P2/FGD1:** The pressure of having a huge number of patients you are not able to spend time with each client and listen to what they really want, there is also paperwork to be completed on the other side. These are among the many aspects from the one nurse... eh! against the client ratio and the nurses end up taking shortcuts when providing RHS instead of advocating for clients according to needs.

Advocacy refers to a process of supporting a proposal or a cause. An advocate is someone who defends or supports the interests of another person (Merriam-Webster, 2017a). Tomajan (2012:15) mentions that performing advocacy requires a set of skills including problem-solving, communication, influence and collaboration. Choi (2015:53) states that there is minimal knowledge on the process of patient advocacy and its practices, and that the concept is poorly understood and conceptualised. Choi (2015:53) further describes three models of patient advocacy and states that their integration yields three essential components that should be performed by nurses in order to provide effective advocacy, namely:

- development of humanistic relationships with patients to protect their interest and well-being;
- respecting and valuing patients' freedom of self-determination and assisting them throughout the decision-making process; and
- sharing information with patients and empowering them to make decisions.

The above findings are supported by the SANC’s stipulation that nurses are to provide effective patient advocacy to allow and/or assist patients to obtain the health care they need (South Africa, 1984:2). It is also outlined in the SANC Code of Ethics for Nursing Practitioners that nurses, in their daily provision of health care to the health care users, are expected to observe, apply and uphold fundamental ethical principles, which include social justice. This principle is about pursuance of justice and advocacy on behalf of health care users at all times, irrespective of their social standing (SANC, 2013:5). According to Lee, Smith and Henry (2013:75), there is a need for more research to establish best practices and advocacy training to inform the debate around the role of
client advocacy. Accordingly, it might be argued that integration of a module on advocacy in the undergraduate nursing students’ curriculum is key, in order to ensure that they are prepared for the advocacy role on completion of their education and training programme.

In support of the importance of the provision of advocacy for women/clients advocacy by health care providers, García-Moreno, Hegarty, d’Oliveira, Koziol-McLain, Colombini and Feder (2015:1567) bring forth another perspective by stating that health care providers are expected to provide women with a safe environment where they can disclose confidential matters. This information confirms one of the three components indicated above, that is, respecting and valuing patients’ freedom of self-determination and assisting them throughout the decision-making process. The Batho Pele Principles policy framework (South Africa, 1997:6) indicates that health care providers should offer full information to clients on standards of care, including willingness to listen to their health needs. It is also essential that women/clients are informed about the reality of contraceptive side effects. With regard to provision of health information to clients, the Wittmann-Price Theory of EDM (Wittmann-Price, 2004:442) advocates for women’s empowerment, which is explained as the information and resources that health professionals provide to women about health care options. An emancipatory curriculum (which enhances critical thinking that facilitates problem solving and decision-making) as a way to establish basic human rights is also proposed within the Wittmann-Price Theory of EDM (Wittmann-Price, 2004:439). The participants described their views regarding provision of client advocacy and on implementation of Batho Pele Principles below:

**P5/FGD1:** Putting people first should be practised during delivery of health care services actually the rights of people must be observed, it is important to remember that clients have the right to information about the health services available to them so that they make decisions or decide on services that are based on knowledge they possess.
**P3/FGD1:** There is a need for supportive policies with resources allocated for implementation of client advocacy. Complaints by women must be well channelled and attended; look at parity, number of children, have less intimidating services which are user friendly respecting and valuing patients’ freedom of self-determination and assisting them throughout the decision-making process and… allowing choice of a method. Posters and pamphlets used to increase information on family planning methods be made available as well.

The lecturers/preceptors in this study expressed that they believe in empowering women/clients about reproductive health to support them in making decisions regarding choosing contraceptive methods; however, this is not happening. This study revealed that professional nurses do not inform women/clients thoroughly about what they will experience when using contraceptive methods. The participants suggested that there should be information sharing pertaining to family planning services between services and women/clients to learn from each other. They suggested that, during information sharing, much attention and encouragement should focus on women/clients to support them to make their own decisions. Sex education and issues of the right to make decisions on family planning were also raised as crucial aspects to constantly empower women on.

Women’s empowerment has been recognised as crucial to women’s access to RHS since 1994. It is also considered as an intervention programme aimed at escalation of contraceptive use, expansion of freedom to make choices and action to shape one’s life. Through empowerment, women will gain power in making decisions and in becoming change agents in managing health-related matters (Do & Kurimoto, 2012:23). These authors further support the participants’ expression regarding the need to empower women by stating that the lack of power on the part of women restricts their ability to make decisions.

Rahman (2013:11) adds that empowerment is a favourable step towards promoting autonomy and independence, a process that lead people to perceive themselves as able and entitled to make decisions, and further interprets it as resources and
information about health care alternatives that health professionals should equip women with. Wittmann-Price (2004:444) further alludes that nurses themselves need emancipation from the constraints imposed on them by the health environment systems; hence, education, training and upgrading of their skills become imperative as an attempt to create an emancipated health care environment for women. Wittmann-Price and Bhattacharya (2008:233) explain that subjecting women to an inflexible and disempowering environment creates a vulnerable position in which women could find themselves oppressed and denied equality in decision-making. Furthermore, Wittmann-Price and Bhattacharya (2008:235) comment that women confronted with making health care decisions should be considered vulnerable and can be affected by oppression.

In addition to the above-stated information, Do and Kurimoto (2012:31) propose strategies that could promote endeavours aimed at supporting women to make informed decisions about contraceptive methods, namely, promoting couples’ discussions about their fertility desires, involving men in decision-making related to fertility and contraception, improving women’s self-efficacy and attitudes related to the negotiation of sexual activity, and efforts to increase contraceptive availability in health care facilities.

The views of participants on women’s empowerment are also supported by Van Lerberghe, Matthews, Achadi, Ancona, Campbell, Channon, De Bernis, De Brouwere, Fauveau, Fogstad, Koblinsky, Liljestrand, Mechbal, Murray, Rathavay, Rehr, Richard, Ten Hoope-Bender and Turkmani (2014:1218), who mention that social integration, gender equity, women’s autonomy and participation are contextual elements that influence health decision-making and health care and, as such, need to be included in the health professionals’ programmes. Do and Kurimoto (2012:23) concur with the above-stated information by proposing an increase women’s education on issues of improvement of sex equality and comprehensive family planning services so that women’s empowerment in decision-making about reproductive health care and rights can be strengthened. Husain, Dutta and Ghosh (2011:39) further add to the above information by explaining that, in order to improve the health status of women and that of their children, it is crucial to increase women’s literacy levels. To emphasise the
importance of women’s empowerment, Young (1993, as cited in Rahman, 2013:13) refers to empowerment as enabling women to take control of their lives, set their own agenda and programme, establish forums to help each other, and make demands on the state for support and on the community itself for changes needed to improve their health.

Based on the above information, the researcher may conclude that women/clients could be able to make informed decisions about family planning methods, provided the services are rendered by health care professionals with relevant knowledge and skills on reproductive health care and who have the ability to provide health education on this issues, as well as to advocate for quality RHS.

In this study, creation of a supportive, safe health care environment was regarded as key in support for women to make informed decisions about family planning methods. The findings of this study that creation of a supportive environment is essential in the support for women concur with Mosadeghrad (2014: 77) who indicates that the environment should be supportive to women’s emancipation and states that the nursing process could be the answer to bringing about a flexible environment in which women could be capable to make decisions about health care. Wittman-Price and Bhattacharya (2008:235) assert that a flexible environment is responsive to change, is emancipating, recognises that sources of power or social norms are unavoidable and allows the person to consider those norms in decision-making. These authors further add that a flexible environment yields personal benefits for individuals and the larger society, and that it allows individuals the freedom of making choices unopposed, thus increasing their self-esteem and understanding.

The lecturers/preceptors mentioned that it is also significant to create a conducive environment for teaching and learning so that nursing students can become competent in the support for women. They mentioned that a flexible environment would enable nurses, women and the community to be more willing to attend awareness and information distribution programmes, such as workshops, seminars, conferences, campaigns. They stated that knowledge is power, which can enable women to make
decisions about health care alternatives. They believe that, to increase women’s empowerment, information could be distributed through campaigns, workshops, pamphlets and any media.

4.2.1.2 Category 2: Characteristics displayed by nurses at RHS facilities

The participants disclosed that some nurses are not sensitive to the needs of women/clients. They described these nurses as displaying non-verbal cues and facial expressions that discourage women/clients from freely expressing their reproductive health needs. The nurses’ tone of voice was also reported to be unfriendly and not assisting in creating a welcoming environment for women to explore their reproductive health needs. Some participants added that nurses are not approachable, not good listeners and that they even impose specific contraceptive methods on women/clients. This is what they said nurses should be in order to encourage women/clients to make decisions about family planning methods:

P6/FGD1: Nurses should be willing to provide family planning services and have adequate knowledge and skills of family planning… she needs to be up to date on RHS information changes.

P6/FGD1: … should be a good listener and good people’s person… she needs to listen and be patient, needs to be up to date with information…

The findings on existence of unacceptable characteristics displayed by nurses in reproductive health care facilities is supported by Wittmann-Price (2004:440), who affirms that nurses in health care settings demonstrate characteristics that are the same as those of oppressed groups, such as association with the oppressor, horizontal violence, fear of freedom, emotional dependence, lack of self-esteem and contempt for other women. Harden (1996, cited in Wittmann-Price, 2004:441) affirms that bad characteristics displayed by nurses are the consequence of exploitation of nurses by health care system since the institutionalisation of patients in hospitals. In these setups, nurses become the sub-servants of administrators and physicians, and have to
assimilate the value system of the oppressed as reflected in the nurse-patient relationship and revealed above in the findings of this study.

According to a report by Mkhwanazi (2012:1), patients at a health facility in Gauteng province, South Africa, complained of appalling staff attitudes, indicating that poor attitudes of health personnel are a great challenge at health facilities because nurses shout and inform them about being short-staffed. According to the participants, creation of a conducive health care environment is critical if women/clients are to be effectively supported in making decisions about family planning methods.

These findings correlate with Kieft, De Brouwer, Francke and Delnoij’s (2014:2) explanation regarding a conducive environment as being characterised by, amongst others:

- good staff attitudes and patient relationship with quality patient care;
- warm learner-staff relationships;
- accessibility and approachability of health personnel;
- support and guidance of learners; and
- help and encouragement of learners and patients.

On the other hand, Klopper, Coetzee, Pretorius and Bester (2012:688), and Ulrich, Lavandero, Woods and Early (2014:64) remark that there is a relationship between a healthy work environment for nurses and patient outcomes. These authors further reiterate that a work environment that tolerates ineffective interpersonal relationships and does not support education to acquire necessary knowledge and skills perpetuates unacceptable conditions at the work place, as do health professionals who remain silent about this state of affairs. Consequently, the authors concur with the findings of this study that revealed that there is a need for all involved with patient care to put more emphasis on positive staff attitude to patients, and creation of work and care environments that are safe, healing, humane and respectful of the rights of individuals, families, groups and the community.
Gotay (2014:19) indicates that health professionals need resources to have the ability to provide best treatment plan in order to decrease the level of developing negative attitudes towards patients. On the other hand, Wittmann-Price (2004:442) proposes that information and resources which health care professionals provide to women about health care alternatives refer to empowerment, which is a positive process that promotes autonomy, independence and power sharing with patients, and forms part of the emancipation process. Wittmann-Price (2004:442) further discloses that curricula could be designed to influence nurses' positive attitudes towards patient care.

From the above-stated information it is clear that some nurses’ bad attitudes at health facilities are beyond tolerance and discourage women/clients to discuss their contraceptive needs with nurses. Nurses often fail to create a conducive environment during consultations with women/clients. There is no encouragement of participative decision-making between nurses and women/clients; nurses frequently impose family planning methods on women/clients.

4.2.1.3 Challenges experienced by nurses and women/clients

The participants cited overcrowded health care facilities and shortage of staff as challenges. Following the perspective of Wittmann-Price's Theory of EDM (Wittmann-Price, 2004:442), women’s environment should be supportive to assist their emancipation. In this theory, it is suggested that it is important that certain critical attributes be present in women for emancipation to occur. A flexible environment which allows women to select health care alternatives unopposed is one of the critical attributes. According to the participants of this study, women’s health care environments are not currently flexible. This is related to overcrowding and shortage of staff, which have a negative impact regarding making informed decisions about family planning methods. The lecturers/preceptors mentioned that this leaves nurses with no choice but to provide RHS routinely to complete the tasks, with no time to give information to the clients about contraceptive methods. They disclosed that overcrowded facilities are compounded by the necessity of completing of paperwork by one nurse who also has to attend to the needs of women seeking reproductive health care. This compromises
teaching of nursing students and provision of quality RHS, especially with regard to assisting women to make informed decisions about family planning methods. This was reflected in the following excerpt:

**P2/FGD1:** The issue of women (clients) not making informed choice about family planning is because the nurses who provide family planning do it as routine, thus they do not have time to give patient information.

Mkhwanazi (2012:2) concurs with the issue of staff shortages by mentioning that the critical shortage of staff at health facility level is such that nurses cannot provide quality care because, for instance, a clinic consults more than 300 patients a day. The author furthermore states that two nurses do the work of five nurses, with the result that they are unable to do a thorough job because of pressure. In some cases, medications are given to patients before checking them, while others are turned away. Staff shortages are reiterated by Coetzee, Klopper, Ellis and Eiken (2013:162), who state that there is an estimated shortage of 30 000 professional nurses in the public health sectors of South Africa.

The lecturers/preceptors further disclosed that they are unaware of new contraceptive methods and they attributed this to lack of provision of in-service training when new methods are introduced. They indicated that they also need knowledge and skills on current contraceptive methods. They further mentioned that lack of knowledge and skills in this regard interferes with attempts to support women/clients to make informed decisions about family planning methods because they (lecturers/preceptors) cannot teach undergraduate nursing students about things they are unaware of. This was stated as follows:

**P3/FGD1:** … nurses are not adequately trained on new contraceptives…

**P7/FGD1:** There is no streamlining of professional nurses in-services with the college nursing lecturers… we are left behind with new contraceptives.
The above-stated information on lack of awareness on new contraceptive methods by lecturers/preceptors is supported by Wittmann-Price (2004:441, 2006:378), who mentions that personal knowledge is described as the ability to understand oneself and how knowledge affects one’s situation. It is also awareness by a woman about alternatives presented to her in the health care context, which in this study does not exist because women/clients are not given any alternatives of available contraceptive methods. Furthermore, Wittmann-Price (2006:381) expounds that a flexible environment and personal knowledge are vital sub-concepts that maximally contribute towards the process of emancipated decision-making and women’s fulfilment with the health care decisions with which they are faced.

The participants added that shortages of resources and contraceptive methods influence the type of reproductive care given to women/clients. They pointed out that a shortage of contraceptive methods discourages nurses to give information to clients about other methods of contraceptives. The lecturers/preceptors expressed this as follows:

\textbf{P5/FGD1}: There is always a challenge with resources, the very different contraceptive methods that you want to educate the client on… but you don’t have them such as… condom and you don’t have a “dildo”...

The lecturers/preceptors furthermore disclosed that there are no structures at the health facilities to ensure privacy during consultations, which profoundly affects maintenance of professionalism by nurses and disclosure of confidential information by women/clients with regard to services needed.

The concerns of the participants are supported and expressed from a broader perspective by Dignam, Duffield, Stasa, Jackson and Daly (2012:65), who confirm that there is a struggle in health services platforms to provide timely, contemporary, quality
health care within the context of demand and supply. Health services are not coping with the increasing demand for services due to workforce supply and demand imbalances, amongst others. Jooste and Jasper’s (2012:59) study findings are congruent with the findings of the current study regarding the limited resources. Their findings also indicated an imbalance between supply and demand of nursing resources in the public health system of South Africa. The current situation has a negative impact on patient care and staff. In the context of this study, this negates support for women to make informed decisions about family planning methods.

According to Ersdal and Singhal (2013:377) and Klopper et al. (2012:693), repeated staff training, conducting refresher courses, orientation of new staff and placing them according to their interest could also contribute towards knowledge and skill retention, including augmenting quality care. This could add value to the sustainability of quality improvement and play a key role in positive patient outcomes and retention of staff.

What was also revealed by the present study was that nurses are not the only ones confronted by challenges at the RHS facilities. Women/clients encounter contraceptive side effects, myths, perceptions and lack of spousal support, all of which influence their ability to make decisions about contraceptive methods. This group of participants mentioned that myths and perceptions about contraceptives, for example, the experience of leucorrhoea, that using condoms seriously diminishes sexual pleasure, and that the pill will make you gain a great deal of body mass. These are real to the majority of women/clients as mostly narrated by them at the RHS facilities. These factors are, amongst other things, thought to be interfering with compliance and choice of family planning methods. Participants stated that most girls who come for contraceptive methods mention that they will gain weight when using family planning methods. This was expressed in the following quotations:

**P10/FGD1:** Effective use, let me say choosing of contraceptive methods are also influenced by myths as you know maybe eight out of 10 girls you consult at the facility will tell you that they will be more wet during sexual play with their partners… and they will be fat, you know.
**P5/FGD1:** And these young girls tell you that my husband or boyfriend will say I am full of water during sex… laughing…

**P1/FGD1:** Women don’t have freedom to choose the kind of contraceptive method they prefer. If it does not suit the husband and because of the myths regarding contraception. If they tell them they might say things that might not be there…. Like wetness (leucorrhoea), things like you cannot be pregnant while breast feeding and more myths you see those things… If the husband knows that the woman is on contraceptives they anticipate wetness before they can feel it and this create a challenge for women.

Cultural and religious influences were also mentioned by the participants in this study as affecting women's/clients’ choice of family planning methods. When probed to tell more regarding the cultural beliefs referred to as a challenge regarding women's/clients' inability to make family planning choices, they mentioned that, culturally, Africans believe that they should have many children to show their manhood. Hence, women will be too afraid of their husbands to choose a method which will be visible. Religion was said to be related to morals, stating that young women/clients are afraid to use contraceptives prior to marriage as they will be labelled to be promiscuous and immoral. This was expressed as follows:

**P2/FGD1:** Some religions prohibit sex prior marriage stating that it is morally incorrect to have sex prior marriage… and this becomes a challenge because the majority of women (clients) think they will be judged if they are seen openly seeking contraceptive methods, let alone choosing the pill, hence they prefer an injectable contraception…

**P7/FGD1:** … Others are afraid of their spouses to even venture into choosing a method of contraception…

In relation to the study findings on cultural and male domination over women and as elaborated upon above, Biswas, Rahman, Kabir and Raihan (2017:11) confirm that oppression is maintained by social institutions, norms and standards, such as
marriages, in order to control women. Furthermore, these authors reported that traditional patriarchal societies in some countries consider women as subordinate and more often they are forced to accept a subordinate role in society. They explain that, irrespective of origin, power or control over women causes oppression and denies them their equality or having a voice to be heard in any situation. Accordingly, Wittmann-Price (2004) advocates methods for change and for creation of a safe space, which is interpreted as a flexible environment for decision-making.

The study further revealed that health professionals do not discuss contraceptive myths with women/clients. This is seen as a challenge as it interferes with choice of family planning methods. Participants further mentioned that it should be the responsibility of nurses to discuss with clients to dispel myths and perceptions while encouraging them to make reproductive health care choices. The challenges were attested as follows:

**P3/FGD1:** The majority of women are not informed; they do not know what is available for them…. Again post-delivery it will not make sense to ask them about a method because the practice is that only Nur-Isterate and Depo-Provera are administered post-delivery routinely.

**P5/FGD1:** … they are not given information on side effects… not told they will get amenorrhoea.

**P1/FGD1:** In my opinion… we do not allow women to exercise their intellectual abilities in making choices, we impose methods… and I see these as violation of women clients.

The findings of this study are supported by Kaida, Laher, Strathdee, Money, Janssen, Hogg and Gray (2010:10), who state that it is essential to take real and perceived side effects of contraceptives, cultural values, and religious and partner influence on contraceptive decision-making into account as these have a negative effect on provision of quality RHS. According to the Wittman-Price Theory of EDM (Wittmann-Price & Bhattacharya, 2008:225), women should be empowered in order to become aware of how society places more value on specific health care alternatives and that social
norms set and establish paradigms that are sometimes difficult to change. However, awareness of these norms will help women to make decisions about their health issues without fear of what value society places on the health decision made by a woman. Matthews, Crankshaw, Giddy, Kaida, Smit, Ware and Bangsberg (2013:467) caution about the importance of an understanding of women’s cultural and religious background by the health professionals in the provision of RHS, stating that people have deeply-ingrained personal and culturally embedded reasons behind their motivation to make decisions about their health matters. Having knowledge of women’s cultural and religious background would ensure that services provided are sensitive to their values and norms.

The concern about contraceptive side effects raised by participants is supported by a study conducted in 2009 on side effects of contraceptives, which revealed that there is evidence of weight gain amongst those using Depo-Provera as a method of birth control (Gueren, 2013:par. 1). The issues of male domination and violation of women’s rights are added factors influencing choice of family planning methods and are oppressive in nature. Biswas et al. (2017:11) view oppression bought about by societal norms as having a negative effect which instils fear and emotional imbalance on the oppressed, not encourage them to express their opinion on most occasions and advocate that it should be replaced with emancipatory activities.

The findings of the present study are consistent with the existence of various forms of male domination over women mentioned in literature (Weldon & Htun, 2013:3). The participants mentioned that, culturally, women play a subordinate role to their husbands. As such, they do not make decisions without their husbands’ involvement. The participants also stated that women do not have freedom to choose the contraceptive method they prefer if it does not meet their husbands’ approval. This information has been reported in the literature as other forms of human rights violations (Weldon & Htun, 2013:3). The researcher believes that the factors highlighted by the above authors should be taken into cognisance and strategies to address them should be devised in order to support women to make decisions about family planning methods.
Essack and Strode (2012:32) state that human rights violations include coercing people to do things against their will as well as infringing several fundamental rights of others. These violations undermine people’s ability to act autonomously with a strong sense of self-awareness in decision-making. These authors further state that building capacity of women to be conscious about their rights and to be substantially empowered to exercise such rights need to be implemented by all health care officials. They further mention that there is also an urgent need to address involuntary sterilisation of women. This is also of paramount importance as it contributes to personal and societal vulnerability and violates women’s autonomy to make reproductive choices.

Staff and resource shortages, overcrowded health facilities and lack of capacity building of nurses, especially on new contraceptives, were cited as significant challenges. From the above-stated information, it may be concluded that these challenges, coupled with lack of confidentiality during consultations, overworked nurses and high staff turnover, contribute to nurses’ inability to support women to make informed decisions about family planning methods and as such need urgent attention.

According to the Wittmann-Price Theory of EDM, the challenges revealed by the findings in this study produce an unsupportive environment that is not favourable for decision-making. Wittmann-Price (2006:377) supports replacement of this environment with the presence of critical attributes in the clinical settings of women’s/clients’ health care for emancipation in decision-making to take place, namely, social awareness, available flexible environment, empowerment, personal knowledge and reflection.

Wittmann-Price and Bhattacharya (2008:235) recommend that health care alternatives should be openly discussed in a flexible environment which motivates empowerment through education. However, nurses may require empowerment on how to produce a flexible, non-judgemental and respectful environment that encourages dialogue and decision-making for women. The Wittmann-Price Theory of EDM (Wittmann-Price, 2004:441) further encompasses the notion that professional nurses need to use reflection activities when providing health care services to women, such as dialogues during which nurses should acknowledge women’s personal knowledge and support
them in the identification of the existence of some incongruity that might affect their choice of health care options. Reflection is referred to as a form of critical thinking and as knowledge acquisition from practical experience. It is a highly interactive process which is promoted by dialogue between nurses and women. This process enables women to consciously engage in considering options in health care (Wittmann-Price, 2004:441).

The lecturers/preceptors focused on teaching undergraduate nursing students to become aware of the importance of supporting women to make decisions about their health within societal norms and standards. They recommended use of various teaching strategies to develop undergraduate nursing students’ competencies on support for women on choices of contraceptive methods and on provision of health education to women, households, schools and the community at large about issues of reproductive rights.

Gordon, Sabates, Bond and Wubshet (2011:3), in noting that it is essential to increase individuals’ personal knowledge, articulate that information about contraceptives plays a pivotal role in protecting women’s health and rights. Health care providers should note that educated and literate women are more likely to be autonomous. Autonomy is linked with power, thus affording women the ability to discuss family planning in terms of size, methods and contraceptive use with their partners.

During dialogue with participants, it was noted that knowledge development takes place within a social context. In support of this statement, Wittmann-Price and Bhattacharya (2008:235) advise that it is essential to understand that social norms have an effect on the process of decision-making. The implication for these findings is that, in the attempt to support women in decision-making, nurses should recognise that cultural and religious factors, inadequate access to RHS and nurses’ bad attitudes form part of the current negative environment in which women live. These factors will influence women’s perception of knowledge regarding their choice on health care options presented to them by health care providers (Gordon et al., 2011:3). Health care providers should also be aware that there are mediating factors, such as women’s empowerment through
community-level education on women’s fertility and contraceptive use, and providing health education and advice on family planning through visits to health clinics. These efforts have also been considered an important variable for contraceptive use and choice of method, and for enhancing women’s ability to make informed decisions (Gordon et al., 2011:4).

4.2.2 Measures to support women to make decisions on RHS

4.2.2.1 Upgrading nurses’ knowledge and skills on RHS

The study revealed that lecturers/preceptors and some nurses at the health care facilities lack knowledge and skills on reproductive health care practices, including new contraceptive methods. Wittmann-Price (2004:442) points out that such an environment can hinder a woman’s choices in health care. The participants mentioned that the need to upgrade nurses’ knowledge and skills on RHS is of paramount importance in order to support women to make informed decisions about contraceptive methods. The participants further explained emphatically that nurses should be adequately prepared to support women in making informed decisions about contraceptive methods. The lecturers/preceptors mentioned that nurses, including themselves, need knowledge and skills upgrading on aspects of reproductive health care, including knowledge and skills on new contraceptive methods. They attributed their lack of knowledge and skills to unavailability of capacity-building programmes on these aspects and lack of in-service streamlining of professional nurses offered at health facilities with the NEIs.

This means that there is no system or structured plan in place that incorporates the NEI academic staff into the ongoing in-service education and training on national health priorities and other developments on nursing issues within the Department of Health. The design of in-service training and education is also not attuned to NEIs’ curricula for nursing students to learn about new health care developments. The participants’ sentiments were expressed as follows:

**P7/FGD1:** There is no streamlining of professional nurses in-services with the college/nursing college lecturers.
The participants further mentioned that they also need technical skills in these aspects of nursing in order to facilitate learning to undergraduate nursing students so that, as future professional nurses, they are able to support women/clients to make choices regarding contraceptive methods. In addition, the participants mentioned that knowledge and skills upgrading is necessary to build nurses’ confidence to go beyond routines in the provision of RHS, while at the same time rendering quality care. This is evidenced by the following quotations:

**P4/FGD1:** The challenge with us lecturers is that we lack knowledge and skills of new contraceptive methods such as the implants and other new developments related to contraceptive health services. When we facilitate learning on these methods during student accompaniment we become embarrassed due to lack of updated information, learner guides are also not updated with current reproductive health practice.

**P8/FGD1:** The providers should be trained and be skilled in order to give the correct information… they need to be really equipped in this regard.

**P7/FGD1:** Our institutions must take a stand and give family planning training so that our clients get proper family planning methods according to their choice. There is a need for support from our leaders from province and political support as well very key and currently such is not visible. New health services should not be imposed on nurses prior providing them with updates, otherwise it leads to service failure because nurses were not involved.

The need for knowledge and skills is also emphasised by Javanparast, Baum, Labonte, Sanders, Heidari and Rezaire (2011:272), who state that women have a right to equitable access to trained health care workers who offer appropriate health care services, focusing on disease prevention and health promotion. These authors also emphasise the principle of a comprehensive PHC approach in the training of health professionals and in providing health services to women. This notion of the need for health professionals to have appropriate knowledge and skills on reproductive health methods is further confirmed by Zenzano, Allan, Bigley, Bushardt, Garr, Johnson, Lang,
Maeshiro, Meyer, Shannon, Spolsky and Stanley (2011:261). These authors note that it is prudent to train and educate all health professionals because they function within diverse and inter-professional models of care and that there is a need for them to be appropriate in their daily provision of health care, and when interacting with women and the other professions.

4.2.2.2 Accessibility of RHS

Physical accessibility refers to availability of good health services that are within reasonable reach and allow people to obtain the services when they need them. Accessibility also means that opening times, appointment systems and other service organisation and delivery are in order so that people are able to obtain health services. Accessibility of services also encompasses people’s willingness to seek services and not being discouraged by social and cultural factors of health providers or by financial constraints (Evans, Hsu & Boerma, and 2013:546). A recent study conducted by Schwandt, Speizer and Corroon (2017:7) revealed that family planning providers restrict women’s access to contraceptive methods. These providers attributed their actions to protecting the client from infertility, following the social norms of their community or protecting themselves from blame caused by contraceptive side effects. The need for accessible RHS as a positive factor to support women/clients in making informed decisions about family planning methods was also mentioned by the participants in the present study. According to the study findings, 23 years into democracy, there are still health care facilities that have times stipulated for RHS. This makes it difficult for women to visit these facilities because the scheduled times do not suit some of them. This was stated as follows:

**P6/FGD1:** There are times that are stipulated for RHS than if there was a supermarket approach it would be easy.

**P1/FGD1:** There is also a need to reorganise RHS to maximise access because as it stands now, mothers do not like it when they meet with the teenagers at the services… eh may be privacy and confidentiality in the provision of these
services should be maintained for women (clients) so that it is not to be known for what service they had come for.

According to the Wittmann-Price Theory of EDM (Wittmann-Price, 2006:378), women should be empowered and their environment should be supportive to help facilitate their emancipation. A supportive environment in this study would be one that offers reproductive services comprehensively (in a supermarket health service delivery approach manner) with other services without having stipulated times that inconvenience some women/clients.

The findings of this study are confirmed by Van Lerberghe et al. (2014:2222), who indicate that initiatives for health system strengthening, such as extension of a close-to-client network of health facilities to improve access to health services, and workforce scale-up to provide needed services to respond to growing demand, need to be implemented to make it easy for women to receive health services at times that are convenient to them. Agbemenu and Schenk (2011:56) add that access to health care services remains a legitimate right to all citizens. As such, all health care providers are compelled to provide comprehensive reproductive health services to women of all ages. The right of all people to access health is enshrined in legislative Acts, laws, policies and Constitutions across countries worldwide. The Constitution of South Africa, Act 108 of 1996, establishes the right to reproductive health care, including access to health care in general. However, it is still noted with concern that post-1994, researchers report technical and social advocacy skills gaps on the part of sexual and reproductive health and rights issues (Allotey, Diniz, DeJong, Delvaux, Gruskin & Fonn, 2011:63).

Lecturers/preceptors in this study shared sentiments that there is a need to assess reproductive health services provided to women/clients in order to check their relevancy to the consumers. This is supported by the following quotation:

P7/FGD1: … the RHS need to be assessed and be checked for relevance to clients’ needs prior provision of such services.
This view is supported by Kaida et al. (2010:2), who assert that assessing the likelihood of behavioural and biological impacts of highly active antiretroviral therapy on contraceptive use, efficacy and safety is crucial to ensure that reproductive health services are safe and made accessible to women/clients according to their choice.

The importance of conducting RHS impact analysis/evaluation by way of collecting data on, amongst others, contraceptive prevalence, barriers to uptake, dual protection and dual-method use, acceptability of new methods, commonly experienced side effects, staff competence in the provision of contraception, and use of service delivery guidelines to improve quality family planning services, is also supported by the Department of Health (South Africa, 2012:29).

The findings of this study revealed that some PHC facilities do not practise a supermarket health service delivery approach. According to the participants, all PHC facilities should practise this approach to widen access to health services. The need for remodelling of the consultation rooms to conceal the type of services offered in order to provide and maintain privacy and confidentiality was also robustly emphasised.

4.2.3 Undergraduate nursing programme

4.2.3.1 Teaching reproductive health care to undergraduate nursing students

This study noted that the programme for undergraduate nursing students contains units on reproductive health care as part of their preparation to become professional nurses. The study participants indicated that undergraduate nursing students are taught about contraceptive methods. They mentioned that anatomy and physiology of reproductive health and pregnancy, clinical pharmacology related to reproductive health and pregnancy are the content covered. The results of this study further revealed that reproductive concepts, its advantages and disadvantages and termination of unintended pregnancy are incorporated in Community Nursing Science and Midwifery disciplines. It was also noted that, although the programme for undergraduate nursing students covers reproductive health care aspects, there is still a deficit with regard to support for women/clients to make informed decisions about family planning methods. The
lecturers/preceptors attributed this deficit to insufficient time allocated to undergraduate nursing students to practise reproductive health care skills and to lack of guidelines for the students to follow to ensure that they become confident in the provision of reproductive health services. The following statements were expressed by the participants:

**P7/FGD1:** *The family planning content is integrated in almost all theory subjects; however the practicals are done in Community Nursing Science, General Nursing Science and in Midwifery components… and the students get the opportunity of integrating knowledge of Pharmacology in these components*

**P5/FGD1:** *… they also learn anatomy and physiology… the anatomy of the very uterus where IUCD is inserted.*

Allotey et al. (2011:66) are in agreement with the findings of this study and add that, without any doubt, sexual and reproductive health and rights content should be fully integrated into the relevant training of public health programmes. Miller, Rice, Schiebinger, Jenkins, Werbinski, Núñez, Wood, Viggiano and Shuster (2013:195) corroborate the above notion by indicating that sex and gender concepts can be covered in Pharmacology and Physiology.

Hewitt and Cappiello (2015:72) confirm the participants’ viewpoint by mentioning that discussion of contraception content can be covered in childbearing courses and should include the teaching of anatomy and physiology of reproduction, pregnancy, and other content related to pregnancy and reproduction, as well as clinical pharmacology. In addition to the above contention, Hewitt and Cappiello (2015:70) report that nursing programmes cover aspects of prenatal care at the expense of prevention of unintended pregnancy and other reproductive issues. This calls for health professionals as curriculum implementers to take note of this reproductive health care knowledge and skills gap in order to ensure that the required reproductive health content is adequately covered.
This study also noted that a substantial amount of time should be allocated for undergraduate nursing students to practise reproductive health care skills – to interact intensely with women/clients and deal with contraceptive challenges in order to be able to support women/clients to make informed decision on contraceptive methods. The lecturers/preceptors mentioned that undergraduate nursing students’ lack of exposure to practising family planning skills does not make them competent nurses, which has a negative impact on supporting women/clients to make informed decisions about contraceptive methods. This was stated as follows:

**P1/FGD1:** I agree that students are taught reproductive aspects as part of the curriculum, however the time spent on this aspect of RHS is too short because the time is divided amongst other aspect of their learning, unlike with the previous nursing curriculum of our time, we had much time to practise and learn the skills of practising RHS.

**P4/FGD1:** Yah… the community exposure time is limited and does not make nurses competent.... I agree that there is a need to intensify the training in this area.... We ask why they do not have clinical skills, students when asked why they are providing the kind of RHS they always say I don’t know I was given the task to perform.... There is a skills gap there; probably due to limited exposure to RHS… the time… or period of exposure is a challenge.

According to Sutton (2016: 647), personal knowledge refers to self-awareness that is both subjective and objective, as well as the ability to influence everything one does due to the awareness of personal feelings. Wittmann-Price (2004:441) further adds that personal knowledge is explained as the ability to understand oneself and how knowledge affects one’s situation. In this study, both the lecturers/preceptors and the undergraduate nursing students were aware of and understood their lack of knowledge and skills regarding the reproductive health methods and how it affects them with regard to supporting women/clients to make informed decisions about contraceptive methods.

The level at which reproductive health should be introduced according to the study findings is in the second year. The undergraduate nursing students at this level have
already done the fundamental subjects such as anatomy, and reproductive health can later be integrated into community nursing science and midwifery disciplines. Furthermore, the undergraduate nursing students are exposed to the PHC facilities at which reproductive health services are predominantly offered. This was mentioned as follows:

**P5/FGD1:** Second year level is ideal year for introducing reproductive health content and the student have knowledge of basic subject and will be placed at the clinics and relevant units such as gynae to learn more about family planning practices.

Findings in this study are similar to the study conducted by Miller et al. (2013:197) on embedding concepts of sex and gender health differences into medical curricula. The study revealed that sex and gender content was incorporated in the second-year curriculum of students’ medical education and training.

The participants mentioned that there is a whole module for teaching students about RHS which is integrated into the Community Nursing Science and Midwifery disciplines. The results of this study also revealed that family planning modules are integrated in other subjects, such as physiology, whereby reproductive system function aspects of contraception are handled. Additionally, undergraduate nursing students are placed at the postpartum units, where they get the opportunity to practise the clinical skills of these aspects. One participant said the following about this:

**P11/FGD1:** There are modules of family planning mainly in the Community Nursing Science, General Nursing Science, even in Midwifery… in Pharmacology is not a full module but the family planning medications are learnt by students.

The participants’ view is consistent with findings by Hewitt and Cappiello (2015:74), who report that family planning concepts are to be embedded and/or introduced within postpartum care modules and that these should include family planning health benefits and different contraceptive methods modules. These authors further suggest that there is a need to include contraception content in other modules beyond maternity courses,
such as community health courses, professional ethics, patient-centred counselling and health policy courses. These modules are needed in order to prepare health professionals to become competent practitioners who can deliver quality RHS.

From the above, it is evident that nurses lack adequate family planning knowledge and skills to support women to make informed decisions about family planning. Although undergraduate nursing students are taught reproductive health theory in various disciplines, they still lack clinical practice thereof due to the limited time allocated to practice during their training. The study findings also revealed that the nursing curriculum for undergraduate nursing students urgently needs to be reviewed to look at creative and innovative ways of increasing exposure time for practising family planning health care services. Deduced from the findings of the study is that contraception content should be included in other modules beyond maternity courses, such as in professional ethics, patient-centred counselling and health policy courses, in order to prepare nurses to be competent in the provision of family planning.

Wittmann-Price (2004:439) mentions that the emancipatory curriculum seeks to replace the traditional method of rote learning and further advocates for a transformed nursing curriculum which incorporates the use of emancipatory educational methods that encourage students to be critical, reflective and analytical thinkers.

4.2.3.2 Teaching practices/methods

From the findings of this study, there is an indication that certain teaching practices/methods should be employed to enhance undergraduate nursing students' learning of reproductive health content. This group of participants stipulated that, at college level, the lecturers that are teaching Community Nursing Science teach reproductive health to undergraduate nursing students. They mentioned that, at third- and fourth-year level, midwifery lecturers take over the teaching of reproductive health. The preceptors are said to be mainly involved with teaching undergraduate nursing students reproductive health at the clinical facilities where students are placed to acquire reproductive clinical care competencies. The participants added that lecturers/preceptors should ensure that the reproductive clinical care learning packages
for undergraduate nursing students address aspects of contraceptive use, dual protection, and HIV transmission risks to ensure that undergraduate nursing students are adequately prepared to empower women/clients to improve their decision-making regarding family planning methods.

Although experts are also reported in this study to be involved in teaching undergraduate nursing students reproductive clinical care practices, the participants maintained that lecturers have the primary responsibility of ensuring that reproductive health forms part of undergraduate nursing students’ curriculum and that knowledge and skills acquisition aims at addressing reproductive and sexual rights of women/clients and preparing them to make informed decisions about family planning methods.

According to the WHO (2011:5), clinical preceptors, obstetricians, public health officers, nurse educators, pharmacists and other appropriate subject specialists should become involved in teaching reproductive health care to undergraduate nursing students. However, it is evident from literature and the results of this study that teaching reproductive health to undergraduate nursing students should be the primary responsibility of lecturers/preceptors to ensure that undergraduate nursing students are equipped with knowledge and skills to become competent in the role of supporting women/clients to make informed decisions about family planning methods.

The study findings revealed that using a variety of teaching methods and activities is recommended in the implementation of undergraduate nursing programme. The participants mentioned that this has the potential to increase undergraduate nursing students’ learning abilities, with the potential to improve women’s/clients’ quality of life and decision-making regarding family planning methods.

In line with the factors that have been suggested above on empowerment of undergraduate nursing students to gain personal and professional knowledge to support women to make informed decisions about family planning methods, the Wittmann-Price Theory of EDM (Wittmann-Price, 2004:438) recommends promotion of emancipatory nursing action which can be made possible by implementing emancipatory curriculum and the use of emancipatory educational methodologies in the teaching of nursing
students. Wittmann-Price (2004:441) suggests that, for emancipation to be achieved on an individual level, there must be reflection, personal knowledge, empowerment, supportive environment and awareness of social norms.

This implies that it is imperative that, during learning, students should be exposed to relevant teaching and learning methodologies that will develop their competencies to support women to make informed decisions about family planning methods. Teaching methods such as peer assessment, journal writing, recordings, demonstrations, posters and video watching (Slavich & Zimbardo, 2012:572) need to be used by lecturers to help undergraduate nursing students reflect on what they know and do not know. According to the Wittmann-Price Theory of EDM (Wittmann-Price, 2004:441), reflection is necessary for an individual to think critically about information obtained from personal and professional knowledge and integrate such information into a decision. Dialogue, journaling and concept mapping are the methods that should be used in teaching students to promote reflection. At the same time, as reflected by the Wittmann-Price Theory of EDM, the learning environment should be supportive to ensure that learning takes place (Wittmann-Price, 2004:441).

The lecturers/preceptors added that undergraduate nursing students are also allocated to do certain learning activities, such as providing health education to women/clients on family planning methods, demonstrating the use of condoms and administering injectable family planning methods, as well as explaining how intra-uterine devices are inserted and how they function. The participants attested to this as follows:

**P3/FGD1:** Strategies used in teaching students include amongst others; use of lecturing, modules are given to students, group discussions, and correlation to theory when they go to practice… at the clinics they got nice pictures on posters which students are requested to use…. They are given time frames and go to real patients and give the feedback… they are required to Identify the women’s real needs…although it is not easy… time is the issue here… time is our constraints…
Studies conducted by Bidabadi, Isfahani, Rouhollahi and Khalili (2016:177), Ford (2013:4), and Tulbure (2011:450) explain that student-centred active methods, problem-based and project-based approaches, debate, investigation, cooperative learning and graphic information organisation, co-teaching, differentiated instruction, and peer mediated instructions and interventions are teaching methods that could be used in the facilitation of learning. Because of their relevancy to this study, problem-based methods are outlined as follows:

- Problem-based approaches could be offered to individuals, groups and communities. These approaches have been found to improve communication skills, increase development of critical thinking skills and promote study skills and interest in learning.

In addition to what is reported in literature about activities involved in teaching undergraduate nursing students, the participants narrated that they also use lecture methods, modules that are given to students, discussion, demonstrations and correlation of theory to practice during clinical placement, as well as pictures at the health facilities and posters. Feedback demonstrations in a simulated environment extended to real life patients and students giving feedback on what has been identified as women’s real needs also form part of activities used, although this was stated as not being easy, due to time constraints. The use of pure lecture methods alone, regardless of what it involves (that is, regardless of how it is implemented) has lost its effectiveness (Bidabadi et al., 2016:174). According to the researcher’s interpretation, the implication of these findings is that lecturers/preceptors should explore other teaching activities and methods during facilitation of learning.

The findings of this study also indicated that in-service training, campaigns and awareness programme seminars are also activities used to disseminate reproductive health care knowledge and skills to undergraduate nursing students, health professionals and clients. In the literature, it is recorded that various teaching and learning approaches, including participative student-centred methods such as case studies, workshops, projects, discussions, experiential learning such as role playing and
simulations, and keeping of reflective diaries during work-integrated learning, are amongst activities used in the education and training of undergraduate nursing students about RHS content (WHO, 2011:17). Similarly, Aebersold, Tschannew and Bathish (2012:2), Asoodeh, Asoodeh and Zarepour (2012:560), and Kilgour, Reynaud, Northcote and Shields (2015:17) add that learning activities used by colleges and university faculties in facilitation of learning include video watching, using interactive whiteboards, role playing, simple modelling, collaborative teaching, and teaching through a virtual or web-based learning environment.

Besides the use of a variety of teaching methods and activities, the study findings showed that lecturers/preceptors need pictures, posters, different methods of family planning and various charts on family planning information as teaching materials to enhance learning of reproductive health. However, these materials are not readily available due to resource constraints. They also mentioned that workbooks, library materials and videos on reproductive health information are used as teaching materials for undergraduate nursing students. The participants’ emphasis on the significance of exposing students to a variety of teaching and learning approaches is also highlighted in the Wittmann-Price Theory of EDM (Wittmann-Price, 2004:438), in which traditional educational systems are discouraged in favour of transformational systems of education because traditional systems are associated with applying negative power to women.

The results of this study also indicated the use of live teaching materials, whereby undergraduate nursing students are given assignments to go to women/clients to identify their needs with regard to family planning methods, could influence teaching and learning outcomes. Sadly, the lecturers/preceptors disclosed that, due to time constraints, this becomes difficult to implement. The lack of time was attributed to the undergraduate nursing students’ programme, which the participants said has many components that are to be completed within time constraints. The lecturers/preceptors expressed that there is a need for all who are involved with teaching reproductive health to undergraduate nursing students to be creative about time by exploring self-study teaching materials such as e-learning family planning materials. This was expressed as follows:
**P5/FGD1:** I think lecturers need to be creative about increasing learning time with students… involve them in electronic self-study materials… maybe seeing a scenario on family planning consultation then give assignment to respond to it.

**P1/FGD1:** Posters depicting different family planning methods with indications and contraindications are displayed at the health facilities… there are also posters… even live methods… mothers are shown these methods and they then decide on a preferred one…

**P3/FGD1:** What I have seen is that in other clinics and in some wards where women stay after delivery…. Health education is given, there are models that show how to help the partner on how to use the methods.

The WHO (2011:17) also found that educational technology, educational aids such as videos, computers and internet connectivity, audio-visual aids, models and charts are reported in literature as teaching materials used to enhance knowledge and skills transfer. Other teaching materials recorded in literature by Aebersold et al. (2012:2), Asoodeh et al. (2012:560), Kilgour et al. (2015:17), Ford (2013:5) and Tulbure (2011:450) include different types of journals, magazines, internet, audio clips, teacher lesson plans, handouts and simple software programs. The journal of student-centred learning encourages college and university institutions to focus on learning that is student-centred. This approach encourages the following:

- students taking responsibility for their own learning;
- involving students directly in the discovery of knowledge and using teaching materials that could challenge students to use their prior knowledge to create new deeper understanding of concepts;
- acknowledging the concept that learning is enhanced through social activities, such as cooperative learning, problem-based learning and team learning;
- using school, work, home and community as resources for collaborative learning;
- involving all constituents (faculty, students, staff, alumni, employers, family and others) in contributing to student learning; and
- using activities for learning beyond classroom to enhance the learning experience.
The findings of this study revealed that there are diverse assessment strategies that could be used to determine if learning has taken place. These include written assessments, demonstrating administration of family planning methods, and script preparation to educate women/clients about family planning methods and reproductive rights, for example, the individuals’ right to decide whether to reproduce and reproductive health rights such as the right to plan pregnancy, terminate a pregnancy, use contraceptives and access reproductive health services (Gerntholtz, Gibbs & Willan, 2011:3). Lecturers/preceptors expounded that teaching that is not followed by assessment has no value, since one cannot measure if learning has taken place. They also mentioned that they follow up undergraduate nursing students at clinical practice to observe how they administer contraceptives and how they interact with women/clients. However, because of the large student intake against the number of lecturers, this has become a wish rather than a reality. Lecturers/preceptors expressed the importance of follow-up activities in assisting correlation of theory to practice and in assisting undergraduate nursing students to develop competencies in clinical reproductive health care. This was uttered as follows:

**P2/FGD1:** Assessments of students for theory content is done through written tests, group presentations… and demonstration feed-backs are used to assess clinical competences before students are exposed for practical assessment…

**P1/FGD1:** Personally I wish a lot of direct students’ observations as also a form of assessment during accompaniment can be increased, you can also see if student has good relations with women (clients) and is competent as well… though this is not happening due to large number of student against tutors and preceptors.

Within the Wittmann-Price Theory of EDM (Wittmann-Price & Bhattacharya, 2008:235), reflection, as one of the sub-concepts necessary for emancipation to occur, is considered a sustainable way of acquiring knowledge from practical experience. This can be made possible through the use of the teaching and assessments strategies cited by participants above. In support of this statement, Karimi, Haghani, Yamani and
Kalyani (2017:1) state that, when students are placed in a tense clinical learning environment and their learning is facilitated through reflective activities, they gain peace and a feeling of effectiveness and usefulness. Accordingly, peace leads to students’ mental health and personal growth, which in turn may lead to an impact on the quality of nursing services. The Wittmann-Price Theory of EDM proposes the reinforcement and updating of non-judgemental communication, which is a component of a flexible environment taught in nursing education but rarely implemented in the practice environment (Wittmann-Price & Bhattacharya, 2008:235).

Bornais, Raiger, Krahn and El-Masri (2012:295), Levett-Jones, Gersbach, Arthur and Roche (2011:64), and the WHO (2011:19) support the narratives provided by the participants above that multiple methods of student assessment, namely, standardised patients, structured observation and assessment of practice, clinical simulations and demonstrations, objective structured clinical examination (OSCE), discussions, extended-answer essays, exhibitions, product items such as portfolios and projects, written critique or review/formal papers, and direct observation, are commonly used to assess students as to whether learning has taken place or not.

According the Wittmann-Price Theory of EDM, nursing care should include the comprehension that social norms can affect the process of decision-making. Wittmann-Price and Bhattacharya (2008:235) encourage professional nurses to create a flexible environment which will foster open discussion about health care alternatives between nurses and women because it encourages empowerment. The implication of this is a need to use various teaching assessment methodologies that will enable students to reflect on what knowledge and skills they have acquired and what they need to learn, as well as development of communication, critical and analytical skills which they will need for support for women to make decisions. Role play, demonstrations, feedback, use of the nursing process when taking women’s history, as well as assessment are some teaching methods mentioned by the participants in this study that can be implemented.

Wittmann-Price (2006:377) explains that reflection is a form of critical thinking – knowledge acquisition from practical experience. It is highly an interactive process
which is promoted by dialogue between nurses and women. Hackathorn, Solomon, Blankmeyer, Tenniel and Garczynski (2011:40) present an arsenal of student-centred, active or experiential teaching approaches at the disposal of lecturers which require students to become involved and be held accountable for their own learning, namely, elaborate demonstrations, structured activities, journaling, small group discussions, quizzes, interactive lecture cues, videos, humorous stories, taking field trips, games, and formative and summative assessments of theory and practice. Lecturers should be encouraged to use these techniques during facilitation of learning to develop undergraduate nursing students’ competencies both in practice and in theory.

The findings of this study on assessment strategies as stated above are consistent with literature information, and as such need to be implemented to improve empowerment of undergraduate nursing students, health professionals and women/clients, thus improving health outcomes.

4.3 SECTION TWO: UNDERGRADUATE NURSING STUDENTS

4.3.1 Reproductive health care services offered to women/clients

4.3.1.1 Nurses’ responsibilities

The undergraduate nursing students who participated in this study indicated that nurses should play a greater role in the provision of RHS because they are the women’s/clients’ first contact at the health care facilities. Nurses do initial identification of reproductive health care challenges, refer women/clients to other members of the multidisciplinary health team, and provide advocacy and health education to women/clients who seek RHS.

The Wittmann-Price Theory of EDM calls for awareness of social norms assumed to affect women’s decision-making about health care issues. More often women feel obligated to choose socially accepted health care alternatives against the choice that suits them. This theory represents a promising process for women confronted with health care decisions based on the identified sub-concepts that should be present in a women for emancipation to be realised, namely, empowerment, flexible environment,
personal knowledge, reflection and social norms (Wittmann-Price, 2006:378). Therefore, with health education, empowerment and advocacy for women as suggested by the participants, it is evident that the process of women’s emancipation can be achieved through continuous awareness of social norms that need to be maintained for women and communities as well as the creation of a flexible environment that supports decision-making. There is also a need for women to be supported to enable them to critically review cultural and religious factors that are oppressing them within their environment. Churches should support women by becoming more active in implementing transformative agendas through teaching and providing public advocacy regarding women’s health care issues.

In support of the importance of health care providers providing women/clients with a flexible environment, García-Moreno et al. (2015:1567) state that health care providers are expected to provide women with a safe environment where they can disclose confidential matters that affect their decision-making processes.

The findings of this study revealed that health care professionals are required to provide health education to women/clients on sexual and reproductive health in order to build their knowledge base that will assist them to make informed decisions on these aspects. However, staff shortages and overcrowded facilities make it difficult for nurses to provide quality health education which should equip women/clients to make informed decisions about family planning methods. Nevertheless, the results of this study also revealed that health education about family planning should be increased and target the broader public in order to assist women to make informed decisions. This is evidenced in the following quotation:

**P2/FGD2:** There is a shortage of staff though… when the ladies are coming for their monthly prevention… there was not a lot of time spent with the women and listen to what they have to say… there is not enough time to give sufficient time to be listened at and given enough information. The clinics are packed, women are not able to make decisions because nurses do not have time to listen to what they are saying due to pressure of work.
The view of the participants on the need to step up women’s education on contraceptive methods resonate with Do and Kurimoto (2012:23), who propound that there is a need for increased and vigorous education of women on reproductive health as a strategy to improve women’s health. The same notion is echoed by Van Lerberghe et al. (2014:1222), who believe that it is important to increase health education to the public and to women in particular. These authors allude that providing health education to women/clients has added value because it increases women’s chances of taking up available health services opportunities presented by health care providers. Health information giving has the potential to increase women’s autonomy and participation, which have been recorded in the literature as contextual elements that influence health decision-making and uptake of care. According to the WHO (2011:5), it is crucial to embark on education about family planning issues to prevent future challenges on reproductive health. As such, health professionals are expected to direct their energies to the success of this.

In this study, the participants cautioned that health education should also focus on bringing awareness to the public that contraception does not prevent sexual transmitted infections and should introduce dual protection. The study also revealed that communicable diseases are given more attention at the disadvantage of contraception, with profound negative effects on family planning services. The undergraduate nursing students in this study further mentioned that information about all aspects of reproductive health, family planning methods included, require publishing in teen magazines to empower them. Educating parents, who must also educate their children at all platforms, such as churches, at schools and wherever the opportunity presents itself, was also cited as very important.

Apart from provision of health education, the results of this study also revealed that nurses should advocate for the health needs of women/clients to ensure that they receive quality health care services. The study noted that some nurses do not even advocate for availability of different types of family planning methods at their facility, which disadvantages women/clients who are found to be subjected to a method despite experiencing side effects. The undergraduate nursing students in this study attributed
the inability of nurses to play an advocacy role for women/clients to a variety of factors, such as inadequate training and mentoring, overcrowded facilities, and some nurses' bad attitudes. This group of participants wished to be skilled and to be mentored in their advocacy role as they believe that this will be a positive strategy to support them in their quest for provision of quality reproductive care.

The study also noted that women/clients will benefit from partner support pertaining to making choices about family planning methods, hence the emphasis that nurses should go all out and advocate for partner support through campaigns and use of any other media to spread family planning information, while at the same time lobbying for support for women/clients. Some of the participants' expressions about this are presented below:

**P1/FGD2:** Members of the family especially the partners must be brought on board on matters of contraceptive because when there is open discussion about this the women will be supported in making choices.

**P9/FGD2:** In addition to inviting the partner... issue some of the pamphlets.... Can be distributed and the women take such home.... Pamphlets that are written in all languages will benefit the public.

Légaré, Politi, Desroches, Stacecy, Bekker and SDM-CPD Team (2012:159) in support of the findings of this study state that nurses should advocate for all adolescents to access RHS and that it is important for all health care providers to provide comprehensive reproductive health care to patients. Other researchers, such as Allotey et al. (2011:66), and García-Moreno et al. (2015:1567), also comment that the provision of advocacy interventions to women by health professionals is important. It has the potential to increase access to reproductive health resources and helps to empower women to take steps to safely improve their lives.

Based on the results of this study, lecturers/preceptors and undergraduate nursing students need to be empowered on new developments regarding reproductive health, especially new family planning methods. They disclosed that they lack knowledge and
skills on these aspects and these affect their ability to support women to make informed decisions about family planning methods. They mentioned that empowered health professionals can effect a profound change in the provision of RHS. They could be able to create a positive work environment that fosters provision of the best possible health care that enables empowerment of women/clients and supports them to make informed decisions about their reproductive health. The participants further narrated that women/clients need to be empowered on family planning methods and human rights issues. However, for this to be realised, women need to be emancipated from external and internal factors deterring them from making decisions.

The findings on the aspects of increasing nurses’ health care knowledge and skills are also emphasised in the Wittmann-Price Theory of EDM (Wittmann-Price, 2004:439), which advocates for transformed nursing education, moving away from a traditional approach and replacing it with emancipatory educational methods to encourage students to be critical, reflective and analytical thinkers, who are able to develop intellectual and emotional powers that will assist them in examining their own learning, everyday experiences and the circumstances surrounding patients’ decision-making. This curriculum is recommended as one way to address the violation of the rights of women seeking family planning services, because it has a flexible environment as its foundation.

Some of the factors that emerged as deterrents during focus group discussions included religious and societal reproach, spousal disapproval, contraceptive side effects, inadequate information about contraceptive methods, limited resources at facilities, perceived bad attitudes of nurses, and overcrowded facilities. These factors have negative effects on the environment where women are to make decisions about health care alternatives. In support of these findings, Wittmann-Price (2004:441) alludes that empowerment is a process that is positive because, through knowledge, power is transmitted to patients. Women’s empowerment is also about the creation of a conducive environment for women where they can make their own decisions for their own personal benefit and that of their society. Empowering women is essential because
of its potential to improve the quality of their lives, as well as that of their families and communities.

CARE International (2012:4) agrees with the above statements on the importance of women’s empowerment by adding that empowering women to overcome obstacles that prevent them access to quality health care and from making decisions about their health care issues is key in improving their health. Similarly, these authors encourage governments to seriously take up the call for increasing public knowledge on reproductive and human rights to ensure that communities know their rights and are empowered to speak up for their own health care needs. These findings reinforce the picture painted by the participants, who argued that health facility environments are currently not encouraging women to make decisions about their reproductive health care issues. They pronounced that it is the responsibility of nurses to ensure that health facility environments are conducive and non-judgemental in order to encourage women to make decisions about contraceptive methods.

The appalling state of health care facilities revealed by participants is also in line with Olifant, Ward and Clausen’s (2016) statement that South African state clinics and hospitals fail to meet even the most basic health care standards. In a report produced by the Office of Health Standards Compliance conducted between 2012 and 2016, there was an indication that, in 1 887 inspections conducted at 1 500 health care facilities, there were damning findings that were putting patients’ health at risk. Hygiene and infection control standards, amongst others, were found being ignored by health facilities (Olifant et al., 2016). This is of concern because provision of certain contraceptive services require implementation of infection control measures.

The findings of this study further revealed that the importance of women’s/clients’ and community empowerment with regard to reproductive and sexual rights cannot be overemphasised and that all efforts should be directed to its achievement. The participants in this study believe that empowerment can be realised through education and emancipation.

The following statements are expressions from the participants:
P10/FGD2: I think another thing is that we nurses we do not have knowledge, we do not know about these services (RHS)… I think knowledge is power. Most of us nurses we lack knowledge on new development on RHS.

P1/FGD2: To sum it up we want nurses to be empowered on new developments and be included in all patient care matters because they are always close to the patient… nurses’ empowerment will build confidence in providing services.

P8/FGD2: More campaigns…. Providing health education to the women so as to empower them to exercise their rights in making choices…

P3/FGD2: I agree campaigns and health education will assist because there are people who are practicing their culture who are not educated about family planning.

(1) Education

The above narrations revealed that nurses and women/clients need to be educated on contraceptive methods and human rights issues, as described below.

(a) Contraceptive methods

Kim et al. (2007:295) write that most contraceptive methods are imperfect, citing that some are inconvenient to use, while others are associated with uncomfortable side effects. Based on this information, these authors stress the importance of providing clients with accurate and relevant information in order to make informed decisions about contraceptive methods. Furthermore, they propose that empowering clients and teaching them skills such as self-disclosure or inquiring about alternatives course of action should be embarked on to improve client decision-making. Do and Kurimoto (2012:31), in support of this study’s findings, submit three strategies to promote women’s empowerment and choice of contraceptive methods, namely:

• improvement of women’s self-efficacy and attitudes with regard to the negotiation of sexual activity;
• promotion of couples’ discussions about their fertility desires; and
• the involvement of men in decision-making with regard to fertility and contraception and direction of all efforts to increase contraceptive availability at health care facilities and other appropriate places.

The above findings are in line with what is proposed through the Wittmann-Price Theory of EDM, which emphasises that knowledge (empowerment) is needed to arrive at an informed decision (Wittmann-Price, 2006:379). The participants of this study concur with this theory as one of them mentioned that:

**P9/FGD2**: *I think they should be knowledgeable about their health care matters when making choice on health… knowledge is power if she understand what it means she will have confidence to choose a method she likes unlike when nurses choose for you.*

(b) Human rights issues

The study findings disclosed that participants felt strongly that lack of observance and knowledge on human rights issues affect women’s decision-making. In South Africa, the emphasis of observing fundamental human rights is endorsed in the Constitution of the Republic of South Africa (South Africa, 1996:6). However, it is disappointing as deduced from the current study that women still suffer human rights violations in health facilities. Ssenyonjo (2007:39) further confirms that women continuously encounter violations of their human rights from various circles.

The SANC affirms all people’s right to access health and states that it will promote the provision of nursing services that comply with universal norms and values to the inhabitants of South Africa (South Africa, 2005:7).

According to the Wittmann-Price Theory of EDM in women’s health care, if there is an incongruence between social norms and personal knowledge, a flexible environment is necessary to facilitate an emancipated decision-making process. It is further explained in this theory that, should a woman choose a health care option because of pressure from social norms, it will yield dissatisfaction with the decision (Wittmann-Price &
Bhattacharya, 2008:226). If this happens, it implies that there has been some form of human rights violation, since the decision taken was not within the free will of the affected woman.

(2) Emancipation

The study findings showed that women/clients need to be liberated from factors that prevent them from making decisions about family planning methods. According to Wittmann-Price and Bhattacharya (2008:235) and as stated in Chapter 1 of this study, nurses are well placed to support women to make emancipated decisions. However, nurses should embrace the concept of women’s emancipation by accepting that there are diverse and complex issues surrounding women’s health that impinge on their freedom to make choices about their health issues. The implication of the findings of this study is that, in the attempt to support women to make informed decisions about contraceptive methods, there is a need to address factors surrounding women’s decision-making. The Bill of Rights theoretically allows for enabling environments to encourage emancipated decision-making for all users of RHS by stating the following, amongst others (South Africa, 1996:6):

> everyone is equal before the law and has the right to equal protection and benefit of the law. This right opens doors to all South African Citizens for equal access to quality reproductive health care; the inherent dignity and right of all South African Citizens that has to be respected and be protected as enshrined in the Constitution.

South Africa saw the launch of a contraception policy within a reproductive health framework and contraception service delivery guidelines in 2001 and 2003. However, factors influencing contraceptive use still remain a challenge (South Africa, 2012:13, 15). From a local perspective, legislation that governs the practice of nurses and medical professionals encourages emancipated decision-making amongst all health care users. Based on the aforementioned explanations, it can thus be concluded that women who do not have access to health care due to environmental factors are completely disempowered. This implies that health care providers should create
enabling environments at health facility level to encourage women to make decisions about contraceptive methods.

The sentiments of the participants are also echoed by Do and Kurimoto (2012:2), who state that there is a relationship between women’s empowerment and their access to reproductive health. A woman who lacks power is said to experience an inability to make decisions about family planning and, as such, fails to openly discuss her reproduction needs with her partners. Sibiya and Gwele (2013:387) share the same sentiments by concluding that the fundamental goal of health education is empowerment of communities to be able to manage their health needs from an informed point of view.

Participants in the current study also brought to light that they believe that there is a need to have formal structures in place to address the issues surrounding women’s inability to make informed decisions about family planning methods. Women’s empowerment through education and provision of a supportive environment was sharply raised by participants as means through which empowerment could be attained. The findings of this study on the need to empower women are consistent with the Wittmann-Price Theory of EDM, which positions women’s health at the centre of the discussion of dealing with patriarchal social norms that may be oppressive, with urgency for the relevant institutions to replace this situation with empowerment. Ushie, Eneji, Ugal, Anyaoha, Ushie and Bassey (2010:75) support the Wittmann-Price Theory of EDM (Wittmann-Price & Bhattacharya, 2008:226) and propose three strategies of increasing women’s empowerment to conquer violence against them. These strategies are depicted in Figure 4.1 below. Figure 4.1 could also add value if it could be implemented by health care providers as another intervention strategy in the empowerment of women to increase their ability to make informed decisions about contraceptive methods.
Adapted from Ushie et al.’s (2010:75) three suggested ways to address domestic violence

**Figure 4.1:** Three ways to increase women’s empowerment on decision-making about contraceptive methods

Figure 4.1 above depicts three types of intervention, focusing on women’s empowerment to increase their ability to make informed decisions about contraceptive methods, as outlined below:

- **At the primary level,** intervention education programmes, namely, seminars, campaigns, group discussions, networking and literacy classes, could be used to provide reproductive health information to women/clients at all forums.
- **At secondary level,** the focus could be on identification of women’s ability to make decisions about family planning methods and challenges they experience with regard to family planning methods. The health professionals could use the nursing process approach in addition to any available assessment tools at health facilities to execute this level of intervention.
- **At tertiary level,** health professionals should focus on creating women’s shelters and community-based support services. These could include formation of women’s
organisations, establishment of group support, women’s literacy clubs, and annual meetings to share experiences and learn from each other.

An additional disclosure from the findings of this study is the participants’ observation that provision of reproductive health care is relegated to lower categories of nurses. They articulated their concern that these nurses do not have the leadership skills that are needed to provide quality health care services. The undergraduate nursing students proposed that professional nurses should always be available to provide RHS because they are trained in leadership skills that can be utilised towards promoting quality health care. The great concern from the participants was that, currently, leadership on the provision of family planning services at facilities is not visible. They associated lack of professional nurses to provide RHS leadership with staff shortages within the departments of health. This is evidenced in the following excerpts:

**P3/FGD2:** I think even the leadership skill of the nurse is very important… in most clinics you find is only the lower staff category who are giving contraceptives as there is no professional nurse because of shortage, so I think it is important that there is always a professional nurse where the service is provided…

Dignam et al. (2012:66) are in agreement with the findings of this study as they mention that leadership and management content should be integrated in nursing curricula because it is important for the development of a positive work environment that can bring about optimal quality patient care as well as encourage women/clients to make decisions about family planning methods. Professional nurses have the potential to provide effective management and leadership in the health care facilities, hence it is recommended that they should always be allocated to function in the reproductive health care unit. It is believed that professional nurses are major attributes in the attainment of positive patient outcome, including women’s/clients’ ability to make decisions about family planning methods.

Based on the information stated above, it is clear that staff shortages and overcrowded health facilities are enormous hindrances that confront health care providers. These
have a negative impact on provision of quality reproductive health services. Nurses also experience lack of support and mentoring from their supervisors on how to provide patient advocacy.

4.3.1.2 Characteristics displayed by nurses in the RHS

Undergraduate nursing students mentioned that some nurses display a lack of reproductive health care knowledge and skills, while others display bad attitudes, and that they also lack professionalism. The participants disclosed that attitudes of health professionals are bad, which hinders women's/clients' ability to make decisions about family planning methods. They further mentioned that the nurses’ non-verbal communication and tone of voice when interacting with women/clients at the health facilities are not of a welcoming nature because they do not give the women privacy to relate the kind of services they prefer; furthermore, some of the nurses are rude. The study also revealed that nurses are judgemental and do not allow women to exercise their intellectual abilities in making choices – contraceptive methods are imposed on them without considering what they prefer. The participants’ concern was that women's/clients' views on choice of contraceptive methods are not taken into account by health professionals or collaboratively discussed with them. This is evidenced in the following quotation:

P10/FGD2: There is a need for information sharing with the recipient of services to learn from them on what is relevant and suitable to their needs. Nurse practitioners need to be encouraged to engage the women’s partners so that decision are taken together, need for advice for partners and spouses about the importance of supporting their women on their choice of contraceptive methods.

P7/FGD2: A welcoming nurse goes a long way in accommodating the clients, a facial expression should talk and can communicate none acceptance of women’s (clients’) requests of preferred contraceptive method.
**P1/FGD2:** Have a friendly face when providing services to them… I too think a friendly face will go a long way, the patient will not be free to decide on a method or a service if you are not friendly with them.

The participants revealed that, because of nurses’ bad attitudes, there is no practice of Batho Pele Principles of service delivery at facilities. As such, women are not privileged to make informed decisions about preferred methods because they are not given information of available services. One of the participants said the following:

**P4/FGD2:** Putting people first… actually respecting the rights of people… right to information so that decisions to decide on services is based on knowledge one possess.

The need for giving communities information about RHS was also mentioned as a strategy that may dispel the nurses’ bad attitudes because women/clients will come to the services already well informed. This is supported by the following quotation:

**P2/FGD2:** … the issue is we should do this awareness campaigns… do community outreach, communicate to the public about the rights of patients and give somebody a space to have a say in the service they prefer.

The bad characteristics displayed by nurses at the reproductive health care facilities revealed in the findings of this study are in contrast with the Wittmann-Price Theory of EDM’s recommendation of an equalitarian nurse-patient relationship in the clinical area so that women may feel secure in the presence of professional nurses to make informed decision about their health care (Wittmann-Price & Bhattacharya, 2008:228).

The study findings also revealed that nurses, undergraduate nursing students included, lack appropriate/required knowledge and skills on new reproductive health care practices. This was associated with the probably uncoordinated and poor management of nurses’ capacity-building that seems to focus on certain group of nurses. The study noted that the existing knowledge and skills gap on the part of some health professionals with regard to provision of reproductive health care compromises the effectiveness of assisting women/clients in making decisions about family planning.
methods. The results of this study indicated that it is critical that all categories of health professionals should be scheduled for in-service training on newly introduced reproductive health care treatment modalities, contraceptive methods included. This has the potential to improve the health of women/clients because nurses will be able to mitigate health care challenges experienced by women/clients. This would also be beneficial to quality of health care, especially to family reproductive health care delivery services. One participant mentioned the following:

**P4/FGD2:** *What the colleagues are saying is true, look at the new contraceptive that just came in, the implant in family planning, only the doctors do it, nurses are excluded, they don't even show us how it is done, its functioning and side effects.*

The need for building health professionals capacity as an attempt to address reproductive health care for individuals is supported by other researchers, who add that strengthening health professionals’ knowledge on sex and gender health care needs require inter-professional collaborative efforts of including reproductive health concepts in all levels of health care professional education and training. It is also recommended that Western health care professionals should receive education regarding culture in general as this will enable them to provide culturally congruent care (Miller et al., 2013:3; Prosen, 2014:151).

CARE International (2012:12), and Hewitt and Cappiello (2015:75) support the above assertion by stating that knowledge and skills gaps in many areas of women’s health care have been identified amongst health professionals and that this gap urgently needs to be closed in the interest of quality health care service delivery. These authors recommend increased availability of trained health care workers to attend to women’s empowerment and transforming inequitable gender and social norms. It is believed that, through addressing these barriers to family planning, access could be addressed at the family and community level to enable women to make decisions about their family size.

Légaré et al. (2012:159) support the participants’ idea by explaining that it is important to incorporate aspects of clinical health care collaborative decision-making between health professionals and patients in nursing students’ education and training
programmes. It might be argued that lecturers/preceptors should utilise teaching methods and learning materials that would develop students’ collaborative decision-making competencies, and create role-played interactive platforms in which patients and health professionals can collaborate to choose health care alternatives while encouraging health professionals to take patients’ values and preferences into account. Légaré et al. (2012:156) further support the findings of this study by mentioning that it is important to provide nurses with proper training in reproductive health care, as it is the basis of acquiring knowledge and skills needed to provide quality care to women/clients while assisting them to make informed decisions about family planning methods. With regard to provision of good service and quality care for women/clients, the participants responded as follows:

**P6/FGD2:** *To me, this will mean that the patient is provided with what they came for to the RHS… eh! They will be given information about available services and be able to make choices.*

The undergraduate nursing students in this study recommended that there should be means to verify whether women/clients coming for family planning methods are pregnant or not, rather than the current practice of turning them away to come when they are menstruating.

In support of the above findings, Légaré et al. (2012:159) add that it important to enter into shared decision-making between women and health professionals, to help women make informed and value-based decisions about their health. In addition, these authors write that it is crucial that shared decision-making content is included in the programmes of health professionals. Shared decision-making is said to be an interactive process that enables patients and health professionals to collaborate to choose health care that takes their values and preferences into account.

Hewitt and Cappiello (2015:74) add another dimension to this and bring in an aspect that could promote adherence to ethical principles in the delivery of women’s health by suggesting that Unintended Pregnancy Prevention and Care (UPPC) concepts be allowed to find space and/or embedded with professional ethics. In this case, course
facilitators can use case studies on UPPC to engage students in real-world applications of professional consciousness, professional ethics and respect for patient decision-making. These authors further mention that health professionals’ capacity building on patient-centred counselling and basic nursing communication skills needs to be facilitated using UPPC in order to provide opportunities to practise non-directive and non-judgemental counselling to women who seek family planning services.

The undergraduate nursing students mentioned that some nurses fail to practise work ethics principles in that they do not create privacy during consultations and do not keep women’s/clients’ confidential matters to themselves. These nurses’ actions are believed to compromise women's/clients’ ability to make informed decisions about family planning methods as well as actual access to RHS. The undergraduate nursing students in this study called for nurses to remember to practise their profession within legal prescripts of the SANC and the Department of Health, including the related legal framework. One of them said:

**P3/FGD2:** *We must remember that as nurses we do not do things on our own, we need to do things within the nursing ethics, as well as guided by the South African Nursing Council, as well as work ethics guided from the government… we work under SANC… combine all these to provide services within the legal framework.*

Russel and Beaver (2013:16) add that nurses’ professionalism will be judged against personal behaviour and how they present themselves to others. This includes attitude, appearance, compassion, patience, morals, ethics and commitment to always act in the best interest of others. Hewitt and Cappiello (2015:74) also confirm the aforementioned by stating that professionalism needs to be maintained in health care services. The authors further state that nurses are to apply their positive emotions and professional competencies to assist health care users in the processes of seeking health services (SANC, 2013:5).
4.3.1.3 Challenges experienced by nurses and women/clients

The participants revealed that, besides the nurses’ bad attitudes and lack of professionalism at the RHS facilities, there are numerous challenges encountered at these facilities by both nurses and women/clients. Nurses are confronted by challenges at the reproductive health facilities that range from resource shortages, and lack of knowledge and skills on clinical reproductive health by some health professionals, to women’s/clients’ low literacy levels. The participants mentioned that there is a strong association between contraceptive use and women’s level of education. The following statement was uttered by one participant:

\[ P3/FGD2: \text{Even their level of education can influence them because if someone does not have that much education they (women/clients) tend to, what can I say, they (women/clients) pull themselves back they isolate themselves from information that could be useful to them.} \]

The quotation above is affirmed by Gordon et al. (2011:3), who mention that educated women are more likely to make decisions about use of contraceptives and negotiate with cultural, religious and other factors hindering their ability to access reproductive services. These authors further mention that women’s/clients’ access to and successful use of contraceptive are very important in health care improvement and that low levels of literacy impact negatively on their decision-making and on the health status of women and infants in general. For this reason, many countries invest in expansion of women’s education in an attempt to improve their health and that of their infants. Husain et al. (2011:41) add that a strong predictor of women’s lack of empowerment is associated with illiteracy and that illiterate women may be unable to voice their choices regarding contraceptive methods. These authors further mention that illiterate women are likely to have limited access to health services, hence health professionals need to double their efforts in increasing health information to assist this vulnerable group, by face-to-face interaction and encouraging development of contact outside their households.

The Wittmann-Price Theory of EDM (Wittmann-Price, 2008:228) validates the findings of this study regarding challenges experienced in the health care facilities through
conceding that oppression is still visible today in women’s health care when social norms obliterate individual consideration in decision-making.

The issue of societal domination described by Wittmann-Price (2008:228) as causing oppression and denying women equality also poses a serious challenge for women who are faced with decision-making regarding their health care issues. According to Feminist Theory, the majority of women were denied the opportunity to be educated because in the early history women took over the role of caregiver while men were allowed time for scientific study that empowered them with professional knowledge. The Wittmann-Price Theory of EDM advocates that this situation should be replaced with emancipatory education for women (Wittmann-Price & Battacharya, 2008:228).

The undergraduate nursing students also expressed that RHS are not prioritised like other programmes such as immunisation programmes, which could be a contributory factor to the many other challenges experienced by nurses and women/clients, such as the shortage of contraceptive methods, which acts as a deterrent with regard to assisting women/clients to make informed decisions about family planning methods. The following expressions are what were said during focus group discussions with undergraduate nursing students:

**P2/FGD2**: … people in the deep rural areas do not have access or easy access to RHS because normally if there are mobile clinics they mainly prioritise immunisation and family planning take a back seat…

**P3/FGD2**: … I think with regard to provision of reproductive health services, eh! Our department not just provincially so but national per se I think they are putting a lot of focus on other aspects and communicable diseases than family planning issues which brings… for example they not giving focus to sex education.

The results of this study are similar to those of Kaida et al. (2010:2), who also discovered that RHS are not prioritised like other health care programmes. These authors state that evidence of prevailing under-emphasis of reproductive health within other programmes is still noted with concern. There is also a lack of nationally
recognised essential competencies for the prevention of unintended pregnancy, which impedes comprehensive nursing education and practice of this aspect of reproductive health care (Hewitt & Cappiello, 2015:70).

The study furthermore noted that culture interferes with quality reproductive health care delivery, as mentioned in the following statement:

**P8/FGD2:** I think one of the challenges for example are male nurses where clients are not free to open up to male nurse because other people are still too much cultural so they will feel I cannot be talking about this information to a male, about my periods about what is happening after receiving the contraceptive, so they might not give all information; so I think reproductive health facilities should have, if ever possible to that clinic to have male and female nurses at the same time just to balance the gender and allow clients to discuss their reproductive issues with female nurses if they feel like.

Besides the nurses’ challenges, the results of this study further exposed that women/clients are not able to distinguish contraceptive side effects from adverse effects. This knowledge deficit is attributed to lack of provision of health education and discussions between health professionals and women/clients on these aspects. The participants mentioned that this affects all efforts of assisting women in making informed decisions about family planning methods. Proper information sharing with women/clients is vital to increase their knowledge and enhance coping with contraceptive side effects. This was expressed in the following excerpts:

**P1/FGD2:** Problems might be that the women they are not fully aware of what are side effects and what adverse effects are so when it happens that they come across side effects they think they are adverse effects and they discontinue contraceptives and they do not have much trust on it any more that is why they do not use them anymore. I think it is crucial that us as practitioners we should fully understand the side effects so that we can explain to the patients or to our clients.
In agreement with the above quotation, it is also reported that the majority of women requiring contraceptive services are not provided with sufficient information and counselling on the expected side effects of family planning methods. This indicates a profound need to strengthen counselling women and giving them information on the expected common side effects of the methods they prefer (South Africa, 2012:15).

The undergraduate nursing students in this study also indicated that there is a shortage of contraceptive drugs at the public health facilities. This discourages nurses to discuss choice of methods with women/clients, followed by subsequent imposition of family planning methods by nurses on women/clients without noting the women’s concerns. The participants mentioned that a shortage of contraceptive methods also limits women’s/clients’ decision-making pertaining to preferred methods, which has a potential to increase the risk of side effects. The Departments of Health should therefore concentrate all efforts to ensure that there are always adequate contraceptive methods at its facilities.

The results of this study indicated that there are myths about contraceptives, which affects women’s choice of family planning methods as stated in the following quotations:

**P3/FGD2:** I believe there is a lot of myths and perception about contraceptives in the community for example girls believe that they might gain weight from actual using contraception, their body might feel with water, there is a lot of myth and perception about contraception I think this causes a lot of problems.

**P7/FGD2:** Yes I fully agree with him about the myths also if the nurse and doctors don’t have full information and do not have skills on explaining this to patient at the end this become not useful.

The notion surrounding myths and perceptions about contraceptives is confirmed by Kabagenyi, Jennings, Reid, Nalwadda, Ntozi and Atuyambe (2014:1), who state that there are concerns that women’s use of contraceptives will lead to extramarital sexual relations, that reproductive health is a women’s domain and that female contraceptive methods disrupt sexual activity because of its side effects.
Undergraduate nursing students indicated that, besides myths about contraceptive methods, women/clients are still culturally subordinate to their husbands because the men expect the women to bear more children. According to the participants in this study, this diminishes the dialogue between women/clients and health professionals concerning the type of reproductive health care needed, since they do not want their spouses to find out that they are on contraceptives. This is also considered oppressive and dehumanising in nature, with consequential restricted decision-making for women. The participants further mentioned that, in some instances, women leave their family planning cards at the health facility because of fear of their husbands. Hence, women/clients are bound to explore methods that are easy to conceal. This was evidenced in the following quotations:

**P7/FGD2:** Also not enough support received from their partners, as others hide that they are on contraceptives and when they experience side effects there is no one to talk about it.

**P1/FGD2:** … she mentioned culture and beliefs I do not know how we can put this but there are some women who are actually unable to do so to go forth choose a method because of their spouses you understand… I don’t know how we can call it, is familial may be because the spouses refuses saying you cannot tell me or do not tell me that you are stopping getting children or what the nurses have told you I want my kids, the husband becomes the constraints in this instance…

**P1/FGD2:** Culturally women play a subordinate role to the family and husband… We come across such instances where women do not make decisions outside their husbands.

**P12/FGD2:** Health professionals should collaborate with our culture and try integrating contraceptives practices in a manner that it does not clash with people’s cultures, get to know what is culturally accepted and take it from there in support of women…
Similar to the findings of this study regarding contraceptive myths, Kabagenyi et al. (2014:1) report that side-effects of female contraceptives which are perceived to disrupt sexual activity are amongst the barriers to male involvement in contraceptive use. Barot (2013:1) confirms that there is indeed evidence of women reporting concerns about side effects such as irregular bleeding, weight gain, low libido, nausea, headaches, increased risk of blood clots and menstrual cycle changes.

Kabagenyi et al. (2014:1) are in agreement with the results of the study and confirm that there is evidence recorded on men’s opposition to and non-involvement in contraception. These authors further conclude that this is obstructive to women’s decision-making on family planning methods since there is no support from their spouses. Furthermore, literature reports high rates of violence against women as one crucial social mechanism forcing women into a subordinate position to their spouses (Weldon & Htun, 2013:3).

Another mentioned barrier hampering women’s effective decision-making regarding their reproductive health is fear of facing social and possibly moral reproach (Campo-Engelstein, 2012:147). On the other hand, it is reported that there are still men who show lack of interest in matters related to reproductive health, which also negatively influences women’s decision-making with regard to RHS. Women still fear spousal retaliation and disagreements about use of contraception. This needs to be addressed urgently in order to improve women’s health (Kabagenyi et al., 2014:1).

The undergraduate nursing students in this study further disclosed that women/clients at RHS still suffer health professionals’ reproach. They mentioned that the attitudes of health professionals in the health facilities play a major role in discouraging women/clients from inquiring about contraceptives information that may assist them to make informed decisions, as one participant said in the following quotation:

**P12/FGD12:** Our attitude is not good… when we are about to knock off duty nurses have tendencies of telling patients things like, I cannot listen to you now, I am going off, and this is not good, it is a bad attitude.
The findings of this study are consistent with global media reports about nurses’ attitudes at health facilities. There are incidences where community members cite being chased away and locked out on cold rainy days and having to deliver babies in pit toilets within a few minutes of being denied access to a health facility. Nurses are perceived as rude, arrogant, inhumane and negligent. Other community members describe nurses’ perceived behaviour as satanic and state that they lost their unborn babies due to nurses’ bad attitudes (Mpumalanga Provincial Department of Health, 2016).

**Staff shortages** were also acknowledged in this study as a stumbling block for women’s/clients’ access to quality clinical reproductive health care, as supported by the quotation below:

**P3/FGD2:** *We agree shortage of staff is a major obstacle in providing quality RHS where women are not allowed to have a say about methods of choice, junior staff without proper RHS skills are sometimes delegated to provide RHS because of shortage of professional nurses…*

According to the participants of this study, adequate staffing has a profound impact on improving patients’ health outcomes, including reproductive health care outcomes. The findings of this study are similar to those of Callaghan, Ford and Schneider (2010:8), who report that sub-Saharan Africa is the region that suffers most crises in shortages of human resources for health, which are intensified by HIV and AIDS pandemic. These authors further state that this has a tremendous negative effect with regard to provision of quality care in the health care platforms. Coetzee et al. (2013:162) comment that a shortage of professional nurses (estimated at 30 000) remains a challenge in the South African health care system, bringing about potential poor quality patient care. The implication is that nurse leaders, managers and educators should prioritise resource management and improvement of conditions of employment so that employees with appropriate knowledge and skills are attracted and retained. These will ensure that the health care environment enables nurses to render quality care (McSherry, Pearce, Grimwood & McSherry, and 2012:8).
In addition, the participants mentioned that the challenges of shortages of staff and highly skilled personnel are further compounded by uneven geographical distribution, fragmented times of providing health care services, scheduled times that do not accommodate working individuals, and social determinants. All of these add as deterrents to equitable distribution of family planning services and further frustrate efforts of health service delivery. One participant uttered the following:

**P12/FGD2**: The timing of providing contraceptive services in some other primary health care facilities is a challenge because such services are provided in the afternoon when the nurses are already tired because it is hectic in these facilities at that time the nurse are tired and play no advocacy at all.

Campo-Engelstein (2012:147) presents a slightly different perspective with regard to limited family planning methods when stating that there are 11 contraceptive methods available for women and only two methods for men, which is a challenge because it leaves women with no choice but to carry the burden of most of consequences of contraceptive use. Though there are 11 available contraceptive methods for women, these are not necessarily all accessible to them. This author adds, in support of the results of this study, that there are various inconveniences and nontrivial burdens acting as deterrents for women to access these methods, ranging from resource shortages, financial burdens, visits to physicians, invasive procedures, dedicating time and energy to contraceptive use, seeking knowledge about contraception and reproduction, and facing social disapproval and probably moral reproach of contraceptive decisions. According to the participants of this study, all these may pose challenges and discourage efforts of assisting women to make choices.

The findings of this study showed that there are enormous challenges (such as staff shortages, overcrowded facilities, shortages of contraceptive methods in public health facilities, lack of privacy during consultation, contraceptive side effects, myths and perceptions, and subordinate positions of women to their spouses) encountered by nurses and women that have a negative effect on support for women to make informed decisions about contraceptive methods. Wittmann-Price and Bhattacharya (2008:441)
caution that exposing women to a lack of resources, tools and suitable environment to achieve their goals interferes with freedom to make choices. Further, it is disempowering, hence there is a need to create a flexible environment which is emancipating to support women in decision-making.

The Wittmann-Price Theory of EDM explains that, for emancipation to be achieved when making health care decisions, it is important that individuals or groups must recognise that oppression exists and that it is dehumanising. Oppression of individuals or groups in any form results in unequal power, which decreases the self-esteem and autonomy of the oppressed and consequently restricts choices. It is of critical importance that, after individuals or groups of people recognise that oppressive or negative forces exist, they should become aware of the types of unequal power or social injustices prevailing within the context where they live. Applied to the context of this study, unequal power would reduce the self-esteem of affected persons (women in this case), with subsequent paralysis of their decision-making ability regarding contraceptive methods they prefer.

Chinn and Kramer (2011:64), who are in agreement with Wittmann-Price (2004:441), also show concern about the importance of emancipatory knowing as the capacity of individuals or groups to be aware of prevailing injustices in their societies and to critically investigate why are these injustices not noticed or not addressed. Chinn and Kramer (2011) and Wittmann-Price (2004) concur that being aware of the feeling or experience of the existence of injustices is essential in order for individuals or groups to understand oppressive forces. According to findings of the present study, the issues surrounding women’s decision-making on contraceptive methods point to the need to conduct research on the whole spectrum of family planning in order to have a holistic approach to near-acceptable contraceptive health care services.

The Wittmann-Price Theory of EDM (Wittmann-Price, 2006:377) emphasises the importance of ensuring that reflection, empowerment, personal knowledge, flexible environment and awareness of social norms are present in women and in the clinical health settings to enhance decision-making. Reflection is referred to as a form of critical
thinking – knowledge acquisition from practical experience. It is highly an interactive process which is promoted by dialogue between nurses and women. This process enables women to consciously engage in considering options in health care (Wittmann-Price, 2004:441).

During focus group discussions with participants, intense dialogue, engagement and self-reflection took place. The participants reflected on their views, opinions and experiences regarding support for women to make informed decisions about contraceptive methods. The information reflected by participants about the phenomenon under study was included by the researcher in the formulation of the guidelines for undergraduate nursing students to support women to make informed decisions about contraceptive methods.

Dialogue, journaling and concept mapping are methods that can be used to enhance reflection (Wittmann-Price, 2004:441). These methods should be used by nurses and lecturers to impart reproductive health care information to undergraduate nursing students and women/clients. Through these interactive methods of teaching, women would be supported to make informed decisions about family planning methods. There will also be a gain of personal knowledge through which women would become aware of available contraceptive methods to choose from. At the same time, undergraduate nursing students' competencies on support for women will be enhanced because they will also become aware of their responsibilities as health care providers. Women will be empowered in order to gain confidence, which will enhance their decision-making. It would also bring awareness that some social norms clash with one's choices. The implication is that nurses should become aware that it is their responsibility to create a non-judgemental environment to encourage women to make health care choices without coercion. Lecturers/preceptors should also take it upon themselves to create teaching and learning environments that stimulate undergraduate nursing students' learning.
4.3.2 Measures to support women to make informed decisions on family planning methods

4.3.2.1 Upgrading nurses’ knowledge and skills on RHS

The participants admitted that nurses’ knowledge and skills on RHS need to be upgraded. They mentioned that nurses, including undergraduate nursing students, lack knowledge and skills on current contraceptive methods and that they need regular in-service education and training on this aspect as more skilled and knowledgeable health professionals would be able to assist women/clients to make informed decisions about family planning methods. There are new family planning methods that are continuously invented, reviewed and introduced at the health facilities, about which they lack knowledge and skills. This is evidenced in the following quotations:

**P8/FGD2:** … we do not know about these services (RHS)… I think knowledge is power. Most of us nurses we lack knowledge on new development on RHS. This is not correct because we should be in a position or be in a manner that we provide information with dignity and respect… and establish good nurse-patient relationship to open up information seeking by clients without reproach by nurses.

**P1/FGD2:** To sum it up we want nurses to be empowered on new developments and be included in all patient care matters because they are always close to the patient…. Nurse empowerment will build their confidence in providing services.

The study findings showed that NEIs are not regularly included in the in-service education programme scheduled for hospital staff affecting both undergraduate and staff development on reproductive health new development issues, among others. This was narrated by the participants as follows:

**P5/FGD2:** In-service training on reproductive services is not done so often…. If they ask me what are the new contraceptives available ….I haven’t seen one of those things…. Nurses must be educated on a new contraceptive methods in the market, the implant really eh!, yes it is a challenge, around here we do not find it and you are also not
informed when women ask you about it you become embarrassed because you cannot advise anybody about it.

4.3.2.2 Provision of support needed by women/clients

According to the participants, another challenge encountered by women at RHS facilities is lack of political support on reproductive health care issues. It is believed that, if there were political commitment and adequate resources on reproductive health care, women would be supported to make informed decisions about family planning methods. The need for political support is consistent with Van Lerberghe et al. (2014:2221), who state that political support gives impetus and continuity to any available current efforts and initiatives on support for women to achieve their reproductive health needs. Visible and empowering leadership, supportive managers, improved interdisciplinary communication, availability of infrastructure such as technology, enabling resources, and organisational arrangements with more positive group environments (elements of group support and collaboration) are also regarded as key efforts towards support for women/clients to make decisions on contraceptive methods.

Political support was also cited by participants as an integral aspect of addressing national reproductive health priorities. Van Lerberghe et al. (2014:1222) point out that one way of attracting political support is to increase provision of health information to civil society, because an informed society may become more critical and vocal about failure to provide adequate health care services, including RHS. These authors further mention that this can become a political liability as civil society becomes more assertive and can expose both politicians and health authorities to the risk of backlash about unsatisfactory service delivery. Lack of political support with regard to provision of reproductive health is confirmed by Allotey et al. (2011:65), who add that it is critical to build capacity and skills to address the political issues raised by sexual and reproductive health and rights. Understanding integration of history, values and politics in addition to technical skills for sexual and reproductive rights is also cited as important in addressing and supporting women on choice of reproductive services (family planning services).
Literature reports also point out that laws and women’s health policies supporting RHS are available globally. Further mentioned in the literature is that government support in other countries is reflected in the funding of institutions to conduct research on sexual and reproductive health and right issues to improve women’s health. Husain et al. (2011:39) support this notion and add that, to improve the health status of women and children, it is crucial to increase women’s literacy levels. However, a need for capacity and skill building to address political issues raised by sexual and reproductive health and rights remains crucial (Allotey et al., 2011:63).

The participants in this study also noted that partner and group support are needed to improve women’s/clients’ capacity to make informed decisions about family planning methods. This was expressed in the following statement:

**P8/FGD2:** Encourage women to engage in group discussion to support one another…. Also do education via the media and at the clinics…. Young people should be welcomed not be chased away.

**P3/FGD2:** Okay I think we must still go an extra mile not focusing on women only, male counterpart should also be involved in these things eh! Complements like real men do not refuse choice of contraceptives… so that male and women also come together in this and one concluded resolution is taken about contraceptives.

**P12/FGD2:** …Also not enough support from their partners, as others hide that they are on contraceptives….

**P5/FGD2:** It is not a matter of being against whites; most farm workers have less access to health services hence a need for political interventions to ensure access to health services to all.

During discussions with the participants on what can be done to improve decision-making with regard to RHS, they stated that availability of group support can impact positively on strengthening women’s/clients’ decision-making capacity. Group support is also supported by De Leeuw and Clavier (2011:ii238), who explain that partner, family
and group support are important in assisting women to make decisions regarding their reproductive health. These authors add the need for development of a healthy public policy to promote reproductive health that will bring awareness to civil society about the importance of supporting women in need of RHS.

Literature and the results of this study have provided evidence that side effects of female contraceptives are perceived by males to disrupt sexual activity; that reproductive health is perceived as a female domain; that there are male concerns that use of contraceptives will lead to extramarital sexual relations; that there is a need to address trust issues between partners, since women have expressed that men cannot be trusted to use contraception and that it is crucial to focus on contraceptive ideology change, i.e., dealing with the belief that contraception is both men’s and women’s responsibility (Campo-Engelstein, 2012:147; Kabagenyi et al., 2014:1). Contraceptive side effects and perceived male concerns with regard to contraceptive use as explained above should be acknowledged and addressed by health care providers in their attempts to assist women to make informed decisions about family planning methods.

The participants indicated that nurses do not conduct home visits as a preventive health intervention strategy with regard to family planning services. They mentioned that women/clients can be supported to make informed decisions through home visits by nurses. During home visits, women could be given individual attention as a household. Furthermore, home visits may also benefit those households with difficulties in accessing reproductive health services. The sentiments were expressed as follows:

**P1/FGD2:** Depending on the availability of resources one of the responsibility of community health nurses is to do home visits, if a women has come to the clinic they have understood everything about family planning and however there is a problem with the spouse the nurse can go as far as doing home visits in order to explain to the spouse the relevance and the important of such…

**P12/FGD2:** Our job as nurses is that we must do a lot of home visits, doing follow up home visit for a child and mother… explain the procedures on baby care and
on family planning for them… what we say that at the same time providing the household with information regarding RHS could have benefit.

The participants viewed undertaking of home visits by nurses as an important aspect in supporting women to make informed decisions about contraceptive methods. Zenzano et al. (2011:56) similarly state that, as a way of providing comprehensive reproductive health and universal health care, rural health centres should conduct regular supervisory visits to households. Van Lerberghe et al. (2014:1218) support the notion of doing home visits by describing that conducting home visits and implementing dedicated village-level health service delivery points are critical health service delivery strategies to improve access to health services.

It is clear that the majority of women do not receive spousal support regarding the use and choice of contraceptive methods. Myths and perceptions about contraceptive methods, including lack of political support, are other hindrances affecting support for women to make decisions about family planning. Family planning services are also not well integrated in the PHC re-engineering health care delivery system packages.

4.3.2.3 Accessibility of RHS

The participants mentioned that family planning services are not accessible to women/clients. They attributed this lack of accessibility to the health system’s failure to provide supermarket approach health care delivery service, as one of the participants said:

**P3/FGD2:** There should not be stipulated date for family planning it should be from day to day visits, if is a CHC it should be on going on all the whole seven days, if it is a PHC clinic it must be from 7-4 so the community should be able to access the services so that there is no pressure such that the person is not confined to say eish! I am working shifts yaah! and then I won’t be able to make it, but they should know that they can come at any time.

The participants further mentioned that it is important for health services to be accessible, non-judgemental, and staffed with sufficiently knowledgeable and skilled
nurses who are able to assist women in making informed decisions. Health services resourced with different methods of contraceptives and creation of privacy during consultation are ideal. Sibiya and Gwele (2013:387) confirm the notion of the need for accessible health services by stating that a comprehensive health care service delivery strategy was introduced in South Africa post-apartheid to ensure availability of a wide range of services available to all people. Sibiya and Gwele (2013:387) mention that health care systems are to promote equity, efficiency, effectiveness and accountability in the delivery of health services. However, Dignam et al. (2012:65), and Reddy, Patel, Jha, Paul, Kumar, Dandona and Lancet India Group for Universal Healthcare (2011:762) report that there is a struggle to provide contemporary quality health care in health service platforms because of increased demand for services within resource constraints.

Literature findings are congruent with the results of this study with regard to the importance of ensuring that health care facilities are accessible through a supermarket health care service delivery approach. Since 1994, equity and access to health care have been regarded as key principles to kick-start the transformation of health services in South Africa. Integrated primary health care (IPHC) was introduced as an approach to deliver the envisaged health services. Although IPHC means different things in different contexts, it is understood as a comprehensive, supermarket approach or one-stop shop. A supermarket approach or one-stop shop is where health services as required by the patients are offered before they leave the clinic, so that they do not have to go elsewhere or be asked to come another day (Sibiya & Gwele, 2013:1). However, evidence recorded in literature and findings of this study shows that it is now 22 years since the democratic government introduced IPHC strategy, yet it is indicated that some health facilities are not able to provide accessible health services.

The participants’ view of the need to afford women access to reproductive health is similar to several researchers who have concluded that appropriate, accessible and acceptable health services are needed to meet women’s needs related to reproductive health. It is also crucial that health professionals embrace the broader issues around reproductive health to enhance their abilities, so that a full range of services can be
offered at all times. It is also widely acknowledged that reproductive health is a comprehensive concept, embracing women’s health from birth to menopause (Do & Kurimoto, 2012:29; WHO, 2011:5).

The undergraduate nursing students in this study indicated that there is a need to conduct further research on family planning in order to identify what works for women/clients, assess promising practices and tracking indicators of success and/or unmet contraceptive needs which can be detected through statistics on number of unintended pregnancies, visits to clinics, mortality rate, abortion rate, as well as reproductive health projects implemented and their impact on improving women’s/clients’ decision-making regarding family planning methods. The participants mentioned that evaluation of provision of family planning services and their impact with regard to improvement of women’s/clients reproductive health is critical. This was evidenced in the following quotation:

**P7/FGD2:** I think if women may know about the whole contraception… if there is some research about contraception side effects and how women can overcome such, also… eh! assess the complications associated with use of contraceptives.

**P4/FGD2:** There will be reduction of unplanned pregnancies …. The attitude of the patient on RHS will be positive…. They will know the contraceptives they are using, their side effects and how to address such will be known by women. The women will also be aware of the other available family planning methods,

**P5/FGD2:** And even on the rate of abortion it shows when it increase it shows that women are not informed about what is happening and when it decrease it shows that women are informed.

**P11/FGD2:** Even the programmes on prevention of HIV, sexual transmitted infections and dual prevention of pregnancy; the success of projects like prevention of mother to child transmission the more the women are participating in family planning services it shows that they have been taught about it or they are aware about it, so it is a way of evaluating impact of services.
The participants’ view on a need to conduct research around the whole contraception concept is consistent with various other researchers who assert that there is a need to conduct more research to (Barot, 2013:1; Campo-Engelstein, 2012:147; Do & Kurimoto, 2012:9):

- understand the mechanism of association between empowerment and contraceptive use;
- answer questions on interactions between empowerment and contraceptive method use;
- understand interaction between empowerment and access to family planning;
- understand couples’ decision-making dynamics against women’s empowerment from the partner’s perspective; and
- research new contraceptive methods that women may find acceptable and new types of male contraceptives.

The findings stipulate that RHS are not readily accessible. It is also speculated that there is not much known about contraceptives for nurses to provide women/clients with information that will enable them to make informed decisions and manage contraceptive side effects. A lack of knowledge of family planning sources and methods is often cited as a key variable in determining contraceptive use and women’s decision-making. Educated women in general are more likely to demand, seek and question service providers, and to adopt a contraceptive method that is ideally suited to them. They are more likely to have knowledge about health care issues, have access to health services and know of contraceptive methods. Gordon et al.’s (2011:5) results revealed that the health clinic and the advice and services supplied by health providers on family planning play a pivotal role in the uptake of contraceptives and women’s decision-making.

4.3.3 Undergraduate nursing programme

4.3.3.1 Teaching reproductive health care practice to undergraduate nursing students

The study revealed that the undergraduate nursing students’ curriculum contains aspects of theoretical and practical components on RHS. The results emphasise that it
is critical to prepare nurses prior to providing RHS for them to be well prepared for their role of supporting women to make informed decisions about family planning methods. The undergraduate nursing students mentioned that their training contains adequate information on reproductive health care. However, they mentioned that they lack knowledge and skills on new family planning methods and that they are not mentored well at the clinical platforms. They also indicated that their curriculum has many things that must be accomplished in a short space of time, which contributes to clinical reproductive health care incompetence with regard to family planning methods on their part because they spend less time on each component. The following was expressed by participants:

**P6/FGD2:** Oh! Is a lot contained in the curriculum, methods of contraception you think eh! available yah! Oh! Is a lot, the definition itself and its effect to the community immediate family concerned and things like that socio-economic status that if you, they practice family planning it will assist in maintaining a good lifestyle…

**P4/FGD2:** The thing about our course is that there is a lot to do in a short period of time….. you are given two weeks in Midwifery… then to Madadeni for Psychiatry… then to other components. However it is also up to individuals to become dedicated and focus on what they want to achieve in order to complete the course…

The undergraduate nursing students, when asked to elaborate on what they really meant when stating that there is a lot in their curriculum, mentioned that there is subject integration, which plays a critical role in preparing them with regard to providing RHS and that they also come across aspects of reproductive health in other subjects as part of their curriculum. They added that Pharmaco-dynamics content also forms part of their curriculum and, through it, they are prepared for aspects of administration of medication, which forms the basis of their family planning knowledge and skills. This was expressed in the following statement:
**P3/FGD2**: Given ehhh! The integration of the subjects that we are studying in class they play a very important role because as you know the contraceptives fall under medication so if you have been well taught regarding the giving of medication the administration such as the right dose, right route, right time, right patient so those also form background and play an important role when it get to carrying of women with reproductive health care needs.

Miller et al. (2013:199) argue that it is critical to include sex and gender topics in the curricula of health professionals to ensure high quality individualised health care to patients seeking reproductive health care.

The need for improved integration of HIV management with reproductive and sexual health services and provision of effective contraception is also supported by country laws and policies, as well as widely documented in literature (Allotey et al., 2011:66; Kaida et al., 2010:10). The participants narrated their views regarding HIV as follows:

**P1/FGD2**: We need to inform the patients about STI and those diseases so that they should not think that contraceptives will prevent such… they will think the family planning is taking HIV away.

**P7/FGD2**: I think more information about dual protection, I mean use of contraceptives and condoms must be made available to the youth. I am saying this because preaching contraceptives only could be interpreted as allowing them to have more sex… they don’t know about the sickness such as sexual transmitted infections… if it does not get mentioned… we forget AIDS is there… and many more diseases are transmitted through sex.

**P7/FGD2**: We need to focus our attention on providing more HIV/AIDS information at schools… the pupils must be told that taking contraceptives does not mean that if they use this method now you will not contact HIV infections. Dual protection must be encouraged as well because it is key in the prevention of HIV infections.
Allotey et al. (2011:65) add their view by stating that multidisciplinary integration of sexual and reproductive health and rights into health professionals’ curricula is essential for the education of future public health leaders as this will prepare them to render quality health care across clients’ lifespan. A literature report also confirms that well-trained midwives are crucial in the delivery of reproductive health care to women (WHO, 2011:6).

This notion is also supported by Hewitt and Cappiello (2015:74), who state that there are essential UPPC competencies that need to be incorporated into the existing nursing curriculum, beyond maternity courses. The authors suggest that, amongst others, these competencies can find expression in community health courses. The mode of delivery for this course would be the PHC re-engineering framework, as this model allows a focus on the specific needs of the vulnerable groupings, the underserved and the general population. This focus also takes care of issues related to health disparities. Hewitt and Cappiello (2015:74) add that the inclusion of professional ethics discussions in the training programmes with regard to, amongst others, UPPC, using case studies to engage students in real-world applications of professional ethics, professional consciousness and respect for women’s decision-making will equip undergraduate nursing students with knowledge and skills to create a positive environment in RHS facilities. The participants in this study shared their views on the importance of teaching students contraceptive health services and on providing nursing care within an ethical code of conduct in the support for women regarding prevention of pregnancy as follows:

**P9/FGD2:** In the curriculum there is training as part of community health…. students are taught all women’s health and should be aware that before the women can engage in sexuality she should be informed about contraceptives in order to prevent unwanted babies as this will also ensure that they engage in sexual activities without fear of pregnancy. Students are taught all the methods of family planning… there is a whole module on reproductive which include extending to PHC facilities for the practical component which students are exposed to.
**P7/FGD2:** Nurses should be adequately prepared on the whole reproductive content and background of giving contraceptives, definition of contraception, different methods, and scientific knowledge on contraceptives, administration of drugs, its effects and side effects.

**P7/FGD2:** There must be dedicated nurses who have the ability to put in practice what they learned on reproductive health care practice. They should be delegated to do family planning the whole day. These nurses should function within the ethics of the profession and observe the acts and omissions… they are to do the right thing, and adhere to the Code of Ethics and conduct themselves as expected, in this way the rights of women will not be violated, eh… like forcing women on family planning methods they do not like.

The study revealed that the suitable level for introduction of reproductive health care content would be second-year level. However, one participant shared that it should be as early as first-year level so that undergraduate nursing students can also be empowered on contraceptive use, protected sex and unplanned pregnancy:

**P11/FGD2:** RHS should be introduced as early as in first year because clients once they see a nurse they want information irrespective of level of study. The information will also empower students and reduce high level of pregnancy seen around the college.

The study noted that reproductive health care content is mainly integrated into the Community Nursing Science, General Nursing Science and Midwifery components, as well as applied in Pharmacology. The undergraduate nursing students in this study indicated that their workbooks contain aspects of family planning which they are expected to complete when allocated to work-integrated learning in the wards and PHC facilities. Furthermore, they expressed that they wish family planning could be done in detail in order to prepare them to provide quality health care to women/clients. This was stated as follows:
P12/FGD2: ... then for practica we are then taken to the local clinics as per allocation whereby when we are in the local clinic at the second year level you get to be delegated to do this family planning in the clinic you are expected to prepare a script on giving health education to the public on family planning its effects, side effects, etc. and you are expected as well to actually to perform the family planning demo... if it is oral contraceptives you show them you educate them if is injectable...

P7/FGD2: We are also taught anatomy and physiology of the reproductive system... function of the systems... in community we do family planning... and midwifery as well, one gets allocated in a RHS unit or one should work in their focus area.... I think we should do those courses in detail to can provide better service.... You find that sister M is good in this service, let them be encourage to specialise in that field.... Work where you are more productive to can provide good service.

Hewitt and Cappiello (2015:74) share the participants’ sentiments by mentioning that reproductive health content should be embedded in community health modules. The PHC re-engineering framework for the health care delivery approach in South Africa can be embraced by educators during undergraduate nursing students' training and education to include professional ethics discussions related to women’s decision-making with regard to RHS.

Miller et al. (2013:3) echo similar sentiments relating to the participants’ view on including reproductive health content in the curricula for health professionals, by suggesting that reproductive health content be included at all levels of the curricula for health care professionals. These authors say that the content can be covered in specific courses such as physiology and pharmacology. Hewitt and Cappiello (2015:70) and Miller et al. (2013:3) concur with the results of this study by explaining that reproductive health content should be included in the curricula of health professionals and further suggest that the content can be embedded into physiology, maternity, anatomy, community health and pharmacology courses. It is also stated in the literature that
health care initiatives are needed at all levels of practice, education and policy to educate and train health professional on sex and gender issues (Wikipedia, n.d.).

In support of the findings of this study, the Wittmann-Price Theory of EDM (Wittmann-Price, 2004:439) proposes that NEIs should implement emancipatory education with the purpose of equalising power between groups, thus creating an environment that permits making choices without coercion. Unequal power in societies produces depression. Oppression is regarded as causing an intellectual, emotional and psychological suppression that develops into a fear of freedom, so that women may feel secure embracing a professional or social opinion because of the presumption that it is superior to their own personal knowledge. The Wittmann-Price Theory of EDM promotes emancipated education to equalise power between health care providers and women/clients for health care choices to be made freely and to allow the creation of a true humanitarian environment.

4.3.3.2 Teaching practices/methods

The undergraduate nursing students in this study indicated that, although lecturers/preceptors are responsible for teaching them reproductive health care, the ward sisters and other members of the health care professionals also contribute in empowering them. The undergraduate nursing students will also continue the cycle and empower women/clients, who will further spread reproductive health information to their households and any community member with whom they interact in regard to that phenomenon. The following was uttered by one participant:

**P1/FGD2:** On who teaches reproductive health... any member of a multidisciplinary health team does the teaching. It is a kind of a cycle because lecturers teach students, students teaches patients, and patients teaches their children. The other health care practitioners continues the cycle of teaching clients during contact with them when need arises. It is also intertwined, but the primary responsibility of teaching the undergraduate nursing students remains with lecturers/preceptors, it also means that if something does not go right with regard to teaching the clients about family planning methods and available
services, the nurse will be hold accountable because she/he is the client’s initial contact as well as a primary source of information.

In support of the participants’ notion above on who teach reproductive health, Dawley, Bloch, Supplee, McKeever and Scherzer (2010:116) mention that lecturers should implement teaching strategies that enhance nursing students’ critical thinking and understanding, as well as provide learning assignments that will prepare them to provide quality health care. Educators and clinicians have the responsibility to provide students with learning exercises that are real and have meaning to them. The exercises can be adapted to the students’ future professional career.

On asking the undergraduate nursing students what teaching methods and activities are used for teaching reproductive health, they mentioned that demonstrations, formal lectures, in-service training, campaigns, awareness programmes and seminars are mainly used as teaching methods and activities to enhance their learning. In the focus group discussion, they had the following to say:

**P6/FGD2:** The nurses in the clinic play a major role in teaching… eh the reproductive services provided and demonstrate how they are administered to the patients.

**P2/FGD2:** Lecturers and health professionals choose what they prefer but a lot more is lecture, self-study and group work.

According to findings recorded by the WHO (2011:17), case studies, problem-based learning, discussions and other kinds of group work, seminar presentation, workshops, projects, keeping of reflective diaries during clinical practice, experiential learning, role play and simulation are other teaching and learning activities that can facilitate acquisition of knowledge and skills. The participants further mentioned that a variety of teaching methods and activities can enhance the teaching of knowledge and skills of reproductive health and enable undergraduate nursing students to acquire the necessary knowledge and clinical nursing competencies. Dimitrios, Labros, Nikolaos, Maria and Athanasios (2013:73) encourage that innovative teaching practices such as
information and communication technologies can also benefit the teaching and learning environment. These authors add that hybrid models of teaching should be accommodated within the education and training environment (Dimitrios et al., 2013:83).

The findings of this study indicated that teaching and learning need to take place in theoretical and clinical settings. Teaching models, video sessions, charts showing condoms and the intra-uterine device in the uterus, workbooks and posters were cited in this study as teaching materials used. This was indicated by participants as follows:

**P5/FGD2:** Commonly used are posters and ah! Another one that students used is role play because with role play they can learn in a funny way how to go about…

**P6/FGD2:** Pamphlets are also issued…. The school health nurse can also use these when doing school health services; the youth can benefit from this as well as well as use of magazines on RHS…

**P12/FGD2:** The workbooks for Community Nursing Science and Midwifery have aspects of RHS and students are to do practical and complete such.

**P9/FGD2:** We have guides from the department…. Stating that we must not force the patient for services they do not want and may have harmful effects to their body…

Similar to this study, the WHO (2011:17) found that educational aids such as videos, computers, internet connectivity, audio-visuals, models and charts are other important assets to the teaching and learning environments that are used by educators. Case studies in real and virtual work environments, interactive television for tele-education, video play and computer programs such as Microsoft PowerPoint should also be used when facilitating student learning (Dimitrios et al., 2013:75).

The participants' responses on the question of strategies used to assess students' learning indicated that most commonly used are questionnaires, written tests and examinations, practical assessments in the form of direct observations, OSCE and
demonstration feedback on real patients and simulated teaching aids. Participants stated the following:

**P1/FGD2:** We are evaluated in various ways, like tests, completion of workbooks, feedback demonstrations.

**P12/FGD2:** Sometimes after eh! Presentation you can have a questionnaire to see if there was understanding of what you were teaching just ask questions random questions about what you were teaching then the client will tell you what they heard or understood.

**P7/FGD2:** And also the preparation of that presentation is important that is why you must have a copy handwritten because that professional nurse that is evaluating she can see a can know you where you got the information from and whether is right kind of information…

**P11/FGD2:** … and our final examination we are exposed to written examinations, OSCEs and comprehensive evaluations… eh, and you get to write for all you learnt the whole year.

Levett-Jones et al. (2011:64) resonate with the above statements by stating that OSCE and structured observation and assessment of practice are amongst techniques used to assess nursing students at the clinical facilities. Direct observation in real-life situations, use of product items (portfolios and projects), written examinations, clinical simulations and demonstrations are amongst assessment methods recorded in the literature. However, using multiple approaches and methods for evaluation is preferred and emphasised as a means to assess student competencies (WHO, 2011:18). The Wittmann-Price Theory of EDM (Wittmann-Price & Bhattacharya, 2008:228) bids institutions of education to be the starting point of emancipated societies through student empowerment in order to support women’s decision-making. Williams (2006:2) supports the Wittmann-Price Theory of EDM by encouraging lecturers to use case-based methods of teaching in clinical practice, which includes real clinical scenarios that introduce students to a patient with a clinical crisis to reinforce student empowerment.
and learning through critical reflection. Lecturers can create virtual learning families who have pre-designated medical and social histories, and specific physiological parameters within these histories. The same scenarios can be created for assessment of students. Podcast learning material can be offered to students as a reinforcing learning tool for students to develop their capacity with regard to support for women (Williams, 2006:2).

Based on the study findings, the researcher derived that some lecturers/preceptors do not identify appropriate teaching materials which are relevant to ensure that reproductive health care competencies are acquired by undergraduate nursing students by the end of the programme. However, workbooks, pamphlets, charts, videos, role play materials, models, posters and magazines on reproductive health were found to be amongst the teaching materials utilised during facilitation of learning. Wittmann-Price (2006:377) advises that reflection must be present in clinical settings to enhance women’s decision-making. Slavich and Zimbardo (2012:572) propose that students should be exposed to learning approaches that are consistent with reflective and transformational learning, such as active, experiential, collaborative and problem-based learning. These methods should be used by nurses and lecturers to impart reproductive health care information to undergraduate nursing students and women/clients. Through these interactive methods of teaching, women would be supported to make informed decisions about family planning methods. There will also be a gain of personal knowledge through which women would become aware of available contraceptive methods to choose from.

4.4 CONCLUDING REMARKS

In this chapter, the findings of the study from the two groups of participants, namely, lecturers/preceptors and undergraduate nursing students were discussed. There were no significant differences deduced from the overall findings of this study between the two groups of participants. Identified themes, categories and sub-categories that emerged out of the data collected from the lecturers/preceptors and undergraduate nursing students were described, discussed, and compared with literature to ascertain their relevancy for inclusion in the formulation of the guidelines. Literature was cited to
support or to refute the research findings. According to the researcher, the findings from both the participants and literature control complement each other with regard to the importance of supporting women/clients to make informed decisions about family planning methods.

The key findings of the study discussed in this chapter were used as the basis of the guidelines developed in Chapter 5. The study findings described the views and opinions of lecturers/preceptors and undergraduate nursing students on support for women to make informed decisions about family planning methods according to three themes that emerged during focus group discussions, namely, RHS offered to women by nurses, measures to support women to make informed decisions on RHS, and the undergraduate nursing programme. The themes, categories and sub-categories for aiding in the process of formulation of guidelines were derived through data analysis, synthesis, and inductive and deductive strategies, and were grouped according to the two groups of participants. Support for women to make informed decisions was discussed under the themes and corroborated in the categories and sub-categories. The link between the findings of this study and the Wittmann-Price theory of EDM was also described. The development of guidelines is dealt with in Chapter 5.
CHAPTER 5:
DEVELOPMENT OF GUIDELINES FOR UNDERGRADUATE NURSING STUDENTS
TO SUPPORT WOMEN TO MAKE INFORMED DECISIONS ABOUT FAMILY
PLANNING METHODS

5.1 INTRODUCTION

Chapter 4 dealt with the discussion of the findings as well as literature used to control the findings of this study. The focus of this chapter is to develop, describe and evaluate guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods. Guidelines are vitally important as they provide a way to support effective clinical practice, a framework against which care can be evaluated and a way to support effective clinical practice. They also have a role in supporting quality assurance, audit and research. The format of guidelines is selected with their use and the target audience in mind (Duff et al., 1996, cited in Miller & Kearney, 2004:814). In this study, the guideline format was chosen to improve family planning practice with women/clients as the target audience in mind. Guidelines form part of an aspect of knowledge and add up to theory development with its foundation in research in a particular field (Scottish Intercollegiate Guidelines Network (SIGN), 2011:2; WHO, 2012:2), hence the guidelines for this current study form part of knowledge development with its primary aim being to promote quality family planning practices.

5.2 DEVELOPMENT OF THE GUIDELINES

The guidelines were developed from the findings of the study as presented and discussed in Chapters 3 and 4 respectively, field and reflective journal notes, as well as from the literature review and literature used to control the findings of this study.

In this study, the EBGD (Faggion, 2013:125) NICE (2014:4) processes of guideline development were adapted, modified and merged into four steps that were followed as a frame of reference in the development and refinement of the current guidelines. The four steps are depicted in Figure 5.1 below.
The Witmann-Price Theory of EDM was used as a theoretical framework to direct the development of the guidelines in this study (Wittmann-Price, 2004:441, and 2006:378). Polit and Beck (2012:128) state that a theoretical framework is made up of abstract generalisations that provide a systematic explanation of how the constructs of a phenomenon under study are interrelated. Furthermore, it is regarded as an abstract and a logical structure of meaning which directs the development of a study. It also enables the researcher to link findings to the body of knowledge in nursing (Burns & Grove, 2009:126).

The findings of this study revealed that the majority of women/clients are still challenged by societal barriers that disable them to make decisions about family planning methods. There were mutual sentiments amongst participants that health care providers are not supporting women to make informed decisions because they lack adequate knowledge and skills on contraceptive methods, especially new contraceptives. Culturally, women are expected to abide by the rules of their societies, which frequently clash with the modern trends of living. It is therefore critical that these women be supported to deal with these challenges from an informed point of view.
Wittmann-Price (2006:377) formulated health care frameworks to help women in making decisions about their health care. It is through these frameworks that Wittmann-Price (2006:437) was able to formulate and explain the concept of *emancipation* for the enhancement of women decision-making about their health care. Wittmann-Price (2004, 2006) states that critical attributes must be present in the clinical settings of women's/clients' health care for emancipation in decision-making to take place, namely, social awareness, flexible environment, empowerment, personal knowledge and reflection. “Emancipate” is defined as “free from restraint, control or power from another or free from any controlling influence” (Merriam-Webster, 2017b). “Emancipate” is also defined as free from legal, social or political restrictions (South African Oxford Pocket Dictionary, 2011:287).

The participants in this study raised the issue of awareness and empowerment which should be intensified in order for women to make informed decisions about family planning methods. The study findings revealed that women should be supported to make informed decisions free from any form of pressure. Chinn and Kramer (2011:2) support the essence of knowledge in nursing by stating that nurses need to consciously consider what they need to know in order to be effective nurses, as well as to think about the value of what they need to know.

Chinn and Kramer (2011:2) made use of the “fundamental patterns of knowing” outlined by Carper in knowledge development in nursing. They admitted that nursing could be more effective by incorporating Carper’s five patterns of knowing as a basis for the value of diverse forms of knowledge and knowing in nursing, namely, empiric, personal, ethical, aesthetic and emancipatory. Chinn and Kramer's (2011:2) pattern of knowing concentrates on developing an awareness of social challenges and taking action towards creation of social change. They furthermore state that, through the integration of these patterns of knowing, individuals could recognise the social-political inequalities deeply rooted in various situations within societies and change them for the better (Chinn & Kramer, 2011:64). Hence, the development of the guidelines for undergraduate nursing students in this study is an effort to strengthen nurses’ knowledge base. It is through knowledge that nurses and women/clients could identify
inequalities and injustices, which are viewed and experienced as circumstances hindering the process of making informed decisions about aspects of health care, in any given circumstances.

5.3 DEVELOPMENT OF DRAFT GUIDELINES FOR UNDERGRADUATE NURSING STUDENTS TO SUPPORT WOMEN TO MAKE INFORMED DECISIONS ABOUT FAMILY PLANNING METHODS

The draft guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods were developed by the researcher based on the findings outlined in Chapter 3, the discussion of the findings of phase one of this study presented in Chapter 4, the literature review outlined in Chapter 1, field and reflective journal notes recorded at the time of data collection, as well as the literature used to control the findings of the study.

The summary of how the guidelines were developed is as follows:

1. Views and opinions of lecturers/preceptors and undergraduate nursing students on support for women to make informed decisions about family planning methods were explored in phase one of this study.

2. The findings from the data collected through focus group discussions were described and presented to indicate the significance. Categories of the views and opinions of participants on support for women to make informed decisions were indicated.

3. Logical reasoning was incorporated in the development of the guidelines, as explained in Chapter 2 of this study. According to Polit and Beck (2008:13), logical reasoning pools together experiences, intellectual faculties and formal systems of thought in solving existing challenges. Inductive and deductive reasoning are two such systems included in logical reasoning. The researcher utilised inductive reasoning to come up with conclusions from phase one. These were summarised and combined to form concluding statements under each theme. Recommendations were developed from relevant literature and from the concluding statements.
4. An extensive literature review was conducted to develop a more inclusive and in-depth understanding of the consolidated categories, which were then discussed in Chapter 4.

5. Draft guidelines were developed based on the discussion of findings in Chapter 4, the in-depth review of the literature and literature used to control the findings.

6. The Wittmann-Price Theory of EDM in women’s health care was also used to direct the development of the guidelines.

7. The EBGD (Faggion, 2013:125) and NICE (2014:4) processes were adapted, modified and merged into four steps and used as a frame of reference in the guidelines development process.

5.3.1 Types of guidelines

The following types of guidelines are outlined by the WHO (2012:5) and NICE (2014:4): rapid advice, standard, full, clinical, public health, medicine practice, social care and safe staffing guidelines. Clinical guidelines recommend how health care practitioners should care for users of health care facilities with specific conditions and are therefore relevant to this study. However, explanation of the other types of guidelines is not done here as they have no relevance to this study.

5.3.2 Purpose for guidelines

Guidelines enable practitioners to justify their practices and legitimise their activities, as well as to work collaboratively with other health care professionals in the provision of health care services to health care users. They are tools that can be used for improving the quality of care. They have the potential to ensure the clinical application of research findings and enable a profession to reject ineffective practices while employing those shown to work (SIGN, 2011:2).

5.3.3 National Institute for Health and Clinical Excellence and Evidence-Based Guidelines Development processes

EBGD and NICE guideline development processes were adapted, modified, merged and followed in the development of the current guidelines (Faggion, 2013:125; NICE,
The choice was based on the strong similarity of the key elements of development processes of guidelines between the EBGD and NICE manuals for guideline development. The processes were also preferred because they are underpinned by the following guiding key principles for development of guidelines:

- basing recommendations on participants’ involvement and available best practice evidence;
- ensuring that guidelines are reliable and credible; and
- ensuring that the guidelines meet the criteria for high quality clinical practice guidelines as measured by the use of the six-domain structure of the AGREE instrument, namely, scope and purpose, participants involvement, rigour of development, clarity and presentation, applicability, and editorial independence.

The AGREE grid is said to currently be considered the international standard that is used to evaluate quality of clinical practice guidelines (Faggion, 2013:127; Fevers et al., 2010:346). A brief explanation of the domains that address the quality of guidelines and can be used by future guidelines reviewers to assess whether the guidelines meet the standard set is given below.

5.3.3.1 Scope and purpose

This domain is about describing the overall aim of the guidelines, the clinical questions to be addressed by the guidelines and specifying the target population for which the guidelines will apply (SIGN, 2011:1). The aim of these current guidelines is to provide direction on how to support women/clients to make informed decisions about family planning methods. Undergraduate nursing students, lecturers/preceptors and other health care professionals involved in mentoring of undergraduate nursing students and in the provision of family planning services will use the guidelines to support women to make decisions about family planning methods.

5.3.3.2 Participants’ involvement

The group identified for guideline development should include all individuals from the professional groups relevant to the phenomenon under study. In this study, heads of
Midwifery and Community Nursing Science, heads of the clinical facilities for placement of undergraduate nursing students in Ehlanzeni and Nkangala districts, and senior lecturers/preceptors for reproductive health care theory and clinical practice participated in the development and evaluation of the guidelines. The head of Clinical Nursing Science, Health Assessment, Treatment and Care (PHC) provided technical support to the researcher during data collection and in guidelines evaluation.

Participants’ views and inputs on empowerment of women to make informed decisions about family planning methods should be the focus of the guidelines (SIGN, 2011:1). The guidelines for this study were based on the data gathered from lecturers/preceptors and undergraduate nursing students, and the focus of the guidelines is on empowerment of women to make informed decisions about family planning methods by the intended users, who are lecturers/preceptors, undergraduate nursing students, and other health care providers who are involved in the provision of family planning services.

Experienced participants as mentioned above contributed to the development of the guidelines through focus group discussions and were also involved in the validation of the draft guidelines. The draft was emailed and/or hand-delivered to them once compiled. The literature review done in Chapter 1 of this study, literature used to control the findings of this study, discussion of findings in Chapter 4, and field and reflective journal notes also informed guideline development, based on evidence-based reports about support for women to make informed decisions about their health care issues.

5.3.3.3 Rigour of development

This domain focuses on the following aspects about the guidelines (SIGN, 2011:1):

- explicit linkage between the recommendations and the supporting evidence;
- use of systematic methods applied to search for evidence;
- clearly described evidence selection criteria and clearly described methods used;
- side effects;
- risk in the development of recommendations;
- review of guidelines by experts/stakeholders before publication; and
• the provision of a protocol for updating the guidelines.

A literature control was undertaken in this study to locate evidence that supports the guidelines. This was done after collecting and analysing data from lecturers/preceptors and undergraduate nursing students on their views and opinions on support for women to make informed decisions about family planning methods. Table 5.1 is provided to evaluate whether these current guidelines are reliable and credible and meet the criteria for high clinical practice guidelines. The process of guideline development documented in literature may also be used in the future for regular review and incorporation of new evidence if need be.

5.3.3.4 Clarity and presentation

The format and language used in the guidelines is simple, unambiguous and easy to follow. The guidelines adhered to the guiding principle for development of good guidelines (SIGN, 2011:2).

5.3.3.5 Applicability

Applicability involves the following (SIGN, 2011:1):

• clearly defining target users of the guidelines;
• discussing potential organisational barriers in applying the guidelines;
• considering potential costs implications in applying the guidelines;
• providing recommendations of tools for application of the guidelines provided; and
• presenting key review criteria present for monitoring and auditing purposes.

The determination of costs implications and organisational barriers will be possible when the guidelines are implemented. The guidelines were developed for undergraduate nursing students and are regarded as applicable because they are based on research findings from the target population of lecturers/preceptors and undergraduate nursing students.
5.3.3.6 Editorial independence

Conflict of interest of members involved in the development of guidelines should be noted and documented, and use of participants should ensure editorial independence of the guidelines. All participants who are members of the guideline development group should sign a declaration of interest.

The researcher should refrain from having any interest in the nature of the outcome of the guideline development activities. The researcher in this study declares that no personal gain was bestowed in the nature of the outcome of the guideline development process. The involvement of participants in the guidelines development and refinement processes also intensifies the editorial independence of the developed guidelines.

The six domain aspects presented above could be used by future guideline reviewers to assess whether the guidelines meet the quality practice standard. Table 5.1 presents a summary of how the above-stated domains have been applied to this study.
Table 5.1: Six domains structure and application of guidelines for quality practice

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>APPLICATION OF DOMAINS TO CURRENT STUDY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope and purpose</td>
<td>• To provide direction on how to support women to make informed decisions about family planning methods.</td>
</tr>
</tbody>
</table>
| Participants’ involvement | • Data were collected from lecturers/preceptors and undergraduate nursing students.  
  • Undergraduate nursing students and lecturers/preceptors involved in teaching of undergraduate nursing students and women and provision of reproductive health care (family planning services) participated in the development of the guidelines. |
| Rigour                  | • Data were obtained through focus group discussions.  
  • An in-depth literature review (in this study literature control) was conducted.  
  • Developed guidelines were evaluated and refined by lecturers/preceptors involved in the teaching of undergraduate nursing students and women/clients and provision of reproductive health care (family planning services). |
| Clarity of presentation | • The format and language used in the guidelines is simple, unambiguous and easy to follow.                                                                                                                                             |
| Applicability           | • Guidelines will be appropriately used by undergraduate nursing students (who are also the target population) to emancipate women(clients) to make informed decisions about their health issues.  
  • The developed guidelines for undergraduate nursing students are based on research findings from the target population of lecturers/preceptors and undergraduate nursing students.  
  • Guidelines provide advice on how recommendations can be put into practice. |
| Editorial independence  | • The use of participants supported editorial independence.  
  • Participants’ first comments were compiled and sent back for validation to justify that the views of the researcher had no influence to the content of the guidelines.  
  • Competing interests of guideline development participants were identified, recorded and addressed. |

The researcher modified, adapted and merged the EBGD and NICE guideline development processes into four major steps, namely, preparing for the development of guidelines, systemic review, drafting of guidelines and compiling of guideline recommendations based on participants’ comments. The steps followed in the development of the current guidelines depicted in Figure 5.1 ensured that development of the guidelines was based on the findings of the study, literature review, field and reflective journal notes, and literature used to control the findings of this study.
Fundamental aspects identified to be included in the guidelines are described below. The NICE (2014:5) process further indicates that the draft guidelines should be developed by the researcher and validated by participants. The guideline development steps depicted in Figure 5.1 were sequentially followed and are discussed in the sections that follow.

5.3.4 Step one: Preparation for the development of guidelines

This step consists of choosing guideline topics, selecting participants, conducting an audit of the baseline data from the current study findings and literature review, literature control, and identifying fundamental areas for inclusion in the guidelines.

5.3.4.1 Choosing guideline topics

The topics for guidelines should come from the impact they will have on practice: areas of interest with high a volume of cases, high risk management and high costs. They are usually derived from a variety of factors, namely (Fevers et al., 2010:345; Kish, 2001:851; NICE, 2007:6, 2014:11):

- divergent practices;
- importance in terms of public health;
- incidence and number of patients potentially concerned;
- mortality and number of deaths potentially avoided;
- proven efficacy in terms of evidence based on situations;
- needs expressed by all involved; and
- interventions or practices that might have significant impact on:
  - improving patients' or carers' quality of life
  - reducing inequalities in health;
  - financial or other resources on the health care system;
  - assisting with reduction or avoiding inappropriate clinical practice; and
  - variation in clinical practice and variation in access or treatment.
The researcher and the two supervisors were involved in the choice of guideline topics which relate to interventions that could significantly improve women’s/clients’ quality of life, reduce inequalities in health care, and avoid inappropriate clinical practice and variation in clinical practice and in access to RHS. The decision was made after the researcher and the two supervisors were convinced that there were no written guidelines available to be used by the undergraduate nursing students to support women to make informed decisions about family planning methods.

The choice of topic was also informed by, amongst others, views of a group of fourth-year Bachelor of Nursing Science students at a university in Gauteng, South Africa, with whom the researcher interacted on areas of reproductive health practice which are not well covered in their training, to enable them to deliver family planning services with confidence. This group of students highlighted that family planning is an area that needs to be focused on in order to empower them for their role of supporting women/clients to make decisions about reproductive health care (specifically, family planning services). According to this group of students, religious and cultural aspects, lack of understanding, men’s refusal to use condoms, nurses’ and women’s (clients’) knowledge and skills gaps with regard to new contraceptives, and lack of spousal involvement, amongst others, negatively affect women’s ability to make decisions on the services they prefer at reproductive health care facilities. The protocol for this study was also approved by SREC and MREC. Hence, the topic “Development of guidelines for undergraduate nursing students to support women to make informed decision about family planning methods” was pursued.

5.3.4.2 Choosing participants for the development of guidelines

The term “participants” in the development of guidelines for this study refers to a sufficiently broad range of heads of subjects and senior lecturers/preceptors to adequately explore the topic under study. Participants usually possess unique insight into guideline-relevant content domains. The ideal number of participants is six to 10 members. Participants should be drawn from members of related disciplines and relevant professional societies who can work towards consensus in the validation of
guidelines based on their insight on the topic under study (Fevers et al., 2010:343). According to the WHO (2012:21), participants should be a multidisciplinary group who are balanced in terms of gender and geography, and who come from regions likely to use the guidelines. The ideal group size is eight to 12. The participants should have topic-specific expertise, be implementers of the guidelines, such as programme managers and health professionals, and representatives of groups most affected by the guidelines, such as patients.

The current guidelines were developed by the researcher, and validated by the same participants who participated in the main study, as follows: heads for PHC, Midwifery and Community Nursing Science, heads of accredited clinical facilities for placement of undergraduate nursing students, and senior lecturers/preceptors involved in teaching reproductive health care practices to undergraduate nursing students and offering reproductive health services to women and undergraduate nursing students. The researcher facilitated the validation of the guidelines and added the technical knowledge in most aspects that needed to be addressed. The lecturers/preceptors and undergraduate nursing students who participated in this study were, respectively, involved with education and training of undergraduate nursing students reproductive health care and enrolled undergraduate nursing students, and were assumed to be knowledgeable and conversant with reproductive health care, including family planning services, as well as involved with the provision of reproductive health care to women/clients.

The researcher selected a minimum of 12 participants as follows: three heads of subjects/components (PHC, Midwifery and Community Nursing Science), two heads of clinical facilities accredited for placement of undergraduate nursing students, four senior lecturer/preceptors, and three undergraduate nursing students. It was a purposive sample which was selected based on work experience with regard to teaching undergraduate nursing students in class and in clinical practice, as well as level of involvement with regard to provision of reproductive health care to women/clients. Recruitment for participants was through meetings. As explained in Chapter 1 of this study, telephone conversations were followed by one-on-one discussion with heads of
components and senior lecturers/preceptors. The researcher requested the expertise of the assistant who was providing support at the time of data collection to assist with technical support with regard to guidelines development. The team involved in validation of guidelines included:

- head and coordinator of Clinical Nursing Science, Health Assessment, Treatment and Care (PHC) education and training, who provided technical support in the refinement of the guidelines because of her experience in guideline development;
- head of Community Nursing Science;
- head of Midwifery;
- two heads of accredited clinical facilities where undergraduate nursing students are placed for clinical learning experience;
- two senior theory lecturers teaching Midwifery and Community Nursing Science respectively; and
- two senior lecturers/preceptors teaching undergraduate nursing students in clinical practice.
- Three undergraduate nursing students.

The descriptive information of the members of participants/stakeholders is summarised in Table 5.2 below.
Table 5.2: Summary of descriptive information of participants

<table>
<thead>
<tr>
<th>NO.</th>
<th>OCCUPATION</th>
<th>QUALIFICATIONS</th>
<th>EXPERIENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Head of PHC component/coordinator for PHC nurse training</td>
<td>PhD</td>
<td>Theoretical and clinical teaching of nurses in the PHC facilities for 11 years, experience in guidelines development and programme management. Coordinator and manager for PHC since 2008 and involved with activities in the communities for the success of the programme. Involved with supervising university students in research.</td>
</tr>
<tr>
<td>2</td>
<td>Head of Midwifery component</td>
<td>Master’s degree in Public Health Advanced Diploma in Midwifery and Neonatal Care</td>
<td>Sixteen years’ experience in teaching: 10 years teaching Community Nursing Science and six year teaching Midwifery. Head of department for Midwifery. Eleven years’ experience as head of department for this component.</td>
</tr>
<tr>
<td>3</td>
<td>Head of Community Nursing Science</td>
<td>Bachelor’s degree in Nursing Education and Community Nursing Science</td>
<td>Ten years’ experience teaching Community Nursing Science.</td>
</tr>
<tr>
<td>4</td>
<td>Head of clinical facility in Gert Sibande District, Mpumalanga</td>
<td>Master’s degree in nursing science Bachelor’s degree in Nursing Education and Community Nursing Science</td>
<td>Ten years’ experience as a Midwifery lecturer and as a head of a clinical facility.</td>
</tr>
<tr>
<td>5</td>
<td>Head of clinical facility in Ehlanzeni District, Mpumalanga</td>
<td>Bachelor’s degree in Education and Community Nursing Science</td>
<td>Eleven years as Community Nursing Science lecturers and as head of a clinical facility.</td>
</tr>
<tr>
<td>6</td>
<td>Senior lecturer</td>
<td>Bachelor’s degree in Nursing Education and Community Nursing Science Advanced Diploma in Midwifery and Neonatal Care</td>
<td>Nine years’ experience as a lecturer in Midwifery.</td>
</tr>
<tr>
<td>7</td>
<td>Senior lecturer</td>
<td>Bachelor’s degree in Nursing Education and Community Nursing Science</td>
<td>Eight years’ experience teaching General Nursing Science.</td>
</tr>
<tr>
<td>8</td>
<td>Senior lecturer/preceptor</td>
<td>Master’s degree in Nursing Science Bachelor’s degree in Nursing Education and Community Nursing Science</td>
<td>Eleven years’ experience as a clinical preceptor for undergraduate nursing students following a four-year nursing programme.</td>
</tr>
<tr>
<td>9</td>
<td>Senior lecturer/preceptor</td>
<td>Bachelor’s degree in Nursing Education and Nursing Administration Advanced Diploma in Midwifery and Neonatal care</td>
<td>Ten years’ experience as a clinical preceptor for a four-year nursing programme.</td>
</tr>
<tr>
<td>10</td>
<td>One undergraduate nursing student</td>
<td></td>
<td>Third-year level of study – seven months into this level. Had attended two theory blocks.</td>
</tr>
<tr>
<td>11 &amp; 12</td>
<td>Two undergraduate nursing students</td>
<td></td>
<td>Fourth-year level of study – eight months into this level. Had attended three theory blocks.</td>
</tr>
</tbody>
</table>
5.3.4.3 Conduct audit of baseline data to provide backdrop to guideline development

The South African Department of Health developed the National Contraception and Fertility Planning Policy and Service Delivery Guidelines, as well as national contraception clinical guidelines in 2012. In these guidelines, the Department of Health committed to and/or recommended the implementation of a number of strategies to reduce maternal and neonatal mortality rates. The strategies included increasing the availability of contraception in all facilities for all individuals requiring it, in order to improve access to contraceptive services. A further commitment by the Department of Health was to increase access to contraceptive services to 90% by 2013. South Africa committed its efforts towards the attainment of the MDGs, focusing on reduction of maternal and neonatal deaths. Efforts were also directed at the attainment of universal access to reproductive health, promoting women’s reproductive rights and improving access to voluntary contraception (South Africa, 2012:14). The MDGs were not achieved by the targeted 2015 and have thus been replaced by SDGs 3 and 10, which focus on good health and well-being, and reduced inequality (Barbier & Burgess, 2017:7).

In addition to the above, the Department of Health adopted a sexual and reproductive health and rights framework in 2012 from which the policies and guidelines for contraception and fertility planning are framed. It is within these policies and guidelines that the guiding principles, objectives and key recommendations are outlined for health care service delivery facilities in South Africa with regard to provision of contraception services (South Africa, 2012:23). However, there are no guidelines for undergraduate nursing students, who are the future nurses, to support women to make informed decisions about family planning methods. Principles, objectives, strategies and recommendations that strengthen the topic under study provided a backdrop to the development of the guidelines in order to ensure that the developed guidelines are in line with the country’s reproductive health care practices and that undergraduate nursing students are adequately prepared to support women/clients to make informed decisions about family planning methods.
In principle, the Department of Health (South Africa, 2012:23) gives direction that there should be strong and visible stewardship for sexual and reproductive health and rights, as well as integrated service delivery which meets the diverse needs of the population and a rights-based approach to contraception and fertility planning in all health care facilities. It is also crucial that a rights-based approach (which is backed up by the principle of informed voluntary contraception, people’s rights to exercise their reproductive choices, confidentiality and privacy, contraceptive choice, informed decision, and shared responsibility) is reflected in all aspects of service delivery of South African health care facilities.

The goal of the National Contraception Policy and Fertility Planning Policy and Service Delivery Guidelines is to ensure availability and accessibility of comprehensive quality contraception and fertility management services in all health care facilities for all people in South Africa (South Africa, 2012:43). One of its objectives is training and capacity building of health care providers, which will ensure that they have knowledge, good attitudes and skills to provide holistic, quality contraceptive and fertility planning services according to their scope of practice and the level of health care.

Although a contraception policy and guidelines on how to provide comprehensive quality contraception and fertility planning exist, there is no guide provided for undergraduate nursing students, who are the future health care service providers in the health care facility platforms, to enable them to support women/clients to make informed decisions about family planning methods. Hence, the researcher set out to conduct this study on the development of guidelines for undergraduate nursing students to support women/clients to make informed decisions about family planning methods. The undergraduate nursing students’ guidelines will be an essential tool to ensure that the students are competent in the provision of quality clinical reproductive health care, thus meeting the set goal of provision of comprehensive quality contraception.

In addition, there are still societal concerns of reproductive health care service failure in South Africa, as measured by an alarming number of unintended pregnancies amongst teenagers and women of childbearing age. The concern surfaced during an interview
with the Minister of Health in South Africa, where his response, amongst others, was that family planning is a societal issue, stating that men are still not supporting family planning practices and that he is still approached by angry men blaming their impotence on contraceptive methods used by their wives (Mabuse, 2017).

This study disclosed that the majority of nurses are not aware of new contraceptive methods, exposing women/clients to unknowledgeable and unskilled health care providers who are unable to support them to make informed decisions about family planning methods. According to Bitzer et al. (2012:74) and Do and Kurimoto (2012:2), evidence demonstrates that comprehensive contraceptive counselling enables women to select methods based on informed decisions, yet a gap exists in this regard. The need to build health service providers’ capacity to prepare them to support women so that they become aware of their rights and are empowered enough to exercise these rights with regard to choice of family planning methods was declared by both the participants of this study and the above authors (Bitzer et al., 2012:74; Do & Kurimoto, 2012:2).

Bitzer et al. (2012:74), Do and Kurimoto (2012:2), and the findings of this study provide convincing evidence that provision of structured contraceptive information and counselling encourages women to select contraception that they prefer and to choose contraceptive methods which match their needs and lifestyle. Information used for literature control in this study shows that intervention programmes aimed at providing quality contraception may require the involvement of different approaches, such as promoting couples’ discussion of fertility preferences and family planning, as well as improving women’s self-efficacy in negotiating sexual activity (Do & Kurimoto, 2012:31). All these can be made possible through training and capacity building of health care providers.

Adamczyk and Greif (2010:656), Allotey et al., (2011:66), and the findings of this study reiterate that it is critical to educate tomorrow’s public health leaders on sexual and reproductive health care. Education should also focus on political, economic, cultural and social issues that impact negatively on women’s ability to make decisions about
family planning. It is also critical to build capacity and skills of future public health leaders in order to address the political issues related to sexual and reproductive health and rights. Equally important is achievement of equitable universal health coverage, which requires provision of needs-based, accessible services for the entire population, regardless of who or where they are, or their ability to pay.

Adamczyk and Greif (2010:658) concur with the study findings as they report that there is evidence of unequal power dynamics in relationships and social norms in sub-Saharan Africa, placing women’s sexual health at risk. They further mention that the majority of women are in a submissive position with men, which weakens their power to have open communication about family planning methods with their spouses. The studies and literature reveal that better educated women are more likely to choose family planning methods that they prefer.

The findings of this study in general disclosed that there is inadequate access to knowledgeable and skilled nurses who can provide quality family planning services. There is also a lack of resources, as well as a lack of therapeutic relationships between women/clients seeking family planning services and nurses. Participants indicated that nurses display bad attitudes, confidential matters are not treated as such, and nurses are rude. The issue of lack of political, spousal and community support for women, coupled with cultural norms, was cited as affecting women’s ability to make decisions about family planning methods. It was further revealed that information given to women/clients is insufficient and hardly covers side effects of contraceptives.

The results of the study further showed that undergraduate nursing students, nurses and other providers of health care need support in the form of mentoring, education and resources, in order to empower women/clients and communities about sexual and reproductive health and rights. The empowered undergraduate nursing students who will become the future of health facilities can be in a position to support women/clients to make informed decisions about family planning methods. NEIs play a very important role with regard to increased provision of quality family planning services by undergraduate nursing students who are future nurses. Undergraduate nursing students
are empowered with the knowledge and skills of family planning to enable them to assist women/clients to make informed decisions competently within the practice of reproductive health care. The results of this study and literature findings further recommend that it should be the lecturers’/preceptors’ primary responsibility to provide undergraduate nursing students with education in order to prepare them for quality reproductive health care delivery, hence the need for the development of guidelines for undergraduate nursing students. The results of this study were also shared with participants/stakeholders for refinement of the guidelines prior to finalisation.

In short, this study argues that professional nurses with the necessary knowledge and skills on women’s empowerment are needed in a mutual intervention with clients seeking information in that field. The need to strengthen reproductive health strategies is widely accepted by many (Jewkes et al., 2009:675; Lorentziaan, 2011:1; South Africa, 2007:12), including the approach of active participation and involvement of women and families, and empowerment of communities in improving access to health, thus reducing teenage pregnancy (Jewkes et al., 2009:676). Households, communities and professional nurses were regarded by participants of this study as key in support for women to make informed decisions about family planning methods. Effective support for women could be made possible if households, communities and professional nurses focus their collaborative efforts in one direction, which is support for women to make emancipated decisions regarding their reproductive health care issues. This is illustrated in Figure 5.3. below.
Figure 5.2: Primary partners collaborating in support for women to make informed decisions about family planning methods
In South Africa, the emphasis of observing fundamental human rights is endorsed in the Constitution of the Republic of South Africa (South Africa, 1996:6). The Bill of Rights theoretically allows for enabling environments to encourage emancipated decision-making for all users of reproductive health services by stating the following, amongst others (South Africa, 1996:6):

everyone is equal before the law and has the right to equal protection and benefit of the law. This right opens doors to all South African Citizens for equal access to quality reproductive health care; the inherent dignity and right of all South African Citizens that has to be respected and be protected as enshrined in the Constitution.

South Africa saw the launch of a contraception policy within a reproductive health framework and contraception service delivery guidelines in 2001 and 2003. However, factors influencing contraceptive use still remain a challenge (South Africa, 2012:13).

The SANC affirms that it will promote the provision of nursing services that complies with universal norms and values to the inhabitants of the Republic of South Africa to ensure all people’s right to access health is fulfilled (South Africa, 2005:7). From a local perspective, legislation that governs the practice of nurses and medical professionals encourages emancipated decision-making of all health care users. It can thus be concluded that women who do not have access to health care due to environmental factors are completely disempowered due to general lack of access to RHS.

In terms of education of health care workers, the SANC curriculum for undergraduate nursing students, for example, gives guidelines on programme content, but gaps still exist on reproductive health practice issues on an EDM level, assuming that graduates will not immediately on completion of a programme be in a position to create health care practice environments that will enhance emancipated decision-making (South Africa, 1985:3).

This study argues that professional nurses with the necessary knowledge and skills on women’s empowerment regarding reproductive health care are needed in a mutual
intervention with patients seeking information in that field. The addition of guidelines for undergraduate nursing students on how to empower women to make informed decisions about family planning methods in the programme is seen by the researcher as one aspect that will increase their knowledge base and that of women under their care.

Considering that one in three women will have an abortion in their lifetime, supportive and non-judgemental counselling, with continual assessment, follow-up and ongoing contraception to prevent recurrence of unplanned pregnancy should be offered to these women to assist them in decision-making (Royal Australian and New Zealand College of Obstetricians and Gynecologists, 2005:2). This underlines the importance of encouraging readiness of undergraduate nursing students, through an education programme, to participate in empowerment of women to make emancipated decisions about family planning methods.

The argument advanced above prompted the researcher to develop and describe guidelines for undergraduate nursing students to empower women in making emancipated decisions concerning family planning methods. The guidelines are a women-centred health care practice aimed at emancipating the students and women at large, as well as encouraging lecturers/preceptors and professional nurses working at RHS facilities to work closely with each other, focusing on empowering women to make emancipated decisions concerning family planning methods. It is also assumed by the researcher that the guidelines may help undergraduate nursing students to internalise the emancipation concept in nursing while improving freedom of choice for women.

5.3.4.4 Identification of fundamental aspects to be covered by the guidelines

Identification of fundamental aspects or core areas to be covered by the guidelines is considered critical because it ensures that the guidelines are developed to address those areas in which health care providers and commissioners of care or services most need assistance with, e.g., in areas of unsafe practice, where evidence suggests that current practice may not be up to standard, and where there is unacceptable variation in practice or uncertainty about what constitutes best practice (NICE, 2014:26). It is further stated that there are criteria that should be considered when identifying fundamental
aspects or key issues to be covered by the guidelines, namely, the envisaged guidelines’ potential for avoiding unlawful discrimination, advancing equality and reducing health equalities; likelihood that the guidelines could contribute to change; and that the guidelines will acknowledge any recommendation in other published guidelines. Furthermore, it is important that the process of identifying the key aspects ensures that a variety of services are considered, which include key areas of quality improvement, and that developed guidelines can be used to inform development of quality standards of care (NICE, 2014:27).

The findings of this study showed that provision of knowledge and skills on reproductive health care is regarded as an empowering method which works like a cycle because undergraduate nursing students are empowered and, in turn, they should empower women/clients and the community at large, while women will empower their children and households. Lecturers/preceptors have the primary responsibility of facilitating learning to undergraduate nursing students who are expected to become skilled and knowledgeable and to confidently support women to make informed decision about family planning methods, hence the need for the development of guidelines for undergraduate nursing students.

Based on the findings of this study and the above-stated information with regard to identification of core aspects to be covered by the guidelines, the researcher identified concepts guided by Chin and Kramer’s (2011:163) approach of concept selection, which states that concept selection should be guided by the purpose of the guidelines and should thus express the value related to the purpose.

Themes that emerged from focus group discussions with lecturers/preceptors and undergraduate nursing students, results of this study, field and reflective journal notes, observations, and literature control information culminated in the selection of core areas which the draft guidelines targeted. These areas pertaining to support for women/clients to make informed decisions about family planning methods were: women’s health care environment, accelerating knowledge on reproductive health care, upholding nursing ethics and professionalism, accessibility of RHS, advocating for women/clients, and
evident leadership. However, categories that emerged during data analysis were used as guiding headings in the formulation of guidelines and similar categories were used by the researcher to draft the guidelines.

5.3.5 **Step two: Performing a systemic review/evidence retrieval and literature control**

This step comprises identifying evidence on the phenomenon under study through a systematic review to collect all available evidence, evaluate its potential applicability to the clinical questions, and extract and summarise the findings. A literature control was also conducted to support the findings of this study. This step also involves acknowledging relevant aspects from the identified clinical practice guidelines to the current study guidelines; examining or searching for current goals; formulating clinical questions to be answered by the guidelines; and methods followed to establish the scientific validity and credibility of the guidelines (Miller & Kearney, 2004:815; Turner, Misso, Harris & Green, 2008:7), as explained below.

5.3.5.1 **Identifying relevant aspects of clinical practice guidelines**

Identification of available clinical practice guidelines is important to avoid duplication of work and waste of resources. The development of the guidelines was undertaken by the researcher as outlined in the protocol of this study. During the systemic review, no guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods were found to be available in the literature. However, as stated in the protocol for this study, aspects of existing contraceptive guidelines and strategic approaches on sexual and reproductive issues which could add value to the current guideline development were considered by the researcher as providing a background in the development of the current guidelines.

The findings of phase one of this study, relevant information from the literature review, literature used to control the findings of this study, and field and reflective journal notes were used as basis to develop guidelines for undergraduate nursing students to support women/clients to make informed decisions about family planning methods. It was also
essential to incorporate nursing education principles reported in literature to enhance students’ clinical competencies into the guidelines, since the guidelines are aimed at preparing undergraduate nursing students to enable them to provide quality RHS, including their ability to support women/clients to make informed decisions about family planning methods. Respecting diverse talents and ways of learning, encouraging active participation, caring, and integrity are some of the nursing education principles cited in literature that should be implemented by lecturers to foster academic environment that embraces acceptance, encourages freedom to explore questions and respects various points of view (National League for Nursing 2012:no.; Starmer, Duquette & Howard, 2015:134). Slavich and Zimbardo (2012:5) posit that it is essential for nurse educators to also utilise transformative learning approaches to facilitate development of undergraduate nursing students and women to engage them in higher-order cognitive strategies such as analysis, synthesis and evaluation when empowering them about reproductive health issues. These approaches are important because they require students to articulate their logic and consider various points of view when solving problems.

5.3.5.2 Examining or searching out for current goals

Discussion of the core findings (women’s health care environment, accelerating knowledge in reproductive health care, upholding nursing ethics and professionalism, advocating for women/clients, evident leadership and accessibility of RHS), literature studies, recommendations from the findings of this study, literature used to control the findings of this study, and discussions of the findings of this study enabled the researcher to observe that there is a need to support women/clients to make informed decisions about family planning methods. The attainment of this support could be made possible through the empowerment of undergraduate nursing students, nurses, other health care professionals and relevant partners in order for them to be knowledgeable and skilled on family planning issues. In turn, they will become aware of the need to support women/clients, including the type of support women/clients need to make informed decisions about family planning methods.
This study argues that undergraduate nursing students with the necessary knowledge and skills of reproductive health care practices, as well as women’s empowerment and support thereof, are needed in a mutual intervention with women/clients seeking information in that field. Adding guidelines for undergraduate nursing students in their programme on how to empower women/clients as well as to support them to make informed decisions about family planning methods is seen by the researcher as one aspect that will increase undergraduate nursing students’ knowledge base and that of women under their care in order to attain proper care of women/clients and a better quality of life for women and their infants.

The study findings and literature studies revealed that, in order to provide quality family planning services, undergraduate nursing students and nurses need continuous support in the form of education and training. This would enable nurses to empower women/clients. It would also enable nurses to become aware and more sensitive of the women’s/clients’ needs, wants and rights, as well as how to advocate for them. Through this, nurses could be in a position to attain objectives of quality family planning services and play the **advocacy role** adequately. The aim of the development of the guidelines for undergraduate nursing students was for them and all relevant partners to be able to support women/clients to make informed decisions about family planning methods.

### 5.3.5.3 Formulating clinical questions

According to the WHO (2012:32), it is helpful to look at the type of information needed when developing clinical questions to be addressed by the guidelines. Furthermore, it is mentioned that there are two types of questions that can be formulated, namely, background questions and foreground questions. Background questions provide background information on issues under consideration. However, these questions do not provide direct evidence informing the recommendations. Foreground questions, on the other hand, are said to be most important for guidelines. They require systematic review and quality assessment of the evidence using the grading of recommendations, assessment, development and evaluation approach. The answers to foreground questions are said to form the evidence base upon which recommendations are made;
therefore, they should be framed in a way that enables a systematic search of the literature. Most organisations are said to use the population, intervention, comparator and outcome format, as it is said to be an effective way to guide the formulation of clinical questions.

The goal for the development of guidelines in this study was to support women/clients to make informed decisions about family planning methods. As such, it led to the development of the following questions:

- At what level should the reproductive health service training be offered?
- What is contained in the curriculum?
- Who teaches the curriculum?
- What activities are used for teaching?
- How is the presentation assessed?

The researcher went further by exploring the characteristics of nurses who are adequately prepared to assist women to make informed decisions regarding reproductive health services. The following probing questions were subsequently developed:

- What are the indicators used to monitor the ability of women to make informed decisions regarding reproductive health services?
- How should nurses support women to enable them to make informed decisions about their reproductive health services?
- What can be done to improve support for women to make free decisions without pressure of any kind?

The researcher continued by eliciting the challenges endured during reproductive health service provision, which was followed by a probing question:

- What skills do nurses need?
These questions were deliberately formulated to direct the development of guidelines for undergraduate nursing students to attain the goal of supporting women to make informed decisions about family planning methods.

Dickoff, James and Weidenbach’s (1968:420) six elements of developing a practice discipline theory were applied in the development of the guidelines in this study, namely, the agents or persons who will perform the activity, recipients of the activity, context or framework in which the activity is performed, purpose or goal of the activity, procedure or protocol of the activity and dynamics which would motivate the nurses and the health care team. These elements are briefly explained below.

(1) **Agents or persons who will perform the activity**

The agents would be the lecturers/preceptors, as well as health care professionals involved in the provision of RHS and/or working in the health care settings or as school health nurses, because they will empower undergraduate nursing students with relevant knowledge and skills to enable them to support women/clients to make informed decisions about family planning methods. In turn, the undergraduate nursing students will become agents, whereby they will empower women and the community with knowledge to enable support for women to make informed decisions about family planning methods. The guidelines will also be used by health care providers when providing family planning (contraception) services to adolescents at schools or any platform where they will be available. Parents at various levels in the community will also be included. They can transfer the information provided by health care professionals to their household and in that sense they will become agents.

(2) **Recipients of the activity**

The recipients of this activity will be undergraduate nursing students. They will be empowered with knowledge and skills that would enable them to support women/clients to make informed decisions about family planning methods.
(3) **Context or framework in which the activity is performed**

The guidelines for undergraduate nursing students will be used by the lecturers/preceptors at nursing colleges, by health care professionals at health care facilities and schools where family planning is offered, in all health care settings accredited by the SANC for education and training of undergraduate nursing students, and at community platforms where health care professionals interact with women/clients, adolescents and the community at large. Parents can also transfer family planning information to their children. The settings may include lecturer rooms, postnatal units, PHC facilities, anti-retroviral (ART) clinics, schools, churches (taking into consideration and being sensitive to those churches where family planning is prohibited) and households. The guidelines for undergraduate nursing students to support women/clients to make informed decisions about family planning methods will be used in nursing profession education and training programmes regulated by the SANC (South Africa, 2005). The use of the guidelines would also be influenced by the National Health Act 66 of 2003 and the Constitution of the Republic of South Africa, Act 186 of 1996.

(4) **Purpose or goal of the activity**

The purpose of developing the guidelines for undergraduate nursing students was to support women/clients to make informed decisions about family planning methods in order to improve their quality of life. The guidelines aim at facilitation of empowerment of the undergraduate nursing students in family planning services. The lecturers/preceptors and other relevant health professionals will empower undergraduate nursing students using a variety of teaching strategies. Consequently, undergraduate nursing students who have acquired the knowledge and skills will empower women/clients, their households and the community at large.

Undergraduate nursing students are future health care professionals; it is therefore essential that they become competent in order to use a reproductive rights-based approach, which is a strategy used in health care services to enhance reproductive health care. It is also essential for undergraduate nursing students to understand that a reproductive rights-based approach involves empowerment of people to enable them to
exercise their sexual and reproductive rights, access to health care services that are client-centred, and advocating for improvements of political and socio-economic environments in an attempt to enhance informed decision-making (Lorentziaan, 2011:1).

(5) Procedure or protocol of the activity

Guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods constitute a protocol in the provision of quality family planning services.

(6) Dynamics that would motivate the nurses and the health care team

During facilitation of learning, the lecturers/preceptors will engage in a dynamic relationship with students. Role plays, group discussions, debates and watching videos are strategies which will further create a dynamic interaction between lecturers/preceptors and students and amongst students themselves. All of these will create knowledge and skills acquisition regarding the dynamics that exist in family planning practice.

(7) Draft guidelines

- The draft guidelines were developed by the researcher and submitted to the two promoters/supervisors of this study for inputs and approval.
- The approved guidelines were presented to the participants to validate the draft guidelines, and add their views and comments, which were included in the guidelines. The descriptive information of these participants is depicted in Table 5.2.
- The draft guidelines indicated evidence from literature that supports the need for development of current guidelines. The findings of the study described in Chapter 3, discussion of findings of phase one of this study, field and reflective notes, and literature used to control the study findings were included in the development of the guidelines.
- The researcher amended the guidelines based on the inputs from the participants/stakeholders.
The guidelines were presented for evaluation (additions, subtractions and for corrections) to the same participants who participated in the pilot study.

(8) Administration of the consultation with participants

Selection of participants was done during data collection. Initial communication with participants in the validation of the guidelines was conducted telephonically, and for those in close proximity, face-to-face sessions were conducted. A brief introduction was done to remind participants about the study since the recruitment phase. The role expectation with regard to validation of the draft guidelines was clarified. The content domain for this study was support for women to make informed decisions about family planning methods. Information on the results of the study and literature review was shared and clarified at face-to-face meetings, telephonically and via emails, as it was discovered that telephone communication would be expensive after the initial telephone contact. The preliminary/draft guidelines about the study, the results of this study and literature review on support for women to make informed decisions about family planning methods, were emailed and/or hand delivered to the participants. A time frame of 10 working days was agreed upon for sending of responses back to the researcher. However, it was also agreed that the researcher would continually communicate with participants until completion of the validation process.

5.3.6 Step three: Drafting guidelines

Formulation of the draft guidelines was done by the researcher, based on the research findings, field and reflective notes recorded during data collection, literature used to control the findings of this study, the discussion of the findings, and evidence from literature on available clinical practice guidelines and on needs for guidelines to support women/clients to make informed decisions about contraceptive methods. The synthesis of these enabled the researcher to arrive at five core areas that should prevail in a women’s health care environment to support them to make informed decisions about family planning methods, namely: **advocating for women/clients**, **evident leadership**, **accessibility of RHS**, **upholding nursing ethics and professionalism**. These areas
are depicted in Figure 5.3 below. All five core areas contribute to positive output on support for women to make informed decisions about family planning.

The draft guidelines were presented to the same participants (depicted in Table 5.2) who participated in the main study for validation, inputs, comment and recommendations. The researcher amended the draft guidelines based on inputs from participants and returned it to the same participants who participated in the pilot study for evaluation.

The initial draft guidelines before validation consisted of 19 guidelines. The participants suggested merging of guidelines 7 and 8, and 10 and 11. Nine of the 12 participants who validated the guidelines suggested that guideline 19 be removed because its actions were repeated within the other guidelines. Validation and suggested changes from the participants that were attainable were incorporated in the guidelines.
Figure 5.3: Five core areas of the guidelines for undergraduate nursing students playing a pivotal role in support for women to make informed decisions about family planning methods.
5.3.7 Step four: Compilation and evaluation of final guidelines

A total of five (n=5) participants (three lecturers and two preceptors) who participated in the pilot study evaluated the final guidelines. Participants were purposefully selected based on their experiences and knowledge of reproductive health care practices, on facilitation of clinical and theoretical learning for nursing students respectively, on guideline formulation and guideline evaluation.

The critical reflection method as outlined by Chinn and Kramer (2011:184) was utilised to evaluate the developed guidelines. Critical reflection is a process that can be used to scrutinise how useful the guidelines are with regard to the purpose for which they were developed (Chinn & Kramer, 2011:184). During evaluation, the participants were expected to look at clarity, simplicity, generality, value, accessibility and perceived utility in relation to practice, the importance of the formulated guidelines, and the applicability of the guidelines proposed activities to nursing practice, nursing education and nursing research (Chinn & Kramer, 2011:197). The participants were also requested to comment on the importance of these guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods. A space for remarks was provided for participants. The comments and suggestions of the participants were included in the final version of the guidelines.

The participants were provided with guidelines on how to conduct critical reflection on the guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods, as follows (Chinn & Kramer, 2011:197):

- **Clarity** refers to how well the guidelines’ intended purpose can be understood and how consistently the ideas are conceptualised.
- **Simplicity** refers to the number of elements within the description of each category, how simple they are and whether the guidelines give straightforward instructions.
- **Generality** refers to whether the guidelines can be used in a wider context, i.e., primary, secondary and tertiary level prevention of health care challenges.
- **Accessibility** refers to the ability of lecturers/preceptors, undergraduate nursing students and other health care professionals to use the formulated guidelines.
• **Importance** refers to the extent to which the guidelines lead to valued nursing goals in practice, education and research.

5.3.7.1 *Participants’ critical reflection feedback*

Critical reflection feedback was received from the heads of Community Nursing Science and Midwifery, as well as from three lecturers/preceptors for the components of theory and accompanying undergraduate nursing students in the clinical facilities. These participants participated in the pilot study. During the recruitment process described in Chapter 2, they were informed that they would form part of the evaluation of the guidelines developed by the researcher. Telephone communication was utilised to determine the participants’ availability for guidelines evaluation. Because of geographical distance, two participants received the guideline document electronically, followed by telephone communication to ensure that they understood what was expected of them. The other three participants were provided with hard copies of the guidelines because of geographical proximity to the researcher. The suggestions and comments that were received are discussed below.

(1) **Clarity**

All five (n=5) participants stated that the guidelines were clear and that they were explained in detail. One participant added that the guidelines gave a clear direction to the expected role of NEIs in preparing undergraduate students with regard to support for women to make decisions about family planning. Another participant wrote in the return email:

> The guidelines are very, very well planned and structured and easy to understand, I can seriously not comment much or improve anything.

One participant commented that, though the guidelines were clear, words such as activities were repeated differently and suggested they be merged into one. Suggested changes were effected by the researcher on the final guideline document.
(2) Simplicity

All participants (n=5) indicated that the guidelines were easy to understand and use.

(3) Generality

Three (n=3) participants stated that it would be possible to generalise these guidelines to a wider context of health care professionals, however minor changes to suit circumstances might be necessary. One (n=1) participant stated the following:

Yes the guidelines can be applied to other nursing education institutions involved in training of undergraduate nursing students, but cannot be applied to people in general.

The final participant (n=1) suggested that community health care workers (CHCWs) could be provided with workshops to use these guidelines within their scope of work. This participant further suggested that action in guideline 10: “Conduct school health visits for information dissemination in collaboration with school health teams” should include CHCWs in the collaboration. The researcher amended the guidelines as suggested.

(4) Accessibility

All five participants (n=5) indicated that the guidelines would be accessible to lecturers/preceptors, undergraduate nursing students and other health care providers in the health care settings. One (n=1) further added that the guidelines should be adjusted to the level and scope of CHCWs and be made available to them as well.

(5) Importance of the developed guidelines

All five participants (n=5) stated that the guidelines are very important and applicable to the nursing practice, nursing education and nursing research. According to these participants, the guidelines will make a valuable contribution towards the improvement of the lives and health of women, their babies, as well as the community at large. The guidelines will also enhance undergraduate nursing students education and training.
One (n=1) participant stated as reflected in the direct quote as follows: “these guidelines if coordinated well might be able to encourage partnership that is currently fragile between nursing practice and nursing education with regard to nurse training.”

5.3.7.2 Summary

The guidelines for undergraduate nursing students to support women to make informed decisions about issues of their reproductive health were described and evaluated by lecturers/preceptors. All participants stated that the guidelines adhered to the critical reflection criteria for clarity, simplicity, generality and accessibility. They also commented that the guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods are important to Community Nursing Science, Midwifery and management of these nursing components, CHCWs, women’s support endeavours and other health care workers who could benefit nursing practice, nursing education and research who could implement these guidelines. Suggested changes that were attainable were incorporated to complete the final guidelines.

5.4 GUIDELINES FOR UNDERGRADUATE NURSING STUDENTS TO SUPPORT WOMEN/CLIENTS TO MAKE INFORMED DECISIONS ABOUT FAMILY PLANNING METHODS

The title of the guidelines is Guidelines for undergraduate nursing students to support women/clients to make informed decisions about family planning methods. The aims of the guidelines are to provide guidance for undergraduate nursing students on support for women/clients to make informed decisions about family planning methods; to enhance competencies of undergraduate nursing students on family planning health care services; to improve quality of life for women and their children; and to create positive practice health care environments. Undergraduate nursing students in general are the users of the guidelines while women/clients are the beneficiaries. Each developed guideline is supported by a rationale for being included as well as the actions to be executed by the undergraduate nursing students and nurses.
Guideline 1: NEIs, in collaboration with nursing practice, need to strengthen undergraduate nursing students’ education and training to ensure that they are competent in the provision of reproductive health care and in support for women to make informed decisions about contraceptive methods.

Rationale

Adequate training for undergraduate nursing students, who are the future professional nurses, to render quality RHS to women and support them to make informed decisions about contraceptive methods is critical in ensuring that the health of women and that of their children is improved. This is also aligned to the attainment of SDGs 3 and 10: Good health and well-being and reduced inequality.

Actions

In strengthening undergraduate nursing students’ education and training to increase support for women to make informed decisions about family planning methods, NEIs, in partnership with accredited clinical facilities, should:

- Conduct regular skills audits of lecturers/preceptors and professional nurses on provision of contraceptive methods to ensure effective support for undergraduate nursing students to become competent in provision of quality contraceptive services. This will also assist in the planning and implementation of appropriate in-service training.

- Identify gaps in the curriculum for current undergraduate nursing students on support for women to make informed decisions about contraceptive methods, for review of the curriculum.

- Develop or review undergraduate nursing students’ curriculum, in collaboration with the Department of Health, to incorporate new developments on contraceptive
methods to ensure that undergraduate nursing students have access to new contraceptive developments.

• Develop or obtain up to date provider or operational manager/supervisor job aids (a brief summary of instructions, such as checklists designed to reduce avoidable mistakes by helping people to remember what to do or to be sure that they have completed all steps required). These need to be aligned to provincial, national and international evidence-based materials to incorporate these in the teaching of reproductive health care practices to undergraduate nursing students.

• Provide continuous supervision and mentoring after training at facility level.

• Expose undergraduate nursing students to different teaching and learning strategies (WHO, 2011:17), such as videos, computers, internet connectivity, audio-visual aids, and models and to charts to enhance transfer of knowledge and skills.

• Require lecturers/preceptors and professional nurses involved in teaching undergraduate nursing students and in the provision of RHS to attend in-service training on new developments in contraceptive methods.

• Conduct a review of local, national and other contraceptive programmes to identify differences and needs for alignment of RHS practices in order to increase focus on support for women.

• Identify (through literature searches) current evidence-based strategies to embed concepts of support for women to make informed decisions about contraceptive methods and on concepts of sex and gender health into undergraduate nursing students’ curricula.

• Provide continuous professional development (CPD) points workshops and seminars on reproductive health care practices, focusing on support for women. This should capitalise on the SANC CPD point system programme and be aligned with objective 3 of the National Contraceptive and Fertility Planning Policy and Service Delivery Guidelines, namely, training and capacity-building (South Africa, 2012:27).
• Plan compulsory adequate training for nurses and undergraduate nursing students on contraceptive methods and counselling, focusing on technical competence, interpersonal communication, administrative skills, as well as skills, competencies and information that undergraduate nursing students will require to support women to make informed decisions about contraceptive methods.

Guideline 2: NEIs are to ensure that undergraduate nursing students receive adequate education and training on contraceptive methods and on support for women/clients to make informed decisions.

Rationale

Health care providers with appropriate knowledge and skills on reproductive health care practices are better positioned to support women to make informed decisions about contraceptive methods.

Actions

To ensure that undergraduate nursing students receive adequate education and training on contraceptive methods and on support for women to make informed decisions, lecturers/preceptors should:

• Develop or review reproductive health care curricula in line with the latest national contraception policy guidelines, service delivery guidelines and evidence-based best practice recorded in literature.

• Ensure that RHS and support for women to make informed decisions are integrated across all subjects of undergraduate nursing students’ curriculum to ensure that appropriate theory and practicals are provided to prepare nurses to be relevant in the health care facilities.

• Include values clarification; client-centred approaches of care to ensure upholding of clients’ rights; provision of effective counselling and proper information dissemination to the public and clients; technical knowledge and skills on contraceptive...
technologies methods provision; and follow-up, including infection prevention, in the undergraduate nursing students’ learning packages (South Africa, 2012:23).

- Assign undergraduate nursing students to complete case studies on actual support for women to make informed decisions about contraceptive methods in order to equip the students and develop their competencies in this regard.

- Use teaching and learning materials and methods that facilitate development of contraceptive health care competencies, such as role play, teaching through a virtual learning environment, videos, flip charts, models, mannequins, diagrams, and live patients to enhance undergraduate nursing students’ understanding (Aebersold et al., 2012:2; Asoodeh et al., 2012:560; Kilgour et al., 2015:17). Lecturers/preceptors should provide problem-based scenarios for students to enable them to apply their critical thinking skills in assisting women to make informed decisions, and assign students to conduct research on problems they identify with regard to family planning and ethical issues during clinical placement.

- Develop community outreach programmes for undergraduate nursing students that require them to intensify provision of persistent, complete and accurate information and knowledge on management of all types of contraceptive side effects for women; for example, evidence of having twice provided health education for women on this aspect in a quarter.

- Clearly spell out contraceptive health care practice competencies to be achieved by undergraduate nursing students in the educational programmes designed by NEIs.

**Guideline 3:** NEIs, in collaboration with practice, should prepare undergraduate nursing students to ensure that they provide sustained contraceptive health care services information to women/clients over a long period of time on the importance of family planning in order to influence and/or change women’s aspirations and behaviour.

**Rationale**
Encouraging women to plan for healthy pregnancies, including timing and spacing, has the potential to improve health outcomes for both mothers and their babies.

**Actions**

In preparing undergraduate nursing students to provide sustained contraceptive health care services information to women/clients, lecturers/preceptors and professional nurses should:

- Ensure that undergraduate nursing students prepare structured health education programmes focusing on support for women to make informed decisions about contraceptive methods and sensitising parents on the importance of female education beyond secondary level in order to increase contraceptive decision-making and level of confidence in entering into a dialogue with their spouses, health care providers and other relevant stakeholders (Gordon et al., 2011:3).

- Provide undergraduate nursing students with opportunities for:
  - compulsory development of schedules for implementation of health education on contraceptive methods and benefits of family planning as educational projects at outpatient departments, obstetric units, community settings and schools;
  - conducting village sensitisation campaigns concerning the use and importance of contraceptives and family planning/planning family size; and
  - implementing village-level sensitisation seminars to access women/clients who could not be reached via the mass media (Bbaale, Mpuga & Rwanda, 2011:41).

These may also assist undergraduate nursing students in ensuring and lobbying for partner, community and political support, as well as understanding of gender justice and equity, including sustaining provision of consistent information and creating public awareness on issues around contraceptives. Lecturers should use transformative learning approaches to engage students as agents for social change, namely: active learning and student-centred, collaborative, experiential and problem-based learning (Slavich & Zimbardo, 2012:569). This is in line with the Wittmann-Price Theory of EDM (Wittmann-Price, 2004:442), which advocates for
transformative curricula to empower students to support emancipate women on matters of reproductive health care issues.

**Guideline 4:** Establishment of educational projects for undergraduate nursing students designed to empower women, households and the community. This will be done to ensure that undergraduate nursing students are provided with training and capability building on appropriate knowledge and skills to support women to make informed decisions about contraceptive methods and on prevention of HIV/AIDS within their scope of practice (emphasis on dual protection within making informed decisions).

**Rationale**

Knowledge of use of contraceptives and HIV will ensure that undergraduate nursing students are able to support women/clients to make informed decisions about family planning methods within the context of HIV/AIDS.

**Actions**

In the development of undergraduate nursing students’ reproductive health care practice competencies, lecturers/preceptors should:

- Expose undergraduate nursing students to various contraceptive methods, their impact on HIV for HIV-positive and HIV-negative women, their impact on transmission and disease progression, and drug interaction, as well as overall guidance for contraceptive use by HIV-positive women.
- Mobilise and build awareness at local level about reproductive health issues and dual protection.
- Develop innovative and participatory approaches to ensure that reproductive health care receives adequate attention in order to support women to make informed decisions about family planning methods.
- Utilise all points of contact to provide information about contraceptive and reproductive health that would encourage women to make informed decisions, for example in waiting and consultation rooms, and using any platform that could be amendable to a healthy conversation. Within resource constraints, consider using
entertainment formats such as drama, music and games to attract larger audiences and model desired attitudes and behaviours.

**Guideline 5:** NEIs, in collaboration with practice, should develop and/or implement leadership development programmes for undergraduate nursing students, focusing on improvement with regard to the provision of contraceptive information and services.

**Rationale**

Development of undergraduate nursing students’ competencies for leadership and management roles as future health care providers is key, because provision of quality patient care requires professional nurses with the ability to develop positive work environments that can bring about positive patient outcomes, including support for women/clients to make informed decisions about contraceptive methods.

**Actions**

In the development of personal and professional leadership and management skills of undergraduate nursing students, NEIs should:

- Integrate leadership and management content, including advocacy and professionalism, in the curriculum for undergraduate nursing students.
- Develop management skills training programmes that include quality improvement methods, recording of client information, and collection and collation of health facility client data.
- Conduct on-site training and periodic training updates to fill the identified gaps in provider knowledge, skills, values and attitudes.
- Ensure that professional nurses are always available in the RHS facilities to provide structured supportive supervision and monitoring to undergraduate nursing students, in addition to the provision of RHS to women/clients.
• Regularly provide updated training for academic staff and managers/supervisors to enable them to give support and mentor undergraduate nursing students on all aspects of contraceptive service delivery.
• Conduct structured orientation sessions for new staff and undergraduate nursing students, as well as regular sessions on new developments for all academic and service staff.
• Attend periodic refresher courses, on-the-job training and supervised practice to ensure competent and adequate performance.
• Familiarise undergraduate nursing students with institutional enabling standard operating procedures which are aligned to provincial and national enabling prescripts for the provision of contraceptive services.
• Train supervisors on coaching and facilitation skills.
• Establish formal recognition programmes, such as “employee of the month”, to strengthen good performance.

Guideline 6: NEIs are to ensure that undergraduate nursing students’ competencies on management of contraceptive stocks are developed (encourage someone to make a decision on family planning methods unless based on availability of stock).

Rationale

Ensuring an uninterrupted supply of contraceptives will ensure that services become reliable and trusted by women/clients and communities.

Actions

In the development of undergraduate nursing students’ competencies on management of contraceptive stock, undergraduate nursing students’ learning packages should contain knowledge and skills on:

• National, provincial and local policies and standard operating procedures on efficient management of contraceptive stock.
• Stock ordering and stock procedures for the unit which are aligned to the provincial drug management protocols. This should include inventory and reordering protocols.
• Implementation of the procedures and logistics of obtaining contraceptive stocks, including orientation on national standards for the equipment and suppliers necessary to deliver high-quality contraceptive services.

• Establishment of efficient systems for inventory control, projection of supply needs, procurement and distribution within the scope of practice of undergraduate nursing students.

• Appropriate storage procedures and quality standards for equipment and suppliers.

• Creation of databases on selection of contraceptives and estimation of quantity to be ordered based on past use and previous statistics.

• Implementation of meticulous record-keeping systems to ensure replenishment of stocks, including ensuring availability of pregnancy testing kits (South Africa, 2012:24).

• Development of institutional policies to deal with emergency orders, expired drugs and borrowing supplies from other facilities if there is a sudden increase in demand.

**Guideline 7:** NEIs are to develop learning packages on patients’ rights and nursing ethics and professionalism for undergraduate nursing students to ensure that, on completion of the course, nurses would at all times respect patients’ rights and adhere to professional behaviours in the provision of contraceptive health care services.

**Rationale**

Nurses are to ensure that they follow ethics of caring and respect women’s rights at the RHS facilities.

**Actions**

In the provision of RHS that embrace patients’ rights and acknowledge the importance of professional conduct by nurses at all times, lecturers/preceptors should ensure that, through learning packages and assessment strategies, on completion of the course, undergraduate nursing students would:
• Provide non-discriminatory contraceptive information and services, and ensure that women/clients know their reproductive rights.
• Provide contraceptive information and services that respect individual confidentiality, privacy and informed choice.
• Ensure consistent respect for women’s rights to autonomy and privacy.
• Ensure implementation of legal environment policies and protocols that are in line with human rights standards (eliminate parent and/or partner authorisation to choice of contraceptive methods).
• Ensure that women/clients requesting contraception are not sent away without being provided with a suitable method of their choice.
• Practise (through lecturers'/preceptors’ and professional nurses’ role modelling) provision of RHS with compassion and professionalism: respect for the inherent dignity, worth and uniqueness of every woman (client) seeking contraceptive services, without the influence of personal values/biases.
• Provide emotional support for women/clients who are experiencing contraceptive challenges.
• Act as a communicator, liaison, educator, interpreter and provider of needed services and use translators who belong to the community if need be. Use visual tools and be attentive to nonverbal cues.
• Conduct personal research and engage in respectful discussions with local representatives to gain more cultural knowledge about the community in to provide culturally sensitive family planning services.
• Identify family planning policies that are in conflict with cultural norms and address these.
• Develop a structured mentoring system to support undergraduate nursing students’ development and offer them clinical mentoring to foster cultural appropriateness in the provision of contraceptive services.

Guideline 8: Undergraduate nursing students and nurses should be respectful of the values and cultural practices of women/clients and be responsive to their needs in order to promote a culture of shared decision-making.
Rationale

Every woman (client) is a unique being with her own values and cultural beliefs. It is inherent in the nursing profession for nurses to become conversant with patients’ cultural norms and beliefs, to respect their rights in a culturally sensitive manner and to protect their dignity in order to support them to make decisions about health care options.

Actions

To support women/clients to make informed decisions about reproductive methods, undergraduate nursing students should be encouraged to:

- Provide privacy and assure confidentiality during provision of contraceptive services.
- Attentively listen and respond to women’s/clients’ needs, concerns, perceptions and myths, evaluate their understanding by encouraging them to ask questions and ask what more they want to know about contraceptive methods.
- Use a friendly tone of voice and welcoming or attentive body language during conversations with women/clients, and avoid imposing ideas; instead, advise women/clients on the options and support them to make a decision.
- Encourage women/clients to re-affirm their choice of methods.
- Summarise the whole discussion and ascertain the woman’s (client’s) decision.
- Ensure that information provided is tailored to the needs and circumstances of the woman/client.
- Support women/clients to make decisions from a range of different contraceptive methods.
- Establish mechanisms for receiving women’s/clients’ feedback and for resolving complaints.
- Be placed with a professional nurse with relevant reproductive health care knowledge and skills for learning activities about support for contraceptive choices.
- Have outcomes set to focus on the women/clients and how to support them to make informed decisions.
• Receive facilitated learning on the awareness of factors that influence women's decision-making on contraceptive services and the rights of women/clients to make decisions without coercion or pressure from any source.
• Take part in learning activities, for example, participation in community campaigns, to create awareness of the importance of support for women/clients from all stakeholders to make informed decisions about family planning methods.

Guideline 9: Undergraduate nursing students/nurses are to focus on implementation of a rights-based approach contraceptive services (CARE International, 2012:7; South Africa, 2012:23).

Rationale

The emphasis on observing fundamental human rights is endorsed in the Constitution of the Republic of South Africa, which calls for equal access to quality reproductive health care for all South African citizens (South Africa, 1996:6). It is thus important to encourage the readiness of undergraduate nursing students to implement a rights-based approach to contraceptive services through education programmes.

Actions

In the preparation of undergraduate nursing students by NEIs to implement a rights-based approach contraceptive services, the undergraduate nursing students' workbook assignments should be designed to require them to:

• Practise the principle of informed voluntary contraception, confidentiality and provision of privacy, allow contraceptive choice, and promote informed decision-making and shared responsibility.
• Establish and/or participate in health facility committees and support their functioning.
Guideline 10: Undergraduate nursing students are to be prepared to identify characteristics displayed by nurses at the reproductive health care facilities to establish and identify acceptable communication strategies that could increase public/community awareness of contraceptive and reproductive rights, choices and services.

Rationale

Characteristics displayed by nurses at the health care facilities can either encourage or discourage women to make informed decisions about contraceptive methods. It is necessary to identify negative characteristics early in order to institute remedial interventions that could promote positive patient outcomes. Acceptable communication with women/clients and communities would not only ensure that people’s right to information is respected and fulfilled, but also improve their decision-making about health care issues.

Actions

In the preparation of undergraduate nursing students for the role of identifying characteristics displayed by nurses that could be detrimental to women’s decision-making, as well as establishing and identifying acceptable communication with women/clients and communities, lecturers/preceptors should create learning opportunities for undergraduate nursing students within their educational requirements to:

- Prepare learning packages for undergraduate nursing students on shared decision-making programmes that have a clinical domain and that encourage interactive processes in which patients and health professionals can collaborate to choose health care options that take patients’ values and preferences into account.
- Conduct periodic Knowledge, Attitude, Practice and Behaviour studies to evaluate characteristics displayed by nurses and the impact of services.
- Conduct periodic employee satisfaction or opinion surveys to develop plans to promote staff engagement.
• Establish employee forums meetings to raise awareness of concerns, as well as to ensure that communication is credible and promotes a sense of trust.

Undergraduate nursing students, meanwhile, should:

• Provide non-judgemental contraception services in a respectful manner.
• Embark on active information distribution through education, communication, outreach and community mobilisation programmes to promote the advantages of family planning services within the context of available contraceptive methods, dual protection, rights of making choices, informed decisions and shared responsibility.
• Select various communication strategies, such as radio campaigns or mobile technology, appropriate to communities within their scope of practice and the protocols of the local Department of Health.
• Conduct school health visits for information dissemination in collaboration with school health teams.
• Offer a wider selection of family planning methods, family planning services that reflect high standard health care practice and family planning services that are sensitive to cultural conditions. Additionally, provide sufficient information about proper use and/or possible side effects.

Guideline 11: NEIs are to ensure that undergraduate nursing students'/nurses' competencies on monitoring and evaluation of contraceptive services are developed.

Rationale

Monitoring and evaluation of contraceptive services is critical because it informs service improvement strategies.

Action

Preparation of undergraduate nursing students/nurses for contraceptive health care service monitoring and evaluation requires those undergraduate nursing students, as part of their training, to actively:
• Identify key national, provincial and local indicators and appropriate data collection methods to be implemented, such as periodic surveys through routine health information systems.

• Conduct regular client feedback sessions to service delivery points in accordance with clinical facilities’ protocols and under the guidance of their lecturers/preceptors.

• Use available and appropriate tools to assess the quality of reproductive health care provided and initiate appropriate improvement strategies, e.g., local audit of method continuation rates, and self-assessment exercises on acceptability of the services provided to clients. Undergraduate nursing students could be allowed to use their creativity to develop service assessment tools guided by their lecturers/preceptors.

• Conduct operational research using measurable indicators of achievement for various aspects of contraceptive service delivery. These may include user satisfaction surveys, commonly experienced side effects, staff competence in the provision of contraception, and service delivery guidelines.

Guideline 12: Undergraduate nursing students/nurses are to focus on improvement of their values and attitudes on provision of contraceptives services.

Rationale

Positive attitudes displayed by health care providers at the RHS facilities are key in improving access to health services. It is also important that health professionals’ values are kept in check to avoid being judgemental about health care choices made by women/clients.

Actions

In the improvement of values and attitudes, lecturers/preceptors should:

• Build undergraduate nursing students'/nurses’ capacity on Department of Health policy documents that focus on the delivery of quality health care and are pertinent to the provision of contraceptive and RHS, namely:

  o National Contraception and Fertility Planning Policy and Service Delivery Guidelines;
• Conduct impact analyses to find out what works to improve on it and develop strategies to address what does not work in the provision of contraceptive services.
• Conduct campaigns to create community awareness about RHS and the right of women/clients to have a say in the service they prefer.

**Guideline 13:** Lecturers/preceptors are to ensure that undergraduate nursing students are exposed to various teaching and learning skills to prepare them for performing a client advocacy role when providing health care services.

**Rationale**

Protection of patients' interests and well-being by health care providers will ensure that quality health care services are provided, because these would bring in a sense of self-worth on the part of the patient, who may feel respected and valued in the health care facilities. Through these, humanistic relationships between health care providers and patients may be developed, which may encourage information sharing and empowerment.

**Actions**

In the preparation of undergraduate nursing students to become competent in the performance of client advocacy, lecturers/preceptors should:
• Educate undergraduate nursing students on the process of patient advocacy and its practices, and incorporate the essential components to be performed by nurses in order to provide effective advocacy (Choi, 2015:15; Tomajan, 2012:13).

• Teach undergraduate nursing students the role of client advocacy in nursing and how to identify and manage barriers in order to effectively provide client advocate.

• Allocate a mentor or preceptor who has a strong record as an advocate for women/clients to help undergraduate nursing students understand and to give direction or guide the process to the advocacy role.

• Ensure that undergraduate nursing students have an understanding of the ethical issues in health care, as well as knowledge of the laws and regulations that affect nursing practice and public health.

• Utilise a variety of teaching strategies to develop undergraduate nursing students' skills needed in the performance of advocacy. Skills needed include problem solving, communication, influence and collaboration (Tomajan, 2012:13).

• Educate undergraduate nursing students on the importance of instituting clear, effective communication when advocating for women and keeping anger and emotional frustration to a minimum.

• Keep lines of communication open and form relationships with other members of the health care team. Being aware of the rules of practice will make the advocacy role much easier.

• Have knowledge of their scope of practice and the written rules governing their practice to help them to be a more effective advocate.

• Model positive professional behaviours and help undergraduate nursing students to acquire these behaviours as a way of teaching.

• Document their interaction with women/clients and put these notes on the front chart to draw attention to the women's/clients' needs or concerns based on the discussion.

• Know institutional committees who might support their advocacy initiatives and talk to their peers.
Develop health education programmes that empower women and communities to take control of their reproductive lives and enable them to hold health systems accountable for providing high-quality, responsive systems.

**Guideline 14:** Ensure protection and promotion of human rights in the context of contraceptive information and services.

**Rationale**

Addressing human rights pertaining to provision of contraceptive information and services is a step towards support for women to make informed decisions on contraceptive methods, with the benefit of reduced maternal and infant morbidity and mortality.

**Actions**

To ensure development of undergraduate nursing students’ patient advocacy role competencies, lecturers/preceptors should:

- Develop undergraduate nursing students’ advocacy capabilities by supporting open communication, collaboration and conflict resolution skills, and allowing them to autonomously address concerns.
- Develop undergraduate nursing students’ capacity and capability for professional advocacy. Lecturers/preceptors must also model advocacy behaviour for students in both education and practice settings.
- Collaborate with nursing managers in practice to encourage professional nurses to be role models for patient advocacy and to provide ongoing mentoring to nurses, including undergraduate nursing students, in their role of providing patient advocacy while allocated at the clinical facilities.
- Develop case scenarios and assign undergraduate nursing students to role play patient (client) advocacy activities.
- Develop, with undergraduate nursing students, institutional contraceptive health policy protocols and programmes that are grounded in a human rights framework.
• Identify and have a dialogue with undergraduate nursing students on strategies to address coercive sexual relations as well as socioeconomic and/or political circumstances that could hinder women’s decision-making on the choice of contraceptive methods.

• Integrate all aspects of care for women/clients in undergraduate nursing students' curriculum and ensure that concerns receive attention.

• Ensure that undergraduate nursing students are made aware of the importance of adhering to organisational, state and national laws when discussing contraceptive needs to ensure that women’s/clients’ and family information is treated as privileged and confidential.

• Recognise that provision of contraceptive health care services should not be relegated to lower categories of nurses other than professional nurses with relevant reproductive health care knowledge and skills. The focus should be on the women/clients who are to be supported to make informed decisions about contraceptive methods.

ACCESSIBILITY OF REPRODUCTIVE HEALTH SERVICES

Guideline 15: Accelerate access to reproductive health services focusing on support for women/clients decision making on family planning methods.

Rationale

Access to reproductive health services remains a legitimate right for all citizens and this right compels all health care providers to provide comprehensive reproductive health services to women of all ages (Agbemenu & Schenk, 2011:56).

Actions

In accelerating access to reproductive health services, nurses should:
• Implement information, health education and communication strategies that are in local languages, appropriate to age, and customised to specific target groupings. Displayed wall posters should be up to date and in good position.
• Provide integrated-approach health care and information that allow women/clients to make informed decisions about treatment options (family planning methods).
• Identify and develop strategies that could enhance women’s/clients’ access to reproductive health services in partnership with communities.
• Create a positive health care environment for contraceptive health services and ensure provision of accessible and acceptable contraceptive services.
• Provide convenient PHC facility opening times, reasonable waiting times, and a clean and safe health facility environment.
• Provide integrated contraceptive services, i.e., with other PHC consultations.
• Form and strengthen partnership with other government and private sectors, and NGOs to increase access through other channels, including non-PHC facility-based delivery systems such as social marketing, community-based programmes, and private sector, NGO, school-based and employment-based clinics (CARE International, 2012:20).
• Use mobile outreach services to improve access to contraceptive information and services to bridge geographical barriers, e.g., undergraduate nursing students can conduct four outreaches spread out over four years.
• Provide sexual and reproductive health services, as well as contraceptive information and services for adolescents at schools to meet their educational and service needs.
• Provide comprehensive contraceptive information and services to those in crisis who might need emergency contraceptives.
• Expand choice of contraceptives by stocking a wide range of contraceptives in health care facilities.
• Provide services during a single visit to avoid rescheduled visits.
• Women/clients should not be denied contraceptives.
• Create awareness on availability of contraceptive services and the rights of women/clients to make informed decisions without coercion or pressure from any source and to hold health care providers accountable for quality health care.
• Explore household support and challenges experienced by women/clients with regard to making decisions on contraceptive methods. Devise strategies to address and refer such challenges within the scope of practice of health care providers.
• Conduct community campaigns to create awareness on the importance of support for women/clients from all stakeholders to make informed decisions about contraceptive methods.

Guideline 16: Educate undergraduate nursing students/nurses about the importance of ensuring that access to contraception and fertility planning is increased for women/clients with special needs (physical and intellectual disabilities, adolescents, menopausal women and women with chronic conditions).

Rationale

Acknowledging that all people have the right to make informed sexual and reproductive choices is important to ensure that they also are supported by nurses to make decisions on contraceptive methods.

Actions

• Treat every woman (client) as an individual, with respect and dignity.
• Conduct assessments of women’s/clients’ needs, capabilities and aspirations in a participative manner.
• Ensure physical access to facilities for women/clients with disabilities, assistance with communication for sign language or translation needs, and supportive staff attitudes.
• Obtain consent from women/clients to involve family members or carers during assessment should the need arise, while upholding privacy and confidentiality at all times.
• Provide undergraduate nursing students with knowledge from available contraceptive policies and clinical guidelines on factors that need to be taken into account when considering contraceptive options for all target groups with special needs.

• Provide youth-friendly contraceptive services, such as providing a youth magazine on contraceptive methods.

• Collaborative decision-making that includes the woman (client), the caregiver and the nurse, or practice collaborative decision in dyad (client and nurse).

5.5 SUMMARY

Sixteen guidelines with their rationale and actions have been outlined. The process of developing guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods was discussed in detail. The draft guidelines were sent for refinement to the participants as outlined in protocol for this study after approval was obtained from the supervisors. The final chapter is on the overview of the research findings, recommendations, implications, limitations and conclusions deduced from the study.
CHAPTER 6:
OVERVIEW, RECOMMENDATIONS,
LIMITATIONS AND CONCLUSIONS

6.1 INTRODUCTION

The aim of this chapter is to present an overview of the research findings, tabulate limitations, outline recommendations, explain the implications of the findings for nursing education, practice and research and the Department of Health, as well as to draw conclusions from the study findings. This research, based on guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods, was conducted in two phases and presented in the first five chapters. This chapter features the main issues raised in the study; the arrangement is therefore in accordance with the layout of the individual chapters of the thesis.

6.1.1 Phase one

The objective of this phase was met by conducting focus group discussions with lecturers/preceptors and undergraduate nursing students with the aim of exploring their views and opinions on support for women to make informed decision about family planning methods. Probing was done during focus group discussions to further explore and describe the phenomenon under discussion.

The first step of phase one was achieved by exploring and describing the views and opinions of lecturers/preceptors and undergraduate nursing students on the ability of nurses to support women to make informed decisions about family planning methods.

The second step of phase one was achieved by exploring and describing the views and opinions of lecturers/preceptors and undergraduate nursing students on issues surrounding women’s health that impinge on women’s freedom to make informed decisions about health care alternatives. The participants revealed that nurses' responsibilities, characteristics displayed by nurses, challenges experienced by nurses and women/clients, accessibility of RHS, teaching undergraduate nursing students...
reproductive health care practices and teaching practices/methods are key contributory factors in the support or lack thereof for women to make informed decisions about family planning methods.

The third step of phase one was achieved by exploring and describing the views and opinions of lecturers/preceptors and undergraduate nursing students regarding the type of content that needs to be included in the education and training of nurses to support women to make informed decision about family planning methods. The study revealed that reproductive health care modules are integrated in Physiology, General Nursing Science, Community Nursing Science, Pharmacology and Midwifery. However, insufficient time allocated for undergraduate nursing students to practise reproductive health services was compromising nurses’ ability to support women to make informed decisions about family planning methods.

6.1.2 Phase two

The objective of phase two, which was the development and refinement of guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods, was also achieved. The guidelines were developed from the findings of phase one of the study as presented and discussed in Chapters 3, 4 and 5, field and reflective journal notes, literature review, and literature used to control the findings of this study.

Chapter 1 presented an introduction to and background of the study. Chapter 2 discussed the research design and methodology, while Chapter 3 presented the research findings from the two groups of participants (lecturers/preceptors and undergraduate nursing students) regarding their views and opinions on support for women/clients to make informed decisions about family planning methods.

Chapter 4 focused on discussing the core findings of the study as presented in Chapter 3. The discussion showed that the findings on support for women to make informed decisions from the two groups of participants complemented findings from literature.
The need for support for women to make informed decision was reinforced by the study findings as well as by the Wittmann-Price Theory of EDM (Wittmann-Price, 2004:441).

Six elements of developing practice discipline theory cited by Dickoff et al. (1968:420) were applied in Chapter 5, as follows:

- Who performs the activity?
- Who is the recipient of the activity?
- In what context or framework is the activity performed?
- What is the purpose of the activity?
- What is the guiding procedure or protocol of the activity?
- What are the dynamics which would motivate the nurses and the health care team for the activity?

Seeing that the study aimed at developing guidelines for undergraduate nursing students to support women to make informed decisions about their health care issues, Chapter 5 focused on the development, description and evaluation of these guidelines. Existing evidence pertaining to support for women's empowerment to make informed decisions about their health care issues was synthesised from literature used to control the findings of this study to enhance the researcher's understanding of the phenomenon under study. The findings of this study were also strengthened by the Wittmann-Price Theory of EDM (Wittmann-Price, 2004:441) regarding support for women through education, empowerment and advocacy as the most cardinal strategy for improving women’s decision-making, their lives and those of their children.

A qualitative, explorative, descriptive and contextual design was used in this study for its potential to explain, describe and define the phenomenon. The qualitative research approach was used to understand support for women to make informed decisions from the participants' opinion and point of view (De Vos et al., 2011:64; Polit & Beck, 2012:487). The use of descriptive and explorative design helped the researcher to precisely describe the phenomenon with deeper understanding of the situation on the ground about support for women/clients to make informed decisions about family planning methods.
The study findings showed that women need to be supported, liberated and freed from oppression used against them from various factors, as revealed by participants during focus group discussions. The Wittmann-Price Theory of EDM (Wittmann-Price & Bhattacharya, 2008:226), in line with the findings of this study, proposes five sub-concepts that need to be present in order for women to be emancipated decision makers, namely, awareness of social norms, flexible environment, personal knowledge, empowerment and reflection.

The findings of this study support women/clients making informed decisions about family planning methods. The literature review, literature used to control the findings of this study, results of this study, and field and reflective journal notes demonstrated the importance of the following:

- support for women to make informed decisions about their health care issues;
- replacement of oppression with emancipatory activities; and
- improving the quality of lives for women, their children and communities.

The findings of this study revealed that women and nurses need to be provided with information and to be empowered on reproductive health care knowledge. It also became evident that nurses need to be provided with education and training on advocacy skills to become women’s advocates. Nurses’ bad attitudes, lack of spousal and political support, societal norms and standards, inaccessibility of RHS, overcrowded facilities, and shortage of staff and contraceptive methods were profoundly raised during the focus group discussions as having a negative impact on support for women to make informed decisions about their health care issues. The need to review undergraduate nursing students’ curriculum to incorporate new developments in reproductive health care practices, and the use of innovative, creative teaching and learning approaches to strengthen development of nurses competencies in order to support women to make informed decisions were also strongly raised by the participants of this study.

The EBGD and NICE guideline development processes were modified, adapted, merged into four steps and utilised for the development of the current guidelines. Twelve participants who participated in the main study were selected to participate in
the validation of the guidelines. The participants were purposefully selected based on their work experience with regard to teaching of undergraduate nursing students in class and in clinical practice, level of involvement with regard to provision of reproductive health care to women/clients, and guidelines development. The guidelines were presented to five participants who participated in the pilot study for evaluation. An audit was conducted of the baseline data from the current study findings, literature review and literature used to control the findings of this study to identify core areas that needed to be addressed by the guidelines, namely: accelerating knowledge on reproductive health care, upholding nursing ethics and professionalism, accessibility of RHS, advocating for women and evident leadership.

6.2 RECOMMENDATIONS

The study presented the views and opinions of lecturers/preceptors and undergraduate nursing students on support for women to make informed decisions about family planning methods. Based on the aim of the development of guidelines for undergraduate nursing students, the recommendations are presented under the three intervention strategy levels advocated by Ushie et al. (2010:75), namely, primary, secondary and tertiary level intervention. Clark (2015:449) concur with the Ushie et al.'s (2010: 75) suggested three ways of increasing women’s empowerment by mentioning that planning to meet the health care needs of women as the users of health care services should involve classifying of recommendations as primary, secondary and tertiary level interventions.

Vlok (1996:8) states that preventive and health promotive measures should be executed at three levels of prevention, namely, primary, secondary and tertiary. Vlok (1996) is supported by Allender, Rector and Warner (2013:19), who refer to these three levels as levels of a preventive pyramid that consists of primary, secondary and tertiary levels of prevention. Clarke (2016:2) agrees to the same levels of prevention cited by the above authors, but further adds a fourth level of prevention – the primordial, which includes prior conception activities, for example, performing genetic screening and counselling to avoid abnormalities.
The recommended interventions in this study are based on the above three levels and further sub-divided to cover nurses, lecturers/preceptors and undergraduate nursing students, as well as women/clients.

6.2.1 Primary level prevention/intervention

Primary level prevention/intervention constitutes an individual’s point of entry into a comprehensive community health care system. It encompasses active health-promoting actions planned to reduce occurrences of illnesses while improving people’s overall well-being (Clarke, 2016:3; Stanhope & Lancaster, 2004:52; Vlok, 1996:9). Primary level recommendations for nurses, undergraduate nursing students and lecturers/preceptors, as well as for women, are described below.

6.2.1.1 Recommendations for nurses, undergraduate nursing students and lecturers/preceptors

- Be knowledgeable about the oppressive factors in the environment of women’s health care that hinder women’s effective decision-making about health care issues.
- Commit to developing and implementing health care plans and intervention strategies to replace women’s oppression with emancipatory decision-making activities.
- Develop policies to support women to make informed decisions about family planning methods.
- Develop guidelines to be used by nurses/preceptors and undergraduate nursing students to support women/clients to make informed decisions about family planning methods.
- Allow nurses/preceptors on a rotatory basis to attend workshops regarding support for women/clients to make emancipatory decisions on family planning methods.
- Provide continuous support and counselling to women/clients.
- Lobby for inclusion of a reproductive health services module in the Life Skills subject at high schools.
- Provide ongoing mentorship by experienced professional nurses, peer assessment and conduction of client satisfaction surveys in order to maximise competencies of
undergraduate nursing students, nurse educators and preceptors regarding reproductive health service provision.

- Place undergraduate nursing students with a professional nurse with relevant reproductive health care knowledge and skills for learning activities with regard to support for women on contraceptive choices.
- Set outcomes for undergraduate nursing students to focus on women/clients and how to support them to make informed decisions about contraceptive methods.
- Include learning activities such as participation in community campaigns to create awareness of the importance of support for women/clients to make informed decisions from all stakeholders.
- Provide a supportive environment for women to make emancipated decisions.
- Learn the local language, use translators who belong to the community if need be, use visual tools or communication aids and become attentive to nonverbal use.
- Use all available points of contact, such as waiting rooms, consulting rooms and any platform amendable for healthy discussions to provide information about contraceptive and reproductive health to further encourage women to make decisions on family planning methods.

6.2.1.2 Recommendations for women

- Utilise education programmes, such as seminars, campaigns, group discussions, networking and literacy classes, which could be used to provide reproductive health information to women/clients at all forums.
- Information on different contraceptive methods should be included in the Life Skills subject at high schools.
- Use teaching aids and video to enhance understanding of the content.
- Use media, e.g., televisions and radios, to teach women about women’s health.
- Conduct road shows and campaigns about self-determination and women’s health.
- Formulate women’s groups to encourage women to discuss issues that affect them.
- Establish a call centre for dissemination of reproductive health information to keep women informed of their reproductive rights.
• Teach women skills to negotiate safer sex.
• Hold open discussions with women/clients about reproductive health care issues, including choice of contraceptives.
• Take time to become familiar with the local culture and its impact on the provision of contraceptive services.
• Establish mechanisms for receiving women’s/clients’ feedback and for resolving complaints related to RHS.

6.2.2 Secondary level prevention/intervention

Secondary level prevention constitutes cure and prevention of disease processes, the spread of communicable diseases, and complications and consequences of diseases (Clarke, 2016:3; Vlok, 1996:9). According to the Wittmann-Price Theory of EDM (Wittman-Price & Bhattacharya, 2008:228), which guided the development of guidelines of this study, professional nurses should be aware that oppression is still observed in women’s health care settings and that societal norms still overshadow individual thoughts in decision-making. Based on these statements, recommendations appropriate to the secondary level of prevention follow hereunder.

6.2.2.1 Recommendations for nurses, lecturers/preceptors and undergraduate nursing students

• Identify women’s ability to make decisions about family planning methods and challenges they experience with regard to family planning methods.
• Make use of the nursing process approach, in addition to any available assessment tools, to identify abilities and challenges that may occur.

6.2.2.2 Recommendations for women

• Provide individualised health education to women/clients about available reproductive health services.
• Encourage information sharing between nurses/preceptors and women.
• Explore issues surrounding decision-making as well as those hindering it, pertaining to different contraceptive methods, side effects, household support, and societal and cultural issues.

6.2.3 **Tertiary level prevention/intervention**

This level comprises limiting advanced diseases through rehabilitation and maintenance in communities, which can be achieved by re-training and re-education (Vlok, 1996:9).

6.2.3.1 *Recommendations for nurses, lecturers/preceptors and undergraduate nursing students*

• Create women’s shelters and community-based support services, such as formation of women’s organisations, establishment of group support, women’s literacy clubs, and annual meetings to share experiences and learn from each other.
• Implement different emancipatory teaching and learning methodologies in order to develop critical and analytical skills.
• Provide non-discriminatory contraceptive information and services, and ensure that individual confidentiality, privacy and women’s/clients’ reproductive rights are respected.
• Avoid imposing ideas – rather advise women/clients on options and support them to make a decision.

6.2.3.2 *Recommendations for women*

• Strengthen re-education of women on matters of reproductive health care practices and rights.
• Urgently establish multilateral support systems.

6.3 **RECOMMENDATIONS FOR NURSING EDUCATION, PRACTICE AND RESEARCH**

The recommendations for nursing education and practice, policymakers (Department of Health) and further research follow below.
6.3.1 Nursing education

- A transformative curriculum is necessary to deliver emancipated education, focusing on equalising power between health care providers and women to enable the creation of environment of true humanism which encourages free choice. It is therefore urgent for NEIs to review the curriculum to accommodate emancipatory teaching and learning methodologies to develop undergraduate nursing students’ competencies to support women’s emancipation in decision-making.
- Nursing educators and preceptors should guide undergraduate nursing students towards effective and informative communication with women regarding reproductive health.
- Provide continuing education to nurse educators and preceptors to capacitate them with reproductive health care service provision.
- Educate undergraduate nursing students on effective strategies for eliciting honest disclosure of information.
- Ensure that nurse educators and preceptors have knowledge and skills in counselling so as to guide undergraduate nursing students.
- Ensure that nurse educators and preceptors have knowledge of social norms of the community so as to guide undergraduate nursing students.
- Conduct sustained mass education for both men and women on championing support for women, including creating awareness on gender equity, cultural norms and societal expectations that perpetuate oppression of women regarding decision-making about family planning methods.
- Ensure development of undergraduate nursing students’ competencies, knowledge and skills on the role of client advocacy and effective patient counselling for new approaches.
- Put systems in place to incorporate NEIs’ academic staff into continuing in-service training on National Health Priorities.
- Keep nurse educators and preceptors updated on new guidelines relating to provision of reproductive health services.
• Establish partnership with other stakeholders such as NGOs for collaborative efforts to support women to make decision on contraceptive issues.

• Implement transformational teaching and learning in the facilitation of learning. This will enable undergraduate nursing students to build competencies for supporting women/clients in making emancipated choices about their health care issues.

• Conduct workshop to introduce the guidelines to nursing education academic staff.

6.3.2 Nursing practice

• Ensure availability of systematic referral of women according to their family planning service needs.

• Conduct workshops on professionalism to improve women’s quality of life.

• Lobby for availability of resources.

• Capacitate health professionals. This will improve confidence in providing services; thus, their attitude will be positive.

• Maintain a good nurse-to-patient ratio to allow ample time to educate women requesting family planning methods. This will assist women to make informed decisions regarding family planning methods.

• Develop a retention strategy for nurse educators and preceptors to address staff shortages so that good support for undergraduate nursing students can be maintained.

• Family planning services should be provided by knowledgeable and skilled professional nurses.

6.3.3 Department of Health

• Lobby for political will as well as support to improve adequate accessibility of reproductive health services and budget for resources.

• Lobby for prioritisation of reproductive health services.

• Develop, implement and monitor policies that support women’s emancipation in terms of decision-making activities.
6.3.4 Research

- Follow-up research should be conducted on the entirety of family planning services, available policies on this topic, and sociocultural determination in relation to what works in support of family planning services.
- Research needs to be conducted to evaluate the guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods to determine their applicability and suitability for nursing practice.
- There is a need to test the guidelines in a clinical setting in order to arrive at a conclusion about their feasibility and applicability.
- Further research should be conducted to determine the impact of using the guidelines to support women to make informed decisions about family planning methods and to improve the quality of health care for women.

6.4 LIMITATIONS OF THE STUDY

As the study was conducted in one province (Mpumalanga), it is entirely possible that the findings would differ if the same study were to be conducted in another province cannot be disputed. The undergraduate nursing students struggled to express themselves in English. This is a limitation because, if the data collection instrument could have been in Isiswati, which is the students’ home language, more information could have been extracted about the topic under study. Some participants could have been more free to narrate their views and opinions about the topic if data collection had been through individual interviews rather than focus group discussions. This will then require workshops to introduce the guidelines to the relevant nursing education and practice forums.

6.5 CONCLUSION

The aim of the study was to develop guidelines for undergraduate nursing students in order to support women to make informed decisions about family planning methods. The findings of this study confirmed that women are currently not supported to make
informed decisions about family planning methods. Methods are imposed on them without their consideration.

Furthermore, lecturers/preceptors and undergraduate nursing students admitted that they lack knowledge and skills on reproductive health care practices (family planning services), especially new developments. There are also numerous challenges experienced by nurses and women in RHS facilities and in society. This produces oppression of nurses and women, with nurses consequently being unable to support women to make informed decisions about family planning methods. It is therefore paramount that nurses should explore with women all negative encounters that discourage women’s decision-making and replace these with emancipatory activities that encourage women’s decision-making without coercion. Guidelines for undergraduate nursing students that may facilitate support for women to make informed decisions about family planning methods have been developed, described and presented, as well as evaluated by participants. This proved conclusively to the researcher that the guidelines are functional and implementable. It is envisaged that on implementation of the guidelines developed from this study, it would improve support for women decision making on their reproductive healthcare needs.

This study further offers undergraduate nursing students, nurses, other health professional and the Department of Health the opportunity to participate in supporting women to make informed decision about contraceptive methods to improve their lives, as well as those of their children and community. Undergraduate nursing students, nurses and other health professionals can relate the guidelines to practice in order to improve health outcomes for the country.
REFERENCES


Barot, S. 2013. In search of breakthroughs: Renewing support for contraceptive research and development. *Guttmacher Policy Review*, 16(1). Available at:


Clarke, M. 2016. Vlok’s community health. 6th revised ed. Cape Town: Juta.


NICE see National Institute for Health and Care Excellence.


Sanjari, M., Bahramnezhad, F., Fomani, F.K., Shoghi, M & Cheraghi, M.A, 2014. Ethical challenges of research in qualitative studies: the necessity to develop a specific guideline. Journal of Medical ethics and History of Medicine, 7: 14.

SANC see South African Nursing Council.


SIGN see Scottish Intercollegiate Guidelines Network.


WHO see World Health Organization.


ANNEXURE A: INFORMATION LEAFLET AND CONSENT FORM

1. INFORMATION LEAFLET AND CONSENT FORM FOR FOCUS GROUP DISCUSSIONS

UNIVERSITY OF LIMPOPO (Medunsa Campus) Informed consent form

Statement concerning participation in a Research Project

Name of Study: Guidelines for Undergraduate Nursing Students to support women to make informed decision about family planning methods

I have read 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 pressurized 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 my learning in this school.

I know that this study has been approved by the Medunsa Campus Research and Ethics (MREC), 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 guardian   Date

________________________
Statement by the Researcher

I provided verbal 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
2. INFORMATION LEAFLET AND CONSENT FORM FOR GUIDELINE DEVELOPMENT AND REFINEMENT PARTICIPANTS

Information pamphlet

Dear Stakeholder/Participant

1. INTRODUCTION

Kindly receive an invitation for you to participate in the refinement of guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods. Participation is voluntary. This information pamphlet will assist you to decide if you want to participate in the study. If you have any questions that this pamphlet does not address, please do not hesitate to ask the researcher. However it is important that you understand what is involved

2. THE PURPOSE AND NATURE OF THE STUDY

I am developing guidelines for undergraduate nursing students based on the findings on the views and opinion of lecturers/preceptors and undergraduate nursing students to support women to make informed decisions about family planning methods. You as a stakeholder are a very significant source of information for refining of the guidelines. The guidelines are intended for use by undergraduate nursing students, lecturers/preceptors and other health professionals to support women to make informed decision about family planning methods in order to promote their health and that of their babies. You have been identified to participate in the refinement of this guidelines based on your experience in the field of family planning services and in teaching undergraduate nursing students reproductive health care, family planning services included

3. PROCEDURES TO BE FOLLOWED IN GUIDELINES REFINEMENT

Should you agree to participate:

- You will be required to refine the draft guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods.
• Correspondences regarding the whole guidelines refinement process will be done through emails. However clarification of queries may be followed telephonically.
• All stakeholders that will participate in this study will remain anonymous to one another and their inputs will be kept confidential.
• The researcher will consolidate all inputs from stakeholders

4. POSSIBLE DISCOMFORTS AND RISKS

• There will be no risks involved in participating in this study

5. POSSIBLE BENEFITS

• Your participation will help the researcher in refining the guidelines. There will be no direct benefit to you from participating in this study

6. YOUR RIGHTS AS A PARTICIPANTS

• Your participation is voluntary
• You may refuse to participate or withdraw your participation at any point. This will not affect you in any way

7. ETHICS COMMITTEE

• The study received clearance of the Sefako Makgato Health Sciences University and Mpumalanga Department of Health Ethics Committee

8. INFORMATION AND CONTACT PERSON

• The contact person for this study is the researcher, Ms Theira Julia Maunye
• For any queries, please contact me on Cell number: 0834842149/0797396115; email address: juliamau@mpuhealth.gov.za
• You are also allowed to contact my supervisor on Cell number: 0823481944

9. COMPENSATION

• There will be no payment for participating in this study

10. CONFIDENTIALITY

• Correspondences and records in this study will be kept confidential
• After analysis of the information no one will be able to identify stakeholders
• Should there be any assistant needed in analysing the data, there will be a confidential consent to sign by the assistance.
• Reports and articles in scientific journals will not include any information that may identify you as a participant.
INFORMED CONSENT FORM

Statement concerning participation in a Research Project

Name of Study: Guidelines for Undergraduate Nursing Students to support women to make informed decision about family planning methods

I have read 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 pressurized 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 my learning in this school.

I know that this study has been approved by the Sefako Makgato Health Sciences University Research and Ethics (MREC). 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  Date

____________________  ________________  ______________
Witness           Signature of witness  Date

Statement by the Researcher

I provided verbal 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
INVITATION TO PARTICIPATE IN THE EVALUATION OF GUIDELINES FOR UNS TO SUPPORT WOMEN TO MAKE INFORMED DECISIONS ABOUT FAMILY PLANNING METHODS

I am a PhD student in the department of nursing science at Sefako Makgato Health Sciences University. My supervisor is Professor MLM Sengane and I am conducting a study on development of guidelines for undergraduate nursing students to support women to make informed decisions about family methods.

AIM OF THE STUDY

The aim of the study was to develop guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods using Mpumalanga College of Nursing as a focal area.

OBJECTIVES FOR THE STUDY

To achieve the above aim, the study was conducted in two phases.

Phase 1 focused on exploration of views and opinions of participants. The objectives were:

- To explore the views and opinions of undergraduate nursing students, lecturers and preceptors on ability of nurses to support women to make informed decisions about family planning methods (phase 1 step 1),
- To explore the views and opinions of undergraduate nursing students, lecturers and preceptors on factors surrounding women’s health that impinges on their freedom to make informed decision about family planning methods (phase 1 step 2),
- To explore the views and opinions of undergraduate nursing students, lecturers and preceptors, the type of content that need to be included in the education and training of nurses to support women to make informed decision about family planning methods (phase 1 step 3).

Phase 2 focused on the development of guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods. The objective was to:
• To develop guidelines for undergraduate nursing students to support women to make informed decisions about family planning methods.

You are therefore invited to participate in the evaluation of the guidelines for UNS to support women to make informed decisions about family planning methods. There are 19 guidelines with rationale and actions that should be implemented by UNS, lecturers/preceptors and nurses on support of women to make informed decisions about family planning methods. Please read through each guideline and comment based on table 5.4. provided in chapter 5 Or, You may also make suggestions at the end of each actions of the guideline or at the end of all the guidelines whichever way convenient for you. The refinement will take two hours of your time to complete.

You are requested to return your comments not later than 01 November 2017. Your comments are highly valued. The comments will be consolidated and analysed for final compilation of the guidelines.

For any clarification you might need contact me on cell number: 0834842149/0797396115. Email address: juliamau@mpuhealth.gov.za
Dear Sir/Madam

Re: Request to conduct a research study at Mpumalanga Nursing College

Permission is hereby requested to conduct a study on guidelines for UNS to assist women to make emancipated decisions about family planning methods in Mpumalanga Province at the Nursing Education Institutions and its clinical training facilities.

Iam Theira Julia Maunye, student at University of Limpopo (Medunsa Campus) studying for PhD in Nursing Science.

The study will be conducted in the South African Nursing Council (SANC) accredited NEI and its clinical training facilities, and this are done in fulfilment of my studies. The title for my study is ‘guidelines for UNS to assist women make emancipated decisions. The study is supervised by Dr. MLM Sengane and Dr. J Dippernaar.

The purpose and objectives for this study will be provided to the participants in a leaflet form. The study will involve student nurses, lecturers, professional nurses and medical practitioners. Confidentiality, privacy and informed consent will be obtained. Medunsa Research Ethics Committee (MREC); and the Mpumalanga Province Research Ethics Committee approved the research proposal.

Yours Sincerely

Theira Julia Maunye

Student No: 2010

Cell No: 0834842149

E-mail: juliamau@mpuhealth.gov.za
ANNEXURE B: INTERVIEW GUIDE

Biographical information for participants for all participants

Code (category of participants)____________________ Date ________________

Tick the appropriate answer:

Gender

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
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Age

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<th>31-40 Years</th>
<th>41-50 Years</th>
<th>51 and above Years</th>
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Marital status

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<th>Widow</th>
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Religion

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Occupation

<table>
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<tr>
<th>Student nurse</th>
<th>Lecturer</th>
<th>Preceptor</th>
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</thead>
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</table>
FOCUS GROUP DISCUSSIONS FOR ALL PARTICIPANTS

Title of the study: Guidelines for UNS to support women to make informed decisions about family planning methods

Date FGD Conducted __________________

Number of FGD members _______________      FGD Code ______________

1. Let us talk about the reproductive health services offered to women by undergraduate nursing students.
   
   a. What is your opinion about these services?

2. Explain the role of the nursing profession in the provision of reproductive health services for women

3. Let us discuss about how undergraduate nursing students are prepared for their role in the provision of reproductive health services
   
   a. At what level of study should the training be offered?
   
   b. What is contained in the curriculum?
   
   c. Who teaches that curriculum?
   
   d. What activities are used for teaching?
   
   e. How is the presentation assessed?

4. What teaching materials are used to prepare nursing students to assist women in making decisions on reproductive health services for women?

5. Let us talk about the characteristics of nurses who is adequately prepared to assist women to make informed decisions about reproductive health services

6. What are the indicators that women we serve are able to make informed decisions about their reproductive health services?

7. What can be done to improve support of women to make free decisions without pressure of any kind about family planning methods?
8. What challenges do nurses experience with regard to support for women to make decisions about family planning methods?

   a. What skills do nurses need?

9. Is there anything else that you would like to tell me about the provision of reproductive health services?

This bring us to the end of discussion and thank you very much for your time and your valuable information you shared with us.
ANNEXURE C: ETHICS COMMITTEE LETTER OF APPROVAL

UNIVERSITY OF LIMPOPO
Medunsa Campus

MEDUNSA RESEARCH & ETHICS COMMITTEE

CLEARANCE CERTIFICATE

MEETING: 08/2013
PROJECT NUMBER: MREC/H266/2013: PG

PROJECT:
Title: Guidelines for undergraduate nursing students to support women to
make informed decisions about family planning methods

Researcher: Ms TJ Munyu
Supervisor: Dr MLM Sengane
Other Involved HOD: EJ van Asweegen
Department: Nursing Sciences
School: Health Care Sciences
Degree: PhD Nursing Sciences

DECISION OF THE COMMITTEE:
MREC approved the project.

DATE: 03 October 2013

PROF N EBRAHIM
DEPUTY 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.

Finding Solutions for Africa
ANNEXURE D: APPROVAL LETTER FROM THE DEPARTMENT OF HEALTH
MPUMALANGA PROVINCE

MPUMALANGA PROVINCIAL GOVERNMENT

Building No. 3A
No. 7 Government Boulevard
Riverside Park Extension 2
Nelspruit
1200
Republic of South Africa

Department of Health

Enquiries: Thembeka Mulunge (013) 766 3511

24 February 2014

Ms. Julia Maunye
Mpumalanga College Of Nursing
P O Box 716
KABOKWENI
1245

Dear Ms. Julia Maunye

APPLICATION FOR RESEARCH & ETHICS APPROVAL: DEVELOPMENT OF GUIDELINES FOR UNDERGRADUATE NURSING STUDENTS TO SUPPORT WOMEN TO MAKE INFORMED DECISIONS ABOUT FAMILY PLANNING METHODS

The Provincial Research and Ethics Committee has approved your research proposal in the latest format that you sent.

Kindly ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Kind regards

[Signature]

DR. WILLIAM MAPHANGE
CHAIRPERSON PHREC

Use this logo in your report?
Introduction

Welcome to this group discussion session and thank you very much for honouring the invitation

My name is Julia Maunye, Sefako Makgato Health Sciences University (Nursing Science Department) student, I will be facilitating this session. With me are Dr. Ramaite Mookamedi and Mrs Ina Bence who will be assisting me in taking notes and recording the whole session. Dr Mookamedi will also provide technical support for this session

Objective of this focus group as explained to you during the recruitment session is to talk about reproductive services and to request you to share your views, opinions and experiences with me about this topic so that we can develop guidelines for undergraduate students to assist women to make informed decisions about reproductive health services

Participation is still voluntary, there is no right or wrong answer to the question, if you feel uncomfortable in the process you can pull out there will be no punitive measures against you
Confidentiality, respect for each other is of outmost important as well you are kindly not to mention the names of each other will discuss.

The session will be recorded as well as notes taking will be done.

Kindly fill in the biographical data form before we commence with the questions, the information will be kept by me (the researcher) in a safe.

Let us now commence the session which is estimated to take less than an hour; please feel free to request repeat of a question if you need clarification.

<table>
<thead>
<tr>
<th>R:</th>
<th>Let us talk about the reproductive health services offered to women by nurses, what is your opinion about these services?</th>
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<tbody>
<tr>
<td>P:</td>
<td>P1/FGD1: I can start... reproductive services, they are offered taking a variety of forms such as of family planning as is commonly referred to. For family planning women are basically afforded an opportunity to plan for their pregnancies. During the provision of reproductive services women are suppose to make their choice of contraceptive methods based on the information we are giving them. As educators we teach student nurses about educating the women to ensure that they are informed about use of contraceptives to plan for their pregnancies. However whilst women are supposed to be deciding on methods of contraceptive, they do not decide in some instances, for example, during pregnancy they are told to make choices but after delivery in some instances they are given the injectable;</td>
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<tr>
<td></td>
<td>R: according to your view, why are they not allowed to make choices and be given injectable method only?</td>
</tr>
<tr>
<td>P:</td>
<td>P1/FGD1: May I make a follow-up because I came up with this information; personally I have directly asked this question as to why are women given the injectable contraceptives post-delivery. Most of the time they do not decide, they find themselves expose to injectable method.... After delivery they are not given a chance to make the choices, they are given the injection. What I got from the patients is that they are of the opinion that they have to get the injections until they can get back to the clinic. It is a practice not a protocol; in my opinion patient have a right to make choices, but in this instance that right is violated, I think because of the high rate of pregnancy, nurses give all post-delivery women injectable methods</td>
</tr>
<tr>
<td>P:</td>
<td>P2/FGD1: Some religions prohibit sex prior marriage stating that it is morally incorrect to have sex prior marriage... and this becomes a challenge because the majority of women (clients) think they will be judged if they are seen openly seeking contraceptive methods, let alone choosing the pill, hence they prefer an injectable contraception...</td>
</tr>
<tr>
<td>P:</td>
<td>P7/FGD1:... Others are afraid of their spouses to even venture into choosing a method of contraception...</td>
</tr>
<tr>
<td>P:</td>
<td>P2/FGD1: The issue of not making informed choice is because the nurses who provide these services they do these as a routine they do not have time to give patient information, is like they are pushing to finish the routine work</td>
</tr>
<tr>
<td>R:</td>
<td>R: What do you think are the contributory factors for nurses to provide family planning services as routine services?</td>
</tr>
<tr>
<td>P:</td>
<td>P3/FGD1: Overcrowded facilities with limited resources. Family planning should starts prior to conception, where nurses give information, nurse should go teach at schools about family planning. But we find that the prior conception information is not given to the women in the community. Another thing is that only two methods are used as contraceptives, the Nuristrate and Depo-Provera. The oral ones and other methods are not used until after six weeks when women come for post-delivery check-up, like my colleagues mentioned there is no protocol on this but nurses continue doing it. In practice or from what I have observed, usually post-delivery women are undecided on contraceptives, when we ask them they tell you they have not yet decided on a method because of family dilemmas. The other methods are not used at all.</td>
</tr>
</tbody>
</table>

286
After 6 weeks they can go to the clinic and choose contraceptive methods;

O: ALL participants nod heads while this participant continues narrating; others say they cannot use contraceptives, they need to inform their husbands first. I think we should start focusing on prior conception family planning services health education. We need to go to schools and teach those school children, to give more information about family planning. According to other hospital practice only two methods are administered to women, that is, Nuristrate and Depo-Provera. Women are not decided after delivery because they are not provided with an opportunity to do so. These women are not able to make decisions on which methods they will use.

R: In your opinion why are these women not able to make decisions?

P3/FGD1: The majority of them are not informed, they do not know what is available for them. Others are afraid of their spouses. Again post-delivery it will not make sense to ask them about a method because the practice is that only nuristrate and Depo-Provera are administered post-delivery routinely.

R: What is your view about this practice?

P7/FGD1: Colleagues will agree with me that we surely do not respect the right of women and this practice need further Investigation because irrespective of whatever circumstances people have the right to have a voice about health care option they prefer.

P5/FGD1: Putting people first should be practiced during delivery of health care services...actually the rights of people must be observed, it is important to remember that clients have the rights to information about the health services available to them so they can make decisions or decide on services that are based on knowledge they possess.

P: Yes, all agree

R: Does it mean women commonly do not make decision about contraceptive methods outside of their husbands’ permission?

P1/FGD1: We come across such instances where women do not make decisions outside their husbands’ permission. The majority of women because of their culture are subordinate to their spouses.

P4/FGD1: In my opinion I think we are judgemental, we do not allow women to exercise their intellectual abilities in making choices, and we impose methods. We think we are supposed to choose for them, we look at what is available in our facility, from there we just choose a method for them, we also look at parity and what methods will prevent women falling pregnant again, and make them stay away from health services for a long time; and we think we keep them away from coming to the health facility. There are also limited methods of contraceptives, unlike in the private sector where women are exposed to other methods. In other setups in other clinical areas before our clients can come to our clinic, we have already prepared the Injectable without knowing how many will use the method. It is presumed that all women are to get pitogen injection. We look at the number of babies and decide...on a method for these women and this is a serious misconduct but because nurses are overworked they do not discourage those who are involved in this bad practice.

R: May I understand, why are you nodding your head?

P3/FGD1: You see me nodding my head because indeed women are given injections without their choices, however I still believe that it is the right of women to make choices on a method. I totally do not agree with making choices for women, but routinely this is what we do, deciding for women. I think is because nursing is no longer a calling but a poverty alleviation, hence no advocacy is practiced.

P7/FGD1: Problems might be that the women they not fully aware what are the side effects or... what are adverse effects so when it happens that they come across side effects they think they are adverse effects and they discontinue and they do not have much trust on it any more that is why they do not use them anymore.

P5/FGD1: Nurses are to give the information to their clients though this is not happening, clients are not...
given the information of side effects…. Not told they will get amenorrhea. The contraception are limited in our practice there are oral or injectable, is like you do not have options to choose from

**P5/FGD1:** … I think knowledge is power, most of us nurses we lack knowledge of new RHS development… this is not correct… nurses and students included must be educated on a new thing to can lead the health care for who need it… you see all these things.

**P6/FGD1:** Most of the people are skilled but the problem with us is that we do not want to take something that takes time, IUCD needs preparation, sterile field while administering Injectable contraception is easy. There is no document stipulating that we should only administer oral and injectable contraceptives we just want to do things that are easy and less challenging and less time consuming within the staff shortage against number of clients to be seen.

R: Based on what you articulated, what could challenges for women seeking family planning?

**P10/FGD1:** Effective use, let me say choosing of contraceptive methods are also influenced by myths as you know maybe eight out of 10 girls you consult at the facility will tell you that they will be more wet during sexual play with their partners… and they will be fat, you know.

**P5/FGD1:** And these young girls tell you that my husband or boyfriend will say I am full of water during sex…. laughing…

**R:** Explain the role of the nursing profession in the provision of reproductive health services for women

**P1/FGD1:** Nursing services has the responsibility to provide information to women; to administering the very services; they have to monitor their clients; follow them up; check adherence; they need to know how the method is treating the women are they comfortable. The service must have intense interaction with women, and to finally check such a method whether the women is experiencing side effects. If the monitoring is not given the women will stop at any time if the side effects are not bearable to them.

**P8/FGD1:** The providers should be trained and be skilled as to give the correct information using many teaching methods, like using charts or creating media awareness as is done on radio talk shows, they need to be really equipped in this regard

R: Are you saying this because you feel that currently nurses are not well trained and skilled to render the RHS

O: All agree at the same time….yes

**P1FGD1:** Nurses have a short fall in this regard, they are not allowing women to decide on a method due to their deficit knowledge and skills and probably because the methods are limited currently and they say, what is the point of exploring other methods when you cannot provide such to the clients

**P7/FGD1:** Our institutions must take a stand and provide nurses with family planning training so that our clients get proper information and make informed choices according to their needs. Nurses complain about the number of clients per nurse ratio. Clients complain about poor services and yet these are not attended, it looks as if it is a minor thing, professional nurses continue not explaining thoroughly about what women report to experience with the methods. Women are leave the reproductive health facilities without getting full information and benefits of methods as well as side effects thereof. Health services need to expand the RHS, we need to promote the super market method of service delivery. The RHS system should be assessed and be checked whether they are still healthy to be implemented. There is a need for information sharing with the recipient of services to learn from them on what is relevant. RHS need to be streamlined with other CHC services and have dedicated nurse practitioners to provide these services, whereby screening is done and much attention is focus on encouraging clients to make own decisions.

**P1/FGD1:** On the issue of service streamlining the service I want to emphasize the need to delegate responsible or dedicated professional nurses specifically to provide family planning services for continuity in client care. The nurses or practitioners need to be encouraged to engage the women’s partners so that
decision are taken together, advice their partners and spouses together during consultation.

P7/FGD1: Yaal! I agree that dedicated nurses with knowledge and skills should be delegated to provide family planning services, like the method, IUCD only one person was trained during my practice…. She give the advantages and disadvantage of a method and more women were attracted to the method because they had more information about it, she will tell them about pap smear…it help most women they were transferred to the gynaecologist…even STI were treated and the rest other findings will be attended and be treated. This become beneficial to clients and women will openly discuss their health issues with this nurse because she had passion for what she was doing. The nurse must advocate for availability of contraceptive at the same time, listening skills should be applied; remember the nurses nature is that of helping patients daily

P3FGD1: I want to add that advocating is our role as nurses, we must ask what services client want or we will mislead the people. Keeping their information confidential is also important.

R: Let us discuss about how undergraduate nursing students are prepared for their role in the provision of reproductive health services:

P: P1/FGD1: In their curriculum there is training as part of their community health. They are taught of all women’s health general health students should be aware that before the women can engage in sexuality she should be informed contraceptives to prevent unwanted babies so that they engage in sexual activities without fear of pregnancy. Students are taught all the methods of family planning there is a whole module for teaching student on RHS which extend to PHC facilities.

O: Making emphasizes with hands while talking

P4/FGD1: Learners are also exposed in the clinical area , the participate in the actual provision of reproductive health services

R: (a) At what level of study should the training be offered?

P5/FGD1: Second year level it is appropriate, they are doing Physiology. They move on to do Midwifery, they need apply knowledge of the Anatomy taught in first year. The Anatomy of the very uterus where IUCD is inserted.

P5/FGD1: Second year level is ideal year for introducing reproductive health content and the student have knowledge of basic subject and will be placed at the clinics and relevant units such as gynae to learn more about family planning practices.

O: All quite no one is talking

R: What are the other colleagues say about this?

P: All agree… yes second year is relevant

P5/FGD1: However the time spent on this aspect of RHS is too short because the time is divided amongst other aspect of their learning, unlike with the previous nursing curriculum of our time. We had much time to practice and learn the skills of practicing RHS. I think is high time that the curriculum is reviewed to incorporate modern and creative ways of increasing student learning time in the reproductive healthcare. Family planning practice time should be intensified in the facilities.

R: (b) What is contained in the curriculum?

P7/FGD1: The family planning content is integrated in the Community Nursing Science subject They should be practically given sufficient time to practice RHS skills, interacting intensely with clients, they should have a particular period of practically doing family planning as this is important as the diseases. They need to
demonstrate the use of condom to the public as a method of family planning and STIs prevention.

**P11/FGD1:** There are modules of family planning mainly in the Community Nursing Science, General Nursing Science, even in Midwifery… in Pharmacology is not a full module but the family planning medications are learnt by students.

**P6/FGD1:** As part of their curriculum students are expected to complete a Community Nursing Science module on family planning there are also other family planning modules which form part of the students curriculum for which they are required to complete during their education and training and these modules are integrated in subjects such as midwifery for reinforcement of reproductive health.

**P4/FGD1:** I am supporting my colleagues, the community exposure time for students is limited and do not make nurses competent. I agree that there is a need to intensify the training in this area especially time spent at the practical site. Students should be given more assignments on the clinical area for reproductive health, they should be exposed to different methods of learning and information to develop their competencies, unlike now they do not learn much. We asked why they do not have clinical skills is because their learning is limited. Students when asked why are they providing the kind of RHS they always say I don’t know I was given the task to perform, they do not apply their mind they just do, and hence they cannot support patients. There is a skills gap there, probably due to limited exposure to RHS, the time spent, how they are taught and period of exposure is a challenge we need to look at this as lecturers.

**O:** They all agreed on this

**R:** (c) Who teaches that curriculum?

**P1/FGD1:** Lecturers are teaching the students. At college the lecturers that are teaching Community Nursing Science are involved in teaching of reproductive health which in third and fourth year enforced by midwifery lecturers, however most of the time expert nurses like PHC nurses are requested to teach the students.

**R:** (d) What activities that are used for teaching?

**P3/FGD1:** Strategies used in teaching students includes amongst; use of lecturing methods, modules are given to students, discussion, and correlation to theory when they go to practice. Clinics got nice pictures posters. Students are given time frames be in the simulation room to practice clinical skills and then go to real patients and give the feedback. They are also assign to identify the women’s real needs, although it is not easy and again time is the issue we try to give more but there is competition of components.

**P6/FGD1:** We use demonstration, formal lecture, in service training, campaigns, awareness programmes, and seminars as methods of educating students regarding reproductive health…

**P5/FGD1:** … also modules are given to students and discussions for correlation to theory when they go to practice… they are given time frames whereby they go to real patients and give the feedback. Identify the women’s real needs… although it is not easy… time is the issue but we try to give more…. I think is high time that the curriculum is reviewed to incorporate modern and creative ways of increasing student learning time in the reproductive health care. Family planning time intensified in the facilities.

**P2/FGD1:** Assessments of students for theory content is done through written tests, group presentations… and demonstration feed-backs are used to assess clinical competences before students are exposed for practical assessment…

**P1/FGD1:** Personally I wish a lot of direct students’ observations as also a form of assessment during accompaniment can be increased, you can also see if student has good relations with women (clients) and is competent as well… though this is not happening due to large number of student against tutors and preceptors.

**P:** All agree at once…yes
R: (e). How is the presentation assessed?

P8/FGD1: How the students are assessed, firstly through the written assessment….testing knowledge. When at the clinic they are tested hands-on. They need to have about 25 patients whom they have administered the family planning method and giving of health education to the whole aspects of reproductive health care.

P7/FGD1: Yes and also we advise the learners to prepare a script where they address the women with family planning…. Like giving health education. We also follow up to see how they administer the contraceptives like the injectable.

R: What teaching materials are used to prepare nursing students to assist women in making decisions on reproductive health services for women?

P: P1/FGD1: Posters, different methods are shown to mothers, even live materials (patients) such demonstration of administration of injectable to real patient and insertion of IUD to real patients, different contraceptive methods, workbooks and learner guides are also used,

P7/FGD1: We use demonstration, formal lecture, in service training, campaigns, awareness programmes, and seminars as methods of educating students regarding reproductive health...

P2/FGD1: … also modules are given to students and discussions for correlation to theory when they go to practice… they are given time frames whereby they go to real patients and give the feedback. Identify the women's real needs… although it is not easy… time is the issue but we try to give more…. I think is high time that the curriculum is reviewed to incorporate modern and creative ways of increasing student learning time in the reproductive health care. Family planning time intensified in the facilities.

P5/FGD1: I think lecturers need to be creative about increasing learning time with students… involve them in electronic self-study materials… maybe seeing a scenario on family planning consultation then give assignment to respond to it.

P1/FGD1: Posters depicting different family planning methods with indications and contraindications are displayed at the health facilities… there are also posters… even live methods… mothers are shown these methods and they then decide on a preferred one...

P3/FGD1: What I have seen is that in other clinics and in some wards where women stay after delivery… Health education is given using models that show how to help the partner on how to use condoms.

P5/FGD1: Use of the language they could understand when giving information to mothers could also be a powerful material to assist women to make informed decision, video material

O: A long pause, no additional input added by participants

R: Let us talk about the characteristics of nurses who are adequately prepared to assist women to make informed decisions about reproductive health services
<table>
<thead>
<tr>
<th>P:</th>
<th>P6/FGD1: Should be a good listener and good people person she needs to be patient. Nurses should be positive about family planning. Should possess more of knowledge and skills on reproductive healthcare practices. She should be able to clarify her values to ensure that such are not imposed to clients. She needs to be up to date on information changes, read articles on family planning.</th>
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<tbody>
<tr>
<td>O:</td>
<td>Silence, no one is talking</td>
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<tr>
<td>R:</td>
<td>What are the views of others about characteristics of nurses re- supporting women to make informed decisions?</td>
</tr>
<tr>
<td>P4/FGD1: Umh…this person must be sensitive and show respect, she must not be coercing patient to choose x method. Should not impose her values as well</td>
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<tr>
<td>P1/FGD1: Professional secrecy should be observed, I remember some people use to leave the clinic cards at the clinic so that the husbands do not know so nurses should not divulge such information even if they know the women’s husband. Yes because of how man act superior to their wives, as mentioned women may tend to use a method that cannot e seen such as IUD and injectable because is easy to conceal such from their husbands</td>
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<tr>
<td>R:</td>
<td>Then what do you think can be done to remedy this status quo?</td>
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<tr>
<td>P8/FGD1: Involve their partners if those males can partake in the women’s reproductive health they will start to appreciate the trouble their wives go through.</td>
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<tr>
<td>P2/FGD1: Give the information fliers to take to the husbands, they might support. We can use the media to talk to all men and the entire community.</td>
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<tr>
<td>P1FGD1: I believe in Empowering women about reproductive health, we need media and all other strategies we know partners eh! may be unapproachable, this woman will assess the partner and agree on best approach. It is important that the nurses must have a dialogue with women about this</td>
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<td>P7/FGD1: I agree we need to extend the service to men, talk about vasectomy, cut the barrier, extend the service to male…We need to discuss this broadly as RHS rather than focus on the name/concept family planning. RHS is inclusive of a variety of aspects in reproductive health.</td>
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<tr>
<td>R:</td>
<td>What are the indicators that women we serve are able to make informed decisions about their reproductive health services?</td>
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<tr>
<td>P:</td>
<td>P1/FGD1: We can refer to the number of women using our contraception, If the number increasing …mmmm it is a positive indicator. The number if unwanted pregnancies should be decreasing, increasing is a negative indicator</td>
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<td>P2/FGD1: Also verbalising which methods of contraceptive are available…</td>
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<tr>
<td>P4/FGD1: What colleagues mentioned is true, and just to add that there are other indicator such as Illegal abortion will drop as an indicator of women making informed decisions without being pushed to do so.</td>
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<td>P8/FGD1: It is good to do research (analysis) on what works for women… so research should be done to find out what is best.</td>
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<tr>
<td>R:</td>
<td>What can be done to improve support of women to make free decisions without pressure of any kind about family planning methods?</td>
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</table>
P: P7/FGD1: Verbalizing which methods are in the facility. Information sharing on available service using any moment so that all the methods can be used. Share with all women even in social gathering.

P5/FGD1: I will add by saying that positive attitude, non-judgemental, respect the autonomy of making own choices. Nurses should have that mind-set and allow women a chance to choose a method....

P5/FGD1: Legal aspects supporting women and enhancing access to RHS should be implemented. Work positive towards creating positive work environment, warm-up for women who are coming to the services as well as availability and accessibility of nurses is a valuable supportive means towards decision making.

P: P1/FGD1: Respect the right of women to make decisions. Implementing the human rights approach services. Allow women space to make own decision after providing adequate information, do not offer what is easy for us and available to us, rather refer. Avoid cohesion women.

P7/FGD1: Iam not sure about this... just tell them that the body should rest ... two three years before another kid. Educate women about spacing of children. Explain all advantages and disadvantages of the methods and emphasize that women have a right to choose

P2/FGD1: The women have the right to choose, hence this right should not be violated, as said an emphasis need to be around their rights all the time.

P4/FGD1: ...eh yeah, I think lecturers must assist UNS to be competent so that they can advocate for their patients, you know, yes...it is important.

R: What challenges do nurses experience?

P: P8/FGD1: There are no structures at facilities to provide the services, there is shortage of nurses against large number of clients seeking health services including RHS and the services must be provided by one nurse

P7/FGD1: Training on provision of contraceptives, resources are needed currently it is not happening, lecturers are not included to the department training plans.. There is no streamlining of professional nurses in-services with the college/nursing college lecturers.

P3/FGD1: ... I think knowledge is power, most of us nurses we lack knowledge of new RHS development... this is not correct... nurses and students included must be educated on a new thing to can lead the health care for who need it... you see all these things.

P3FGD1: To sum it up intensify nurse training... eh! We want nurses to be empowered on new developments and be included in all patient care matters because they are always close to the patient. Nurses’ empowerment will build their confidence in providing services teaching of the undergraduate nursing students...

P1/FGD1:Nurses need to have facilitation, communication skills in order to offer effective counselling

P3/FGD1: There is also a need for supportive policies with resources allocated for implementation of client advocacy. Complains by women must be well channelled and attended; have less intimidating services and replace such with user friendly respecting and valuing patients’ freedom of self-determination and assisting them throughout the decision making process and ...allowing choice of a method. Posters and pamphlets used to increase information on family planning methods be made available as well.

P5/FGD1: There is always a challenge with resources; you want to educate the client but you don’t have. Condom and you don’t have a “dildo”, No privacy to interview this client because of lack of space.

P2/FGD1: The pressure of having a huge number of patients remains a huge obstacle, you not able to spend time with each women and listen to what they really want, there is paperwork on the other side. These are among the many aspects from the one nurse, eh! against the client ratio and the nurses end up
taking short cuts when providing RHS.

P4/FGD1: Another challenge is that as lecturers we are not informed of new developments, such new guidelines, new contraceptive methods, etc…. You know like the implant, you find such implemented in the health facilities when you have not been skilled and be able to updates the learning guides. There is no streamlining of professional nurses in-services with the college lecturers. This practice/ attitude should chance, we are left behind.

P3/FGD1: Nurses not adequately trained, the resources and lack of upgrading and all that are needed if we are to support women effectively. Newly qualified nurses should be mentored and this is not happening.

P7/FGD1: Support from our leader from the province, political support is very important and currently such is not visible. New health service packages should not be imposed on nurses, rather give nurses updates, capacitate them before implementation; otherwise it leads to service failure because nurses were not involved.

R: (a) What skills do nurses need?

P1/FGD1: Skills needed by nurses to render RHS might include counselling skills, eh! Communication skills, facilitation skills, demonstration skills

P6/FGD1: Nurses providing RHS need to have passion and go an extra mile while encouraging clients to make informed decisions

R: Is there anything else you would like to tell us about the provision of reproductive health services?

P: P4/FGD1: Most patients on Pitogen they complain of amenorrhea. We should assess this and look at the parity discuss with patient and try to move to other methods. We should be client friendly, our clients are intimidated by us. We can colour code the uniforms and customise it to our clients so that they do not view us intimidating them.

P12/FGD1: … the RHS need to be assessed and be checked for relevance to clients' needs prior provision of such services.

P3/FGD1: The TOP Act, What is happening now is what was not expected …..

R: What do you mean by that? Is there anyone who want to comment on that?

P6/FGD1: There should be consultation again or regulate it in a way that it is open for women to can come as many a times as they should be…. If nurses could give input. The politicians need to know it is their interest as well. They need to know more about it.

P5/FGD1: Clients for TOP, they come very late, others saying they do not know it is 12 weeks they should come to request TOP…..

R: Thank you for enlightening us, perhaps this is a topic for another time because it is important as well. Is there anything to be said?

P2/FGD1: That family planning was being moved away from health with the opening clinics for abortion and I think this move was a challenge. However the minister has launched the family planning again it is back to health, may they realized that it was not a good decision. The Policy want nurses to be hands on family planning services.

P1/FGD1: There is also a need to reorganize RHS to maximize access because as it stands now, mothers do not like it when they meet the teenagers at the services.
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<tr>
<th>R: What could be the remedy to address the mothers concern, is there anyone with a suggestion</th>
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<tr>
<td>P8/FGD1: There are times that are stipulated for RHS than if there was a supermarket approach it would be easy. <em>I believe supermarket approach service delivery and good infrastructure where consultations are confidential could address their concern</em></td>
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<td>P: All nodding heads, others saying yes in agreement.</td>
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This brings us to the end of this session, thank you all for valuable information you shared with us. There are refreshments for you as you go out the room, please help yourself and goodbye!
Welcome to this group discussion session and thank you very much for honouring the invitation

My name is Julia Maunye, Sefako Makgato Health Sciences University (Nursing Science Department) student, I will be facilitating this session. With me are Dr Ramaite Mookamedi and Mrs Ina Bence who will be assisting me in taking notes and recording the whole session. Dr Mookamedi will also provide technical support for this session,

Objective of this focus group discussion as explained to you during the recruitment session is to discuss about reproductive services and to request you to share your views, opinions and experiences with me about this topic so that we can develop guidelines for undergraduate students to support women to make informed decisions about family planning methods,

Participation is still voluntary, there is no right or wrong answer to the questions, if you feel uncomfortable in the process you can pull out there will be no punitive measures against you,

Confidentiality, respect for each other is of outmost important as well you are kindly not to mention the names of each other during the discussions. The session will be recorded as well as notes taking will be done

Kindly fill in the biographical data form before we commence with the questions, the information will be kept by me (the researcher) in a safe.
Let us now commence the session which is estimated to take less than an hour; please feel free to request repeat of a question if you need clarification.

<table>
<thead>
<tr>
<th>R</th>
<th>Let us talk about the reproductive health services offered to women by nurses, what is your opinion about these services?</th>
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<tr>
<td>P</td>
<td>P1/FGD2: Uhm! most of the women can consult in clinics nearest to their residential area, so I believe reproductive health services (RHS) is good for the well-being of women to can plan their pregnancies</td>
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<td></td>
<td>P2/FGD2: There is a shortage of staff though, when the ladies are coming for their monthly prevention nurse spent less time with them to listen to what they have to say even if different contraceptive methods are available with shortage of nurses there will be not be sufficient time listen to their needs and to give enough information about the different types of contraceptives, risks and benefits of such methods. The clinics are packed, women are not able to make decisions because nurses do not have time to listen to what they are saying due to pressure of work</td>
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<td></td>
<td>O: some participants were nodding heads and making eye contact with each other, others confirm with yes</td>
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<tr>
<td></td>
<td>R: I see most of you are nodding your heads, what does that mean? Anyone who want to say something?</td>
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<td></td>
<td>P3/FGD2: We agree shortage of staff is a major obstacle in providing quality RHS where women are allowed to have a say about methods of choice, junior staff without proper RHS skills are sometimes delegated to provide RHS and this is a setback</td>
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<td></td>
<td>R: What can be done to improve this situation to afford women opportunity to make decisions?</td>
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<td>P9/FGD2: Nurses must provide health education and explain better.</td>
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<td></td>
<td>P2/FGD2: Health education is key to empower women on their rights and RHS because well-educated individuals I believe can be confident to make choices. There is a need for a conversation with these women on pregnancy spacing. Nurses must provide health education and explain better.</td>
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<td></td>
<td>P4/FGD2: I think it is important to give full information about available services and let anyone choose what they want. Giving advice about available RHS options; explain effects and side effects of contraceptives; ...Eh! giving information on HIV/AIDS, dual protection and PMTCT. And I think as well as when it comes to identifying and educating women that are of child bearing age and giving advice with regard to available resources ... so giving information with regard to PMTCT services, available options and resources with regard to their reproductive system and everything is important</td>
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<td>P5/FGD2: Partner involvement is important, some of the pamphlets on RHS even if the partner is not available women can take such home to be read by the partners. I believe that the pamphlets are written in different languages</td>
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<td></td>
<td>P1/FGD2: The Community Nurse (CN) should do as they do with immunization, an emphasis on RHS should be the same like the other programme, the CN must go to schools and crèches and spread the importance of contraceptives in choosing a method of comfort and spacing childbirth</td>
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<tr>
<td>R:</td>
<td>Let us talk about the challenges that women experience regarding reproductive health services; and what are some of the constraints that women have in terms of making decisions about family planning contraceptive?</td>
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<tr>
<td>P:</td>
<td>P6/FGD2: The women suffer from side effects and this leads to them to become non-compliant because they were are not given enough information about what to expect when they are on contraceptives,</td>
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<td></td>
<td>P7/FGD2: Also there is not enough or no support received from their partners, as others hide that they are</td>
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on contraceptives and when they experience side effects there is no one to talk about it and frustrate them hence they discontinue contraceptives,

**O:** use hand to emphasise points when talking

**P1/FGD2:** There are some women who are actually unable to choose contraceptive methods because of their spouses you understand… the spouses refuse, saying you cannot tell me or do not tell me that you are stopping to have kids… I want my kids, the husband becomes the constraint. I think eh… culture and religion at some stage will prohibit women to take contraceptives, yeah! that might be a hindering factor for women to exercise their choice because of religious or cultural belief.

**P3/FGD2:** I believe there is a lot of myths and perceptions about family planning, for example girls believe that they might gain weight from using contraception, their bodies might fill up with water, there is a lot of myths and perceptions about contraception I think this causes a lot of problem. Even their level of education can influence them because if someone does not have that much education they (women/clients) tend to, what can I say, they (women/clients) pull themselves back they isolate themselves from information that could be useful to them.

**P7/FGD2:** Yes I fully agree with him about the myths also if the nurse and doctors don’t have full information and do not have skills on explaining this to patient at the end this become not useful.

**P8/FGD2:** …people in the deep rural areas do not have access or easy access to RHS because normally if there are mobile clinics they mainly prioritize immunization and family planning take a back seat …

**P2/FGD2:** Problems might be that the women they are not fully aware of what are side effects and what adverse effects are so when it happens that they come across side effects they think they are adverse effects and they discontinue contraceptives and they do not have much trust on it any more that is why they do not use them anymore. I think it is crucial that us as practitioners we should fully understand the side effects so that we can explain to the patients or to our clients.

**P12/FGD2:** …. Also not enough support received from their partners, as others hide that they are on contraceptives and when they experience side effects there is no one to talk about it.

**P1/FGD2:** she mentioned culture and beliefs I do not know how we can put this but there are some women who are actually unable to do so to go forth choose a method because of their spouses you understand…I don’t know how we can call it, is familial may be because the spouses refuses saying you cannot tell me or do not tell me that you are stopping getting children or what the nurses have told you I want my kids, the husband becomes the constraints in this instance….. Culturally women play a subordinate role to the family and husband… We come across such instances where women do not make decisions outside their husbands.

**R:** What do you think could be done to improve partner support?

**P8/FGD2:** Conduct more of awareness campaigns, providing health education to the women so as to empower them to exercise their rights in making choices and encourage sharing of information on family planning with health professionals

**P3/FGD2:** I agree campaigns and health education that are culture sensitive will assist because there are people who are practicing their culture and who are not educated about family planning,

**P1/FGD2:** Members of the family especially the partners must be brought on board on matters of contraceptive because when there is open discussion about this the women will be supported in making
choices.

P3/FGD2: I think with regard to provision of reproductive health services, eh! Our department not just provincially so but national per se I think they are putting a lot of focus on other aspects and communicable diseases than family planning issues which brings… for example they not giving focus to sex education.

P9/FGD2: In addition to inviting the partner issue, pamphlets on family planning information can be distributed and the women can take some home for the whole household to read about this in lobbying for support. The pamphlets that are written in all languages will benefit the public, so that each one get to read what they can understand

P10/FGD2: Maybe we need to target where there are large audience such as in sports, school choir competition partner with organizers to spread information on the importance partner women support regarding choice of contraceptive methods,

P11/FGD2: I will add by saying give health education to the public….about family planning….teach maybe at schools (wave with one hand)…… and anywhere they can be found, that is any place convenient to inform the public about RHS. Talk about availability of RHS where they can be found….teenagers are very young people and can be influenced by media so you can get an article on this teen magazine so I think if they can get an article on contraceptives because they will know that magazine is cool, there are hip things I think eh! actually if it is communicated in the language that they understand in that way it will entertain them.

O: Making an emphasis of contributions to the discussions through waving one hand.

P4/FGD2: Health professionals should collaborate with our culture and try integrating contraceptives practices in a manner that it does not clash with people’s cultures, get to know what is culturally accepted and take it from there in support of women …..

R: Explain the role of the nursing profession in the provision of reproductive health services for women

P: P5/FGD2: Clearly the profession has the responsibility of giving health education about family planning to the public through campaigns in the communities, at schools and provide group or individual education to clients at the health facilities and consulting rooms. Also to teach about RHS at schools or in any settings where people are found gathered…and yes one need to request for permission from organisers of such gatherings. We can also use any place convenient to inform the public, talk about availability of RHS and where they can be found,

O: Wave with one hand while talking

P12/FGD2: The timing of providing contraceptive services in some other Primary Health Care (PHC) facilities is a challenge because such services are provided in the afternoon when the nurses are already tired because it is hectic in these facilities at that time the nurse are tired and play no advocacy at all.

P3/FGD2: There should not be stipulated date for family planning it should be from day to day visits, if is a CHC it should be on going on all the whole seven days, if PHC must be provided from 7-4 then the community would be able to access the services with no pressure such that the person is not confined to say eish! I am working shifts yeah! and I won’t be able to make it but they should know that they can come at any time

P1/FGD2: I want to add that advocating is our role as nurses….. we must ask what services the client want or we will mislead the people …..advocate because our clients cannot go all the way to the province level to advocate for availability of these contraceptives so the nurse at the clinic or at the hospital level do advocate for the patient so that these things…contraceptives can be available.

P5/FGD2: I want to add that advocating is our role as nurses…. advocate for partner involvement and for community support…. for better services according to what clients need. Umhh, okay, the nursing
profession is actually one profession that is not biased in any way such that we are expected to communicate or to liaise with the lowest category with regard to social status standing. nurses’ responsibility is to ensure that not only does she research on the most recent available methods of contraceptives to inform clients about, but also on checking the level of literacy of women, that okay! how can it best suit the women, looking as well into the socio-economic status of that particular community or group when advising on a contraceptive method that is not available in the public health facilities as is common not to find all methods… you understand you cannot come with a method that is costly to a lower class group....

P8/FGD2: It is also our role to do house visits for such cases where it is difficult to access the RHS, some women leave the hospital without being attended to due to distances and overcrowded health facilities.

P3/FGD2: I want to disagree with doing home visits. We must remember that as nurses we do not do things on our own, we need to do things within ethics, as well as guided by the South African Nursing Council (SANC) and the department of health policies and combine all these to provide services within legal framework.

P4/FGD2: Yeah! Do home visits to educate the household on the relevance and importance of RHS… Introduce different methods of contraceptives… encourage good parent-child relationships to have open communication on issues of contraceptives and so forth.

R: What is the current practice about conducting home visits?

P12/FGD2: The PHC team should do home visits, what we are saying is that it our job as nurses that we must do a lot of home visits, especially after discharge of women post-delivery we need to do follow up home visit for a child…explain the procedures regarding postnatal care to them … and at the same time provide the household with information regarding RHS could be of benefit to the mother and baby’s health;

P7/FGD2: One of the responsibility of community health nurses is to do home visits. If a woman has come to the clinic they have to understand everything about family planning, and if there is a problem with the spouse, the nurse can go as far as doing home visit in order to explain to the spouse the relevance and the importance of such, more or less.

O: Pointing finger when talking to make an emphasis of what is being said

R: Did we talk about everything we can remember on the role of the profession regarding provision of RHS to women, anyone who want to say something around this aspect?

P2/FGD2: I think the issue is we should do these awareness campaigns at stadiums, do community outreach, communicate to the public about rights of patients and give somebody a space to have a say in the service they prefer

R: I see you almost all nodding your heads and others saying yes, is there anyone who want to say something about this conversation?

P4/FGD2: Yes we agree with what our colleague is saying and add that putting people first is very important, actually the rights of people should be observed by nurses, their right to information is important so that their decisions on services is based on knowledge one possess.

P7/FGD2: The short of staff makes things difficult in providing quality service, giving of adequate information on family planning methods and listening to women becomes compromised

P1/FGD2: Shortage of staff in my opinion is not an excuse, at the end of the day is about the public not about us. We need not make decisions for patients, it is about the patient….. you find that clients suffer severe side effects, you don’t have time to explain….I don’t think we give the public enough attention as we should be. Let us reach out to the public, let them know what services are available for them. No one make choices if you do not know what are you choosing from

P12/FGD2: Our attitude is not good….. when we are about to nock off the person/nurse will tell the patient
that I cannot listen to you know, I am going off, that is very bad, we quickly forget our obligation as nurses.

P 9/FGD2: I agree nurses attitudes need to be checked really... eh! In another incidence the other lady refused to be given nuristrate as a method saying it makes her to bleed and that she prefers female condoms and nurses were swearing at her saying that you will be here tomorrow pregnant, they said this and that to her and it was not nice.

O: They simultaneously said yes in agreement of nurses. Bad attitudes

P/FGD2: I want to support that nurses’ attitude is not good..... all clients seeking contraceptives get nuristrate without them given time to choose a contraceptive they prefer ...... the staff think the women have an attitude when she do not want it...... I think there is no good communication between nurses and clients,

P10/FGD2: I think another thing is that we nurses we do not have knowledge, we do not know about these services (RHS)..... I think knowledge is power. Most of us nurses we lack knowledge on new development on reproductive health care practices. This is not correct because we should be in a position or be in a manner that we provide information with dignity and respect..... and establish good nurse patient relationship to open up to information seeking clients without reproach

O: waving hands while talking

P4/FGD2: What the colleagues are saying is true look at the new contraceptive that just came in, the implant in family planning, only doctors do it.... they did not include nurses when they were doing their in-service training they don’t even show us how it is done, its functioning and side effects..... and as such we cannot even educate clients about it.

R: How do you suggest this current situation can be improved?

P1/FGD2: To sum it up we want nurses to be empowered on new developments and be included in all patient care matters because nurses are always close to the patient. Nurse empowerment will build their confidence in providing services

O: Group head nodding and others saying yes in agreement

R: Let us talk about how undergraduate nursing students (UNS) are prepared for their role in the provision of reproductive health services:

P: P4/FGD2: The thing about our course is that there is a lot to do in a short time..... you are given two weeks in midwifery.... then to Madadeni for psychiatry.... then to other components, though it is also up to individuals, when you want do something you will do it.... When I work I must give the information to the people where I work...... Our efforts of rendering services to clients are not the same.... as we have been trained I think we should do much better

P4/FGD2: Firstly we are prepared theoretically and practically so and theoretically in the lecture or classroom setting whereby we are given information and education under the Community Nursing Science subject.

P3/FGD2: Given ehhh! The integration of the subjects that we are studying in class they play a very important role because as you know the contraceptives fall under medication so if you have been well taught regarding the giving of medication the administration such as the right dose, right route, right time, right patient so those also form background and play an important role when it get to carrying of women with reproductive health care needs

R: (a) At what level of study should the training be offered?

P11/FGD2: (a) RHS should be introduced as early as in first year because clients once they see a nurse
they want information irrespective of level of study. The information will also empower students and reduce high level of pregnancy seen around the college.

O: All nodding heads and saying yes in agreement to the response

R: (b) What is contained in the curriculum?

P6/FGD2: Oh! there are a lot of subjects included in the curriculum which include methods of contraception.

P7/FGD2: (b) We are taught Anatomy and Physiology or the reproductive system… function of the systems… in Community Nursing Science we do family planning … one gets allocated in a RHS unit. I also think that one should work in areas of their expertise and be encouraged to do reproductive courses in detail to can provide better service. If in a hospital you find that sister M is good in reproductive health care services, let them be encourage to specialize in that field… People should be allowed to work they are more productive to can provide good service. Nurses should be adequately prepared on the whole reproductive content and background of giving contraceptives; definition of contraception; different methods; scientific knowledge on contraceptives; administration of drugs; its effects and side effects.

P12/FGD2: … then for practica we are then taken to the local clinics as per allocation whereby when we are in the local clinic at the second year level you get to be delegated to do this family planning in the clinic you are expected to prepare a script on giving health education to the public on family planning its effects, side effects, etc. and you are expected as well to actually to perform the family planning demo… if it is oral contraceptives you show them you educate them if is injectable…

P11/FGD2: Nurses should be adequately prepared on the whole reproductive content and background of giving contraceptives; definition of contraception; different methods; scientific knowledge on contraceptives; administration of drugs; its effects and side effects.

P2/FGD2: The definition of family planning, contraceptives and its effect to the community, to the immediate family concerned and the impact on the socio-economic status if members of the community do not practice family planning are also included in the curriculum. We also learn about information which clients need to know such as the need to know that family planning assist individuals and families in maintaining a good lifestyle.

P5/FGD2: Given ahhh! The integration of the subjects that we are studying in class they play a very important role because as you know the contraceptives fall under medication… medication is treated under Pharmacology subject in our second year and we apply it in General Nursing Science and in Midwifery and in Community Nursing Science

P1/FGD2: At the second year level of study you get to be delegated to do this family planning in the clinic you are expected to prepare a script on giving health education to the public on family planning, its effects, side effects, etc. and you are expected as well to actually to perform the family planning if is oral contraceptives you show them and educate them if is injectable.

P6/FGD2: I think the second year level is fine because when you get to the third level where you are doing midwifery you need that background of giving contraceptives and you need to advice the women so you cannot still be learning about them, so it helps because midwifery on its own has a lot of theory information that you still need to acquire or learn thus it is better to have background to inject, that is how we are prepared.

P9/FGD2: And I also agree with him I think second year is the best year because that is where you are exposed to the pharmacology part of it?

R: What do you mean by good service? Can we all discuss about this anyone can respond to this?

P2/FGD2: To me, this will mean that the patient is provided with what they came to the RHS for… eh! they will be given information about available services and be able to make choices

P7/FGD2: To me... in addition to providing information...umh, they will be informed about advantages and
disadvantages of contraceptives, side effects and how to deal with it as well

**P9/FGD2:** I still want to support specialization in an area of work because for people to give proper care they must specialise in it and get upgrading from time to time.

**R:** (c) Who teaches that curriculum?

**P1/FGD2:** The lecturers are teaching us, we had it last year done by the Community Nursing Science 1 lecturer, she is teaching us; the Anatomy and Physiology lecturers, and Pharmacology does the teaching as well. Any member of a multidisciplinary health team; It is a kind of a cycle because lecturers teach students, students teach patients and their families and communities, patients teach their children and even the other practitioners do the teaching to members of the community. It is also intertwined meaning that if something does not go right the nurse is a primary source of information.

**P6/FGD2:** The nurses in the clinic play a major role in teaching….eh other health professionals responsible for reproductive services in the health facilities demonstrate how family planning methods are administered to the patients. The nurses in the clinic play a major role in teaching….eh the reproductive services provided and demonstrate how they are administered to the patients. Lecturers and health professionals choose what they prefer but a lot more is lecture, self-study and group work.

**P1/FGD2:** On who teaches reproductive health….any member of a multidisciplinary health team does the teaching. It is a kind of a cycle because lecturers teach students, students teaches patients, and patients teaches their children. The other health care practitioners continues the cycle of teaching clients during contact with them when need arises. It is also intertwined, but the main responsibility of teaching the UNS remains with lecturers/preceptors, it also means that if something does not go right with regard to teaching the clients about family planning methods and available services, the nurse will be hold accountable because she/he is the client's initial contact as well as a primary source of information.

**P7/FGD2:** Any member of a multidisciplinary health team; It is a kind of a cycle because lecturers teach students, students teaches patients, patients teaches their children and even the other practitioners also teach. It is also intertwined it also means if something does not go right the nurse is a primary source of information.

**R:** (d) What activities are used for teaching?

**P1/FGD2:** (d) Lecture, self-study, group work. placement at the RHS facilities, demonstrations, video watching and role play

**P2/FGD2:** Lecturers and health professionals choose what they prefer but a lot more is lecture, self-study and group work.

**R:** Anything else?

**P:** All quiet

**R:** How is the presentation assessed?

**P8/FGD2:** (e) Tests, completion of workbooks, feedback demonstrations

**P3/FGD2:** Sometimes lecturers observe us randomly in the facility, I think that is assessment as well, like when we discharging patients in the postnatal wards.

**P12/FGD2:** Sometimes... after eh! presentation you can have a questionnaire to see if there was understanding of what you were teaching just ask questions random questions about what you were teaching then the client will tell you what they heard or understood.

**P7/FGD2:** And also the preparation of that presentation is important that is why you must have a handwritten copy because the professional nurse that is evaluating you can see if you are able to present
and know where you got the information from and whether that information is correct and important.

**P1/FGD2**: Yes. We are evaluated in various ways, like tests, completion of workbooks, feedback demonstrations...Sometimes after eh! Presentation you can have a questionnaire to see if there was understanding of what you were teaching just ask questions random questions about what you were teaching then the client will tell you what they heard or understood”

**P2/FGD2**: And also the preparation of that presentation is important that is why you must have a copy handwritten because that professional nurse that is evaluating she can see a can know you where you got the information from and whether is right kind of information...”

**P11/FGD2**: ...and our final examination we are exposed to written examinations, OSCEs and comprehensive evaluations...eh, and you get to write for all you learnt the whole year.

**R**: Have we said all that needed to be said on assessment?

**P9**: Yes, otherwise one cannot forget assessment because it is uncomfortable

**O**: Laughter from all participants

<table>
<thead>
<tr>
<th>R:</th>
<th>What teaching materials are used to prepare nursing students to assist women in making decisions on reproductive health services for women?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P:</td>
<td><strong>P5/FGD2</strong>: Commonly used are posters and ah!, another one that students used is role play because with role play they can learn in a funny way how to go about...</td>
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<td>P:</td>
<td><strong>P6/FGD2</strong>: Pamphlets are issued....... The school health nurse can also use these when doing school health services, the youth can benefit from this as well as use of magazines on RHS.</td>
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<td>P:</td>
<td><strong>P12/FGD2</strong>: The workbooks for Community Nursing Science and Midwifery have aspects of RHS and students are to do practical and complete such as placement at the reproductive health services facilities and proof to have used live patients to do demonstrations on family planning services.</td>
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<tr>
<td>P:</td>
<td><strong>P9/FGD2</strong>: We have guides from the department of health and these are also used as teaching materials and the lectures provide us with such to read relevant information about family planning matters and the guides are also stating that we must not force the patient for services that have harmful effects...stating that we must force patients for services they do not want and may have harmful effects to their body…. We cannot say we are not taught but it depends with individuals; others do the right things, and there are those who do wrong things. We should develop attitude of providing women with various contraceptive options to choose for themselves as well as giving them correct advice about the different methods, for example we can give them presentations in the morning on how to use condoms and other methods</td>
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<tr>
<td>R:</td>
<td>Let us talk about the characteristics of nurses who are adequately prepared to support women to make informed decisions about reproductive health services</td>
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<tr>
<td>P:</td>
<td><strong>P12/FGD2</strong>: They must know Anatomy and Physiology of the reproductive system, know the culture of the clients they are serving, the different methods and other drugs that work on the reproductive systems...... the side effects of contraceptives should be known and what measures to take when they occur. ... Actually the nurse should have knowledge and skills on contraceptive aspects to know what to advocate for. The nurses should actually portray and apply skills acquired academically, scientifically with regard to ethics and scientific knowledge and with regard to knowing the drugs they are administering, the effects of the drugs, how to administer that drug all that information collaboratively should be put to practice, eh! ...nurses should consider their clients’ spiritual aspect, their social aspect, respecting that particular person… that is ethically correct.... The nurse must show that she/he does have a required skill and can even have the expertise role</td>
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P9/FGD2: Professional secrecy should be observed... keeping women's confidential matters within the consultation room, eh, creating privacy during consultations as well. Sometimes it helps the way the nurse dresses they must not dress like a ‘magogo’ (meaning grannies) … they must be presentable and well identified with name tags and epaulettes with uniform, they should look nice.

P8/FGD2: Professional secrecy should be observed; I remember .... in a clinic I was allocated to, there was an incidence whereby a nurse working in a gynae ward reported a friend's child who came to perform a termination of pregnancy (TOP), so you know that is lack of practising ethical principles as a professional.

P10/FGD2: There is a need for information sharing with the recipient of services to learn from them on what is relevant and suitable to their needs. Nurse practitioners need to be encouraged to engage the women’s partners so that decision are taken together, need for advice for partners and spouses about the importance of supporting their women on their choice of contraceptive methods.

P7: Even, eh! A welcoming nurse goes a long way in accommodating the clients, a facial expression should talk and can communicate none acceptance of women’s (clients’) requests of preferred contraceptive method. Putting people first...actually respecting the rights of people...right to information so that decisions to decide on services is based on knowledge one possess. Have a friendly face when providing services to them...

P1/FGD2: I too think a friendly face will go a long way, the patient will not be free to decide on a method or a service if you are not friendly with them.

P6/FGD2: The nurse should make time to give all the options..... and be able to communicate with the patient .... Explore all contraceptive options with the clients; and look at all aspects from the clients ‘perspective and based on knowledge of anatomy and side effects of all the drugs. We must change the attitude of being always right but put clients first

P2/FGD2: The nurse must be delegated to do family planning the whole day in order to focus on improving her /his practice and have the opportunity to put in practice what she/he has learned. Nurses should function within the ethics, acts and omissions and do the right thing at all times and adhere to the code of conduct as well,

P11/FGD2: The nurse must show that she/he does have a required skill and can even have the expertise role and display it in the provision of RHS.

R: What are the indicators that women we serve are able to make informed decisions about their reproductive health services?

P: P7/FGD2 Assess whether we are on the right tract of providing quality reproductive services by doing comprehensive assessment of the patient to exclude some mental health issues, umh, which might be interfering with ability of women to make decision for herself such that it is contributing to nurses imposing their own opinions. The outcome of such assessment need to be recorded

P4/FGD2: There will be reduction of unplanned pregnancies .... The attitude of the patient on RHS will be positive.... They will know the contraceptives they are using, their side effects and how to address such will
be known by women. The women will also be aware of the other available family planning methods,

**P7/FGD2:** I think if women may know about the whole contraception... if there is some research about contraception side effects and how women can overcome such, also... eh! assess the complications associated with use of contraceptives.

**P5/FGD2:** And even on the rate of abortion it shows when it increase it shows that women are not informed about what is happening and when it decrease it shows that women are informed.

**P11/FGD2:** Even the programmes on prevention of HIV, sexual transmitted infections and dual prevention of pregnancy; the success of projects like prevention of mother to child transmission the more the women are participating in family planning services it shows that they have been taught about it or they are aware about it, so it is a way of evaluating impact of services.

R: are there other indicators you can think of?

O: Along silence

R: It is okay, let us move to the next question

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**R:** How should nurses support women to enable them to make informed decisions about their reproductive health?

**P:**

**P8/FGD2:** Encourage women to engage in group discussion to support one another .... Also do education via the media and at the clinics..... Young people should be welcomed not be chased away.

**P3/FGD2:** Make patient to relax and voice their own opinion about concerns regarding contraceptives and RHS available to them and offer support through counselling and referring them relevant multidisciplinary health care stakeholders should there be a need,

**P9/FGD2:** Issue the pamphlets let her go home to the partners to read. Display a friendly face when providing services to them, I also think a friendly face goes a long way otherwise the patient will not be free to decide on a method or a service if you are not friendly with them

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**R:** What can be done to improve support of women to make free decisions without pressure of any kind about family planning methods?

**P:**

**P1/FGD2:** Woman should be open-minded.....and say what they want, they do not talk... when you don’t have kids nurse give you contraceptives which they think is good for you because women do not talk much, then what nurse do? Impose methods, please do not get me wrong here lam not saying this is correct, but lam saying this is the situation on the grounds.

**P9/FGD2:** I think they should be knowledgeable about their health care matters when making choice on health... knowledge is power if she understand what it means she will have confidence to choose a method she likes unlike when nurses choose for you.

**P3/FGD2:** Okay I think we must still go an extra mile not focusing on women only, male counterpart should also be involved in these things eh! Complements like real men do not refuse choice of contraceptives... so that male and women also come together in this and one concluded resolution is taken about contraceptives.

**P5/FGD2:** It is not a matter of being against whites; most farm workers have less access to health services hence a need for political interventions to ensure access to health services to all.

R: I see your heads are nodding, why is that? Does it mean when clients do not talk much, nurses
can impose their views and opinion?

O: All saying no

P11/FGD2: I think most women are afraid to talk because nurses are said to be rude, and again they lack information, that is why we need to give information about available services and not impose to them

R: What other support can be given to women to be able to make own decisions?

P7/FGD2: Women must be respected, given an ear to talk about what work or not with them

P1/FGD2: I agree nurses must make women feel important when they need RHS, they need to be allowed to exercise their rights. Members of the family especially the partners must be brought on board on matters of contraceptive because when there is open discussion about this the women will be supported in making choices

P11/FGD2: In addition to inviting the partner…… issue some of the pamphlets…These can be distributed and the women take such home. ….Pamphlets that are written in all languages will benefit the public. Also provide advocacy through making available resources and different family planning methods…but we can do these when we are skilled… unlike now you are left at the clinic alone …no support of your supervisors.

P2/FGD2: Other methods such as being shown videos of people talking on the important of contraceptives and what side effects can be expected and remedy for such can help women relax and make choices based on information

R: What challenges do nurses experience?

P: P12/FGD2: Shortages of staff … and medicine, the very contraceptives…eh you find one or two methods such as the injectable. As nurses we work under difficult conditions because of shortage of staff and resources against many clients seeking health services and these results in less time spend with women and listen to what they have to say…women are not able to make decision because nurses do not have enough time to assist them in making decisions for services they require due to pressure of work….contraceptive methods are also not available. We know nurses should give information to clients on these services but they themselves lack knowledge and skills on family planning new developments”.

P7/FGD2: And also the shortage of the drugs can also be a problem, non-availability of infrastructure such as if there are no proper consultation rooms.

P2/FGD2: It does not help to encourage women to make choices sometimes when there are only two methods available in the public health institutions,… In the private institutions there are many methods but they are expensive, women cannot afford them, you see! It is discouraging.

P10/FGD2: Majority of women from deep rural areas are not educated and our program come in English, it is hard to explain to people who English is not their the language……It is high time that more of the pamphlets on contraceptives be written in different languages for people to read for themselves

P6/FGD2: Sometimes there are attitude from patients…..they are arrogant may be is because they are also saying nurses are rude... umh! That is why they become unfriendly with nurses and this is very bad but the nurses should humble themselves and correct this situation

P5/FGD2: In-service training on reproductive services is not done so often…. If they ask me what are the new contraceptives available ….I haven’t seen one of those things…. Nurses must be educated on a new contraceptive methods in the market, the implant really eh!, yes it is a challenge, around here we do not find it and you are also not informed when women ask you about it you become embarrassed because you cannot advise anybody about it

P8/FGD2: .... we do not know about these services (RHS)... I think knowledge is power. Most of us nurses we lack knowledge on new development on RHS. This is not correct because we should be in a position or be in a manner that we provide information with dignity and respect… and establish good nurse-patient
relationship to open up information seeking by clients without reproach by nurses.

R: (a) What skills do nurses need?

P3/FGD2: (a) Good communication skills, patience, listening and interpersonal skills are important and also knowledge of family planning services. When nurses are providing services they must explain what is happening...the leadership role of the nurse is very important, you find that lower categories of nurses are giving contraception while professional nurses are not there to provide leadership role of motivating and guiding clients in making their own choices of contraceptive methods. I think even the leadership skill of the nurse is very important...in most clinics you find is only the lower staff category who are giving contraceptives as there is no professional nurse because of shortage, so I think it is important that there is always a professional nurse where the service is provided......

P8/FGD2: Nurses skills must be supported by resources because when there are frustrations of lack of resources nurses get lost along the way. Other nurses want to implement their skills but they are rebuked by others, they say you are wasting time because there are many clients to be attended

P4/FGD2: Good relationship with the patient should be key to open communication and nurses should refrain from turning back clients away because this discourages them.

R: Is there anything else you would like to tell us about the provision of reproductive health services?

P11: P1/FGD2: We need to inform the patients about STI and those diseases so that they should not think that contraceptives will prevent such...they will think the family planning is taking HIV away...the issue is we should do this awareness campaigns...do community outreach, communicate to the public about the rights of patients and give somebody a space to have a say in the service they prefer. Campaigns on family planning services are important, it will help provide better health care to all the people and reduce things like child mortality. All health professionals, doctors, students and everybody should partner in assisting or supporting women to make choices on which contraceptives they want to use.

P7/FGD2: I think more information about dual protection, I mean use of contraceptives and condoms must be made available to the youth. Iam saying this because preaching contraceptives only could be interpreted as allowing them to or let them have more sex....they don't know about the sickness that can be contracted sexual transmitted infections if it does not get mentioned....we forget that STI's are there, AIDS is there and many more diseases transmitted through sex. More health talks through various means such as teen magazine because the youth will think it is cool need to be directed more at schools to make contraceptives and dual protection known. The pupils must be told it does not mean that if they use this method now they are free from sexual transmitted infections. Duel protection must be encouraged as well.

O: Other participants nodding heads others verbally saying yes!

P12/FGD2: Health professionals should collaborate with our culture and try integrate contraceptives practices in a manner that it does not clash with people cultures, get to know what is culturally accepted and take it from there in support of women ..... P2/FGD2: Educate the public on how lack of pregnancy spacing can affects women's health and the babies you can say if you do 1, 2, 3 this is what is going to happen to you like cervical cancer..... Let's move with the trends, like use of technology in reaching out to the public about the importance of women support

P1/FGD2: It gives me a little concern that our facilities do not have language interpreter... our communities are different.... Maybe some they cannot hear the language. We must think about this.... We should try check if there is no language barrier, In my clinic one lady was speaking Portuguese and no one understood what she is saying and these hinder accessibility to RHS

P10/FGD2: You know knowledge is power, we will keep repeating this because it is true, the same emphasis given to HIV and to other programmes it should be the same for contraceptives. These will assist women and other people in the community to support women to make informed decisions. People must become responsible, they should be encouraged to want to know more the importance of family planning in the prevention of pregnancy related complications. Nurses should Schedule a week in the community to hold meetings with them to inform them about these topics. They should also conduct survey take note of
all the problems in the hospital or PHC health facilities and refer those which are beyond their scope for further intervention.

P10/FGD2: It is good to do research on what works for women, I agree on research especially research on the whole issues around contraceptives, so research should be done to find out what is best

P4/FGD2: I agree this kind of meeting will improve women’s health because they will ask question and network with each other for support

P11/FGD2: I think we must benchmark with other countries on best practices for providing RHS. Zimbabwe for example pregnant women for example they drink something at term they take that something that and they don’t sustain perianal tears, their labour is smooth, they don’t have problems. Maybe through benchmark we may find best family planning practices. We can take what is working if it is there send that to the laboratory and see it can scientifically benefit issues of contraceptive side effects. South African women they tear very easy during delivery and almost every women deliver by episiotomies. One foreign lady come in she was 7cm dilated, the husband had something whether it was castor oil, because there is one thing they are taking it is called ishlambus”…. It is making the babies come fast, With all these we are saying there is a need to conduct research around the whole contraceptive issues to see what works.

O: (very excited show with hands) take.

R: What are you suggesting with regard to assisting women to make informed decisions with regard to family planning methods?

P10/FGD2: May I say something…eh, I think we should listen to what the women says it works better for them rather than giving them nuristrate when they request female condoms. We can also improve this by making sure that we stock different contraceptive methods at our facilities

P4/FGD2: I agree on research though, a research on the whole issues around contraceptives, I think lots of people are not happy about side effects brought by certain contraceptives, so research should be done to find out what is best

R: Anything else?

This brings us to the end of this session, thank you all for valuable information you shared with us. There are refreshments for you as you go out the room, please help yourself and goodbye!
ANNEXURE G: THEMES WITH QUOTES

P=PARTICIPANT
P1=PARTICIPANT NUMBER 1; P2=PARTICIPANT NUMBER 2, ETC.
FGDLP=FOCUS GROUP FOR LECTURERS/PRECEPTORS
FGDUNS=FOCUS GROUP FOR UNDERGRADUATE NURSING STUDENTS

<table>
<thead>
<tr>
<th>FGDLP</th>
<th>THEMES</th>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
<th>VERBATIM QUOTES</th>
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<tbody>
<tr>
<td></td>
<td>1.Reproductive health services (RHS) offered to women by nurses</td>
<td>1.1.Nurses' responsibilities</td>
<td>Provision of health education</td>
<td>“Nursing services has the responsibility to provide information to women about the whole contraceptive concept; “...they have to monitor their clients; follow them up; check adherence; they need to know how the method is treating the women... are they comfortable. “ “.…. and to finally check such a method whether the women are experiencing side effects. If the monitoring is not given the women will stop at any time if the side effects are not bearable to them.” “The providers of health care should be trained and be skilled as to give the correct information…. using many teaching methods, like using charts or creating media awareness as is done on radio talk shows..... they need to be really equipped in this regard” ... as educators we teach the student nurses about educating the women… to administering the very contraceptive services;</td>
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|        |                                                      |                                |                      | “...the nurse must advocate for availability of contraceptives at the same time... listening skill should be applied ...remember the nurses’ nature is that of helping patients daily...” “We need to be women advocates because it is our role as nurses...we must ask what services the client want or we will mislead the people...keeping their information confidential also important...” “...eh yeah, I think lecturers must assist UNS to be competent so that they can advocate for their patients, you know, yes...it is important” “There is also a need for supportive policies with resources allocated for implementation of client advocacy;” “I think is because nursing is no longer a calling but a poverty alleviation, hence no advocacy is practiced” “...In other set-ups or in other clinical areas before our clients can come to our clinic, we have already prepared the injectable methods without knowing how many will use the method. It is presumed that all women are to get pitogen injection. We look at the number of babies and decide on a method for these women”. “The pressure of having a huge number of patients you are not able to spend time with each client and listen to what they really want, there is also paperwork to be completed on
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<td>the other side. These are among the many aspects from the one nurse… eh! against the client ratio and the nurses end up taking short cuts when providing RHS instead of advocating for clients according to needs”</td>
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<td>“Putting people first should be practiced during delivery of health care services actually the rights of people must be observed, it is important to remember that clients have the right to information about the health services available to them so that they make decisions or decide on services that are based on knowledge they possess”</td>
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<td>“There is a need for supportive policies with resources allocated for implementation of client advocacy; Complains by women must be well channelled and attended; look at parity, number of children, have less intimidating services which are user friendly respecting and valuing patients’ freedom of self-determination and assisting them throughout the decision making process and…. allowing choice of a method. Posters and pamphlets used to increase information on family planning methods be made available as well”</td>
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<td>“I believe in empowering women about reproductive health... we need media and all other strategies to make women aware of the rights… we know partners ….eh! may be unapproachable... students must be prepared to educate women”</td>
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<td>“I agree in empowering women… we need to extend the service to men, talk about vasectomy…. cut the barrier, extend the service to male…We need to discuss this broadly as RHS rather than focus on the name/concept family planning…”</td>
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<td>Women empowerment</td>
<td>“More campaigns …. Providing health education to the women so as to empower them to exercise their rights in making choices and …. yah! that is it”</td>
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<td>“In my opinion I think we are judgemental, we do not allow women to exercise their intellectual abilities in making choices, we impose methods.”</td>
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<td>Nurses display negative attitudes</td>
<td>“Umh…this person must be sensitive and show respect…. she must not be coercing the patient …not imposing her values as well”</td>
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<td>“I will add by saying that positive attitude… non-judgemental… respect the autonomy of making own choices … nurses should have that mind-set and allow women a chance to choose a method…..”</td>
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<td>“Nurses should be willing to provide family planning services and have adequate knowledge and skills of family planning…., she needs to be up to date on RHS information changes”</td>
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<td>“… should be a good listener and good people’s person… she needs to listen and be patient, needs to be up to date with information…”</td>
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<td>Challenges faced by nurses</td>
<td>“The issue of not making informed choice is because the nurses who provide these they do these as a routine they do not have time to give patient information”</td>
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<td>“The pressure…. of having a huge number of patients… you not able to spend time to each and listen to what they really want, there is paperwork on the other side. ... the nurses end up taking short cuts when providing RHS”</td>
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<td>“… There are also limited methods of contraceptives in our practice there are oral or injectable... unlike in the private sector where women we are exposing to other methods”</td>
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<td>1.4. Challenges experienced by women/clients</td>
<td>Challenges faced by women/clients</td>
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<td>&quot;Nurses are to give the information to their clients though this is not happening, clients… are not given the information of side effects…. Not told they will get amenorrhea….&quot;</td>
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|       |        |             |               | "Problems might be that the women they not fully aware what are the side effects or .. what are adverse effects so when it happens that they come across side effects they think they are adverse effects and they discontinue and they do not have much trust on it any more that is why they do not use them anymore."
|       |        |             |               | "Yaa, eh!, " effective use , let me say choosing of contraceptive methods are also influenced by myths as you know maybe 8 out of 10 girls you consult at the facility will tell you that they will be more wet during sexual play with their partners …and they will be fat, you know"
|       |        |             |               | "And these young girls tell you that my husband or boyfriend will say I am full of water during sex…laughing …"
|       |        |             |               | "Women don't have freedom to choose the kind of contraceptive method they prefer. If it does not suit the husband and because of the myths regarding contraception. If they tell them they might say things that might not be there…. Like wetness (leucorrhea), things like you cannot be pregnant while breast feeding and more myths you see those things… If the husband knows that the women is on contraceptives they anticipate wetness before they can feel it and this create a challenge for women"
|       |        |             |               | "Some religions prohibit sex prior marriage stating that it is morally incorrect to have sex prior marriage…. and this becomes a challenge because the majority of women (clients) think they will be judged if they are seen openly seeking contraceptive methods, let alone choosing the pill, hence they prefer an injectable contraception…"
|       |        |             |               | "….Others are afraid of their spouses to even venture into choosing a method of..."
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<td>2. Measures to support women to make informed decisions on RHS</td>
<td>2.1. Upgrading nurses’ knowledge and skills on RHS</td>
<td>Provision of in-service education and training</td>
<td>“...I think knowledge is power, most of us nurses we lack knowledge of new RHS development... this is not correct... nurses and students included must be educated on a new thing to can lead the healthcare for who need it... you see all these things” “.... You know like the implant, you find such implement in the health facilities when you have not been skilled and be able to updates the UNS learning guides. There is no streamlining of professional nurses in service with the college/nursing college lecturers. This practice/attitude should change... we are left behind... Yes I agree, “The challenge with us lecturers is that we lack knowledge and skills of new contraceptive methods such as the implants and other new developments related to contraceptive health services. When we facilitate learning on these methods during student accompaniment we become embarrassed due to lack of updated information, learner guides are also not updated with current reproductive health practice” “The providers should be trained and be skilled in order to give the correct information... they need to be really equipped in this regard” “Our institutions must take a stand and give family planning training so that our clients get proper family planning methods according to their choice” “To sum it up Intensify nurse training... eh! we want nurses to be empowered on new developments and be included in all patient care matters because they are always close to the patient. Nurses’ empowerment will build their confidence in providing services teaching of the UNS...” “There is no streamlining of professional nurses in-services with the college/nursing college lecturers”</td>
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| 2.2. Accessibility of RHS | Supermarket approach reproductive healthcare services | Conducting RHS impact analysis/evaluation | “There are times that are stipulated for RHS than if there was a supermarket approach it would be easy” “There is also a need to reorganize RHS to maximize access because as it stands now, mothers do not like it when they meet with the teenagers at the services... eh may be privacy and confidentiality in the provision of these services should be maintained for women (clients) so that it is not to be known for what service they had come for” “Nursing services has the responsibility...... they have to monitor their clients; follow them up; check adherence; they need to know how the method is treating the women, are they comfortable... and to finally check such a method whether the women is experiencing side effects. If the monitoring is not given the women will stop at any time if the side effects are
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<td>not bearable to them.</td>
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<td>&quot;We can refer to the number of women that using our contraception…. If the number increasing …mmmm, the number if unwanted pregnancies…. If this is increasing”</td>
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<td>“… and just to add that there are other indications… illegal abortion will drop mmmm, as an indicator of women making informed decisions without being pushed to do so”</td>
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<td>“It is good to do research (analysis) on what works for women…so research should be done to find out what is best”</td>
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<td>“…the RHS need to be assessed and be checked for relevance to clients’ needs prior provision of such services”</td>
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<td>3. Undergraduate nursing programme</td>
<td>&quot;In their curriculum there is training as part of their community health…. They are taught of all women's health … general health (emphasise with hands) students should be aware that before the women can engage in sexuality she should be informed ……, without fear of pregnancy. They are taught of all the methods of family planning and there is a whole module for teaching student on RHS.”</td>
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<td>“The family planning content is integrated in almost all theory subjects; however the practicals are done in Community Nursing Science, General Nursing Science and in Midwifery components …. and the students get the opportunity of integrating knowledge of Pharmacology in these components” … they also learn anatomy and physiology… the anatomy of the very uterus where IUCD is inserted”</td>
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<td>“I agree that students are taught reproductive aspects as part of the curriculum, however the time spent on this aspect of RHS is too short because the time is divided amongst other aspect of their learning , unlike with the previous nursing curriculum of our time , we had much time to practice and learn the skills of practicing RHS,”</td>
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<td>“Yah…the community exposure time is limited and does not make nurses competent…. I agree that there is a need to intensify the training in this area …. We ask why they do not have clinical skills, students when asked why they are providing the kind of RHS they always say I don’t know I was given the task to perform…. There is a skills gap there; probably due to limited exposure to RHS… the time…or period of exposure is a challenge”.</td>
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<td>3.1. Teaching UNS reproductive healthcare practice</td>
<td>&quot;Second year level is appropriate… they talk about physiology… they move on to partake in midwifery…they need to know the anatomy, the anatomy of the very uterus where IUCD is inserted“</td>
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<td>“…As part of their curriculum students are expected to complete a Community Nursing Science module on family planning there are also other family planning modules which form part of the students curriculum for which they are required to complete during their education and training and these modules are integrated in subjects such as midwifery for reinforcement of reproductive health. There are modules of family planning mainly in the Community Nursing Science, General Nursing Science, even in Midwifery…in Pharmacology is not a full module but the family planning medications are learnt by students”</td>
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|       | 3.2. Teaching practices/methods                  | Responsible person for teaching reproductive healthcare (RH) content | “At college the lecturers that are teaching Community Nursing Science are involved in teaching of reproductive health which in third and fourth year are enforced by midwifery lecturers”
<p>|       |              |                                                 | “(nodding) lecturers are teaching the students. It is true they are doing it …teaching the students; however most of the time expert nurses like PHC nurses are requested to teach the students” |
|       |              |                                                 | “We use demonstration, formal lecture, in service training, campaigns, awareness programs, and seminars as methods of educating students regarding reproductive health…” |
|       |              |                                                 | “…also modules are given to students and discussions for correlation to theory when they go to practice…. they are given time frames whereby they go to real patients and give the feedback. Identify the women’s real needs…although it is not easy … time is the issue but we try to give more….. I think is high time that the curriculum is reviewed to incorporate modern and creative ways of increasing student learning time in the reproductive healthcare. Family planning time intensified in the facilities.” |
|       |              |                                                 | “Strategies used in teaching students include amongst others; use of lecturing, modules are given to students, group discussions, and correlation to theory when they go to practice…..at the clinics they got nice pictures on posters which students are requested to use…. They are given time frames and go to real patients and give the feedback… they are required to Identify the women’s real needs….although it is not easy … time is the issue here…. time is our constraints…..” |
|       |              |                                                 | “I think lecturers need to be creative about increasing learning time with students….involve them in electronic self-study materials….maybe seeing a scenario on family planning consultation then give assignment to respond to it” |
|       |              |                                                 | “Posters depicting different family planning methods with indications and contraindications are displayed at the health facilities….there are also posters …. even live methods…. mothers are shown these methods and they then decide on a preferred one……” |
|       |              |                                                 | “What I have seen is that in other clinics and in some wards where women stay after delivery…. Health education is given, there are models that show how to help the partner on how to use the methods” |
|       |              |                                                 | “How the students are assessed, firstly through the written assessment for testing knowledge. When at the clinic they are tested hands-on…..” |
|       |              |                                                 | “And also we advise the learners to prepare a script where they address the women with family planning…. like giving health education. We also follow up to see how they administer the contraceptives like the injectable.” |</p>
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<td>1.Reproductive health services (RHS) offered to women by nurses</td>
<td>1.1.Nurses’ responsibilities</td>
<td>Provision of health education</td>
<td>“Nurses must provide health education and explain better” “Giving advice about available RHS options; explain effects and side effects of contraceptives; ... Eh! giving information on HIV/AIDS, dual protection and PMTCT” “And I think as well as when it comes to identifying and educating women that are of child bearing age and giving advice with regard to available resources ... so giving information with regard to PMTCT services, available options and resources with regard to their reproductive system and everything is important” “... teenagers are very young people and can be influenced by media so you can get an article on this teen magazine so I think if they can get an article on contraceptives because they will know that magazine is cool, there are hip things I think eh! actually if it is communicated in the language that they understand in that way it will entertain them” “There is a shortage of staff though... when the ladies are coming for their monthly prevention...... there was not a lot of time spent with the women and listen to what they have to say ...... there is not enough time to give sufficient time to be listened at and given enough information. The clinics are packed, women are not able to make decisions because nurses do not have time to listen to what they are saying due to pressure of work” “Give health education to the public.... Campaigns at schools about family planning.... To teach about RHS may be at schools or where they can be found, that is any place convenient to inform the public about RHS. Talk about availability of RHS where they can be found”</td>
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<td>Being women’s advocates</td>
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<td>“...advocate because our clients cannot go all the way to the province level to advocate for availability of these contraceptives so the nurse at the clinic or at the hospital level do advocate for the patient so that these things...contraceptives can be available” “I want to add that advocating is our role as nurses.... advocate for partner involvement and for community support.... for better services according to what clients need” “Umhh, okay, the nursing profession is actually one profession that is not biased in any way such that we are expected to communicate or to liaise with the lowest category with regard to social status standing.... nurses’ responsibility is to ensure that not only does she research on the most recent available methods of contraceptives to inform clients about, but also on checking the level of literacy of women, that okay! how can it best suit the women, looking as well into the socio-economic status of that particular community or group when advising on a contraceptive method that is not available in the public health facilities as is common not to find all methods... you understand you cannot come with a method that is costly to a lower class group....” “... actually the nurse should have knowledge and skills on contraceptive aspects to know what to advocate for. The nurses should actually portray and apply skills acquired academically, scientifically with regard to ethics and scientific knowledge and with regard to knowing the drugs they are administering, the effects of the drugs, how to administer that drug all that information collaboratively should be put to practice, eh! ...nurses should consider their clients’ spiritual aspect, their social aspect, respecting that particular person... that is ethically correct....”</td>
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<td>“Members of the family especially the partners must be brought on board on matters of contraceptive because when there is open discussion about this the women will be supported in making choices”</td>
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<td>“In addition to inviting the partner…… issue some of the pamphlets…… Can be distributed and the women take such home. ….Pamphlets that are written in all languages will benefit the public”</td>
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<td>“Provide advocacy through making available resources and different family planning methods…but we can do these when we are skilled… unlike now you are left at the clinic alone …no support of your supervisors”</td>
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<td>“Any member of a multidisciplinary health team; It is a kind of a cycle because lecturers teach students, students teach patients and their families and communities, patients teach their children and even the other practitioners do the teaching to members of the community. It is also intertwined meaning that if something does not go right the nurse is a primary source of information. “Health education is key to empower women on their rights and RHS because well-educated individuals I believe can be confident to make choices. There is a need for a conversation with these women on pregnancy spacing” …I believe in empowering women about reproductive health to can make choices with knowledge……”</td>
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<td>“I think it is important to give full information about available services and let anyone choose what they want…eh! that is women empowerment”</td>
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<td>“ I think they should be knowledgeable about their health care matters when making choosing health…knowledge is power if she understand what it means she will have confidence to choose a method she likes unlike when nurses choose for you”</td>
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<td>“When nurses are providing services they must explain what is happening…the leadership role of the nurse is very important, you find that lower categories of nurses are giving contraception while professional nurses are not there to provide leadership role of motivating and guiding clients in making their own choices of contraceptive methods.”</td>
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<td>“I think even the leadership skill of the nurse is very important…in most clinics you find is only the lower staff category who are giving contraceptives as there is no professional nurse because of shortage, so I think it is important that there is always a professional nurse where the service is provided……”</td>
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<td>“The nurse must show that she/he does have a required skill and can even have the expertise role and display it in the provision of RHS”</td>
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<td>“I think another thing is that we, nurses do not have knowledge about these services, RHS…I think knowledge is power. Most of us nurses lack knowledge on new developments on RHS. This is not correct.”</td>
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<td>“What the colleagues are saying is true look at the new contraceptive that just came in the implant in family planning, they don’t even show us how it is done, its functioning, side effects….to sum it up we want nurses to be empowered on new developments as they are always close to patients…. nurse empowerment will build their confidence in providing services”</td>
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<td>“Our attitude is not good … when we are about to knock off the person/nurse will tell the patient I cannot listen to you now, I am going off.”</td>
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<td>“Nurses attitudes need to be checked really… eh! In another incidence the other lady refused nurstrate as a method, saying it makes her to bleed and that she prefers female condoms and nurses were swearing at her saying that you will be here tomorrow pregnant, said this and that to her and it was not nice.”</td>
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<td>Professional secrecy should be observed… keeping women’s confidential matters within the consultation room, eh, creating privacy during consultations as well.”</td>
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<td>“Sometimes it helps the way the nurse dresses they must not dress like a ‘magogo’ (meaning grannies) … they must be presentable and well identified with name tags and epaulettes with uniform, they should look nice”</td>
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<td>“Professional secrecy should be observed; I remember …. in a clinic I was allocated to, there was an incidence whereby a nurse working in a gynae ward reported a friend’s child who came to perform a termination of pregnancy (TOP), so you know that is lack of practising ethical principles as a professional.”</td>
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<td>“There is a need for information sharing with the recipient of services to learn from them on what is relevant and suitable to their needs. Nurse practitioners need to be encouraged to engage the women’s partners so that decision are taken together, need for advice for partners and spouses about the importance of supporting their women on their choice of contraceptive methods.”</td>
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<td>“A welcoming nurse goes a long way in accommodating the clients, a facial expression should talk and can communicate none acceptance of women’s (clients’) requests of preferred contraceptive method”</td>
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<td>“Have a friendly face when providing services to them… I too think a friendly face will go a long way, the patient will not be free to decide on a method or a service if you are not friendly with them”</td>
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<td>“Putting people first…actually respecting the rights of people…right to information so that decisions to decide on services is based on knowledge one possess”</td>
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<td>“… the issue is we should do this awareness campaigns….do community outreach, communicate to the public about the rights of patients and give somebody a space to have a say in the service they prefer”</td>
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<td>“To me, this will mean that the patient is provided with what they came for to the RHS… eh! They will be given information about available services and be able to make choices”</td>
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<td>“To me… in addition to providing information…umh, they will be informed about advantages and disadvantages of contraceptives , side effects and how to deal with it as well”</td>
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|        |        |            |               | “Nurses…they turn you back, they should not do this things…they say a client should come during menstruation, they have to see your period first before contraceptives are given, What need to be done is a means to verify if a person is pregnant or not because they turn them back and when they come again they are now pregnant…verification of
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<td>pregnancy is really necessary”</td>
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<td>“We must remember that as nurses we do not do things on our own, we need to do things within the nursing ethics, as well as guided by the South African Nursing Council, as well as work ethics guided from the government….we work under SANC…combine all these to provide services within the legal framework”</td>
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<td>“As nurses we work under difficult conditions because of shortage of staff and resources against many clients seeking health services and these results in less time spend with women and listen to what they have to say…women are not able to make decision because nurses do not have enough time to assist them in making decisions for services they require due to pressure of work…contraceptive methods are also not available. We know nurses should give information to clients on these services but they themselves lack knowledge and skills on family planning new developments”</td>
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<td>Challenges faced by nurses</td>
<td>“And also the shortage of the drugs can also be a problem, none availability of infrastructure such as if there are no proper consultation rooms.”</td>
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<td>Challenges faced by nurses</td>
<td>“It does not help to encourage women to make choices sometimes when there are only two methods available in the public health institutions...In the private institutions there are many methods but they are expensive, women cannot afford them, you see! It is discouraging”</td>
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<td>Challenges faced by nurses</td>
<td>“The Community Nurse (CN) should do as they do with immunization, an emphasis on RHS should be the same like the other programmes, and the CN must go to schools and crèches and spread the importance of contraceptives in choosing a method of comfort and spacing childbirth”</td>
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<td>Challenges faced by women/clients</td>
<td>“The women suffer from side effects that lead them to be non-compliant because they were/are not given enough information about what to expect when they are on contraceptives”</td>
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<td>Challenges faced by women/clients</td>
<td>“There are some women who are actually unable to choose contraceptive methods because of their spouses you understand.... the spouses refuse, saying you cannot tell me or do not tell me that you are stopping to have kids… I want my kids, the husband becomes the constraint”</td>
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<td>Challenges faced by women/clients</td>
<td>“I think eh...culture and religion at some stage will prohibit women to take contraceptives, yeah! that might be a hindering factor for women to exercise their choice because of religious or cultural belief”</td>
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<td>Challenges faced by women/clients</td>
<td>“I believe there is a lot of myths and perceptions about family planning, for example girls believe that they might gain weight from using contraception, their bodies might fill up with water, there is a lot of myths and perceptions about contraception I think this causes a lot of problem”</td>
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<td>Challenges faced by women/clients</td>
<td>“Even their level of education can influence them because if someone does not have that much education they (women/clients) tend to, what can I say, they (women/clients) pull themselves back they isolate themselves from information that could be useful to them”</td>
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|        |        | Challenges faced by women/clients | “...people in the deep rural areas do not have access or easy access to RHS because normally if there are mobile clinics they mainly prioritize immunization and family planning
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<td>take a back seat …”</td>
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<td>“…I think with regard to provision of reproductive health services, eh! Our department not just provincially so but national 'per se' I think they are putting a lot of focus on other aspects and communicable diseases than family planning issues which brings….for example they not giving focus to sex education”</td>
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<td>“I think one of the challenges for example are male nurses where clients are not free to open up to male nurse because other people are still too much cultural so they will feel I cannot be talking about this information to a male, about my periods about what is happening after receiving the contraceptive, so they might not give all information; so I think reproductive health facilities should have, if ever possible to that clinic to have male and female nurses at the same time just to balance the gender and allow clients to discuss their reproductive issues with female nurses if they feel like”</td>
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<td>“Problems might be that the women they are not fully aware of what are side effects and what adverse effects are so when it happens that they come across side effects they think they are adverse effects and they discontinue contraceptives and they do not have much trust on it any more that is why they do not use them anymore. I think it is crucial that us as practitioners we should fully understand the side effects so that we can explain to the patients or to our clients”</td>
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<td>“Yes I fully agree with him about the myths also if the nurse and doctors don’t have full information and do not have skills on explaining this to patient at the end this become not useful”</td>
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<td>“…Also not enough support received from their partners, as others hide that they are on contraceptives and when they experience side effects there is no one to talk about it”</td>
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<td>“…she mentioned culture and beliefs I do not know how we can put this but there are some women who are actually unable to do so to go forth choose a method because of their spouses you understand…I don’t know how we can call it, is familial may be because the spouses refuses saying you cannot tell me or do not tell me that you are stopping getting children or what the nurses have told you I want my kids, the husband becomes the constraints in this instance..”</td>
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<td>“Culturally women play a subordinate role to the family and husband… We come across such instances where women do not make decisions outside their husbands”</td>
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<td>“Health professionals should collaborate with our culture and try integrating contraceptives practices in a manner that it does not clash with people’s cultures, get to know what is culturally accepted and take it from there in support of women …..”</td>
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<td>“Our attitude is not good….. when we are about to ‘knockoff duty nurses have tendencies of telling patients things like, I cannot listen to you now, I am going off, and this is not good, it is a bad attitude”</td>
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<td>“We agree shortage of staff is a major obstacle in providing quality RHS where women are not allowed to have a say about methods of choice, junior staff without proper RHS skills are sometimes delegated to provide RHS because of shortage of professional nurses..”</td>
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|        |        |            |               | “The timing of providing contraceptive services in some other Primary Health Care (PHC) facilities is a challenge because such services are provided in the afternoon when the
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<td>nurses are already tired because it is hectic in these facilities at that time the nurse are tired and play no advocacy at all”</td>
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<td>2. Measures to support women to make informed decisions on RHS</td>
<td>2.1. Upgrading nurses’ knowledge and skills on RHS</td>
<td>Mandatory-in-service education and training on current RHS practices</td>
<td>“I think another thing is that we nurses do not have knowledge, we do not know about these services (RHS)…. I think knowledge is power. Most of us nurses we lack knowledge on new developments regarding RHS, we should be in a position or be in a manner that we provide information with dignity and respect…. and establish good nurse patient relationship to open up to information seeking clients without reproach by nurses”</td>
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<td>“In-service training on reproductive services are not so often…. If they ask me what the new contraceptives available are, I haven’t seen one of those things. Nurses must be educated on a new thing like the implant…eh! (yes) it is a challenge, around here we do not find it”</td>
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<td>“What the colleagues are saying is true, look at the new contraceptive that just came in, the implant in family planning, only the doctors do it, nurses are excluded, they don’t even show us how it is done, its functioning and side effects”</td>
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<td>“To sum it up we want nurses to be empowered on new developments and be included in all patient care matters because they are always close to the patient…Nurse empowerment will build their confidence in providing services”</td>
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<td>“Yeah...members of the family especially the partners must be brought on board on matters of contraceptives because when there is open discussion about this women will be supported in making choices”</td>
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<td>“Encourage women to engage in group discussion to support one another.”</td>
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<td>“People in the deep rural areas do not have access to services, they take a back seat, politics play a role here…people in the farms living with whites, need political interventions for them to access RHS by enforcing access policies”</td>
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<td>“Health professionals should collaborate with our culture and try integrating contraceptives practices in a manner that it does not clash with people’s cultures, get to know what is culturally accepted and take it from there in support of women.”</td>
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<td>“…. Also not enough support received from their partners...”</td>
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<td>“Okay I think we must still go an extra mile not focusing on women only, male counterpart should also be involved in these things eh! Complements like real men do not refuse choice of contraceptives … so that male and women also come together in this and one concluded resolution is taken about contraceptives”</td>
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<td>“It is not a matter of being against whites; most farm workers have less access to health services hence a need for political interventions to ensure access to health services to all)”</td>
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<td>“One of the responsibility of community health nurses is to do home visits. If a woman has come to the clinic they have to understand everything about family planning, and if there is a problem with the spouse, the nurse can go as far as doing home visit in order to explain to the spouse the relevance and the importance of such, more or less.”</td>
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<td>“Do house visits for such cases where it is difficult to access the RHS, some women leave the hospital without being attended to due to distances and overcrowded health facilities,”</td>
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<td>“Yeah! Do home visits to educate the household on the relevance and importance of”</td>
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<td>RHS...Introduce different methods of contraceptives... encourage good parent child relationships to have open communication on issues of contraceptives and so forth.” “Depending on the availability of resources one of the responsibility of community health nurses is to do home visits, if a women has come to the clinic they have understood everything about family planning and however there is a problem with the spouse the nurse can go as far as doing home visits in order to explain to the spouse the relevance and the important of such,...” “Do house visits for such cases where it is difficult to access the RHS, some women leave the hospital without being attended to due to distances and overcrowded health facilities” “Our job as nurses is that we must do a lot of home visits, doing follow up home visit for a child and mother….explain the procedures on baby care and on family planning for them … what we say that at the same time providing the household with information regarding RHS could have benefit”</td>
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<td>“The timing of providing contraceptives services in some other Primary Health Care (PHC) facilities is a challenge because such services are provided in the afternoon when the nurses are already tired because it is hectic... at that time nurses are tired and play no advocacy at all” “There should not be stipulated date for family planning it should be from day to day visits, if is a CHC it should be on going on all the whole seven days, if PHC must be provided from then the community would be able to access the services with no pressure such that the person is not confined to say eish! I am working shifts yeah! and I won’t be able to make it but they should know that they can come at any time”</td>
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<td>“The nursing profession has a role of research that is a nurse’s responsibility” “It is good to do research on what works for women, I agree on research especially research on the whole issues around contraceptives, so research should be done to find out what is best” “I think if women may know about the whole contraception...if there is some research about contraception side-effects and how women can overcome such, also... eh! assess the mortality rate in association with use of contraceptives” “And even on the rate of abortion it shows when it increase it shows that women are not informed about what is happening and when it decrease it shows that women are informed” “Even the programs on prevention of HIV, sexual transmitted infections and dual prevention of pregnancy; the success of projects like prevention of mother to child transmission (PMTC) the more the women are participating in family planning services it shows that they have been taught about it or they are aware about it, so it is a way of evaluating impact of services”</td>
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<td>“Nurses should be adequately prepared on the whole reproductive content and background of giving contraceptives; definition of contraception; different methods; scientific knowledge on contraceptives; administration of drugs; its effects and side effects”</td>
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“Oh! there are a lot of subjects included in the curriculum which include methods of contraception”
“The definition of family planning, contraceptives and its effect to the community, to the immediate family concerned and the impact on the socio-economic status if members of the community do not practice family planning are also included in the curriculum. We also learn about information which clients need to know such as the need to know that family planning assist individuals and families in maintaining a good lifestyle”
“Given ahhh! The integration of the subjects that we are studying in class they play a very important role because as you know the contraceptives fall under medication so if you have been well taught regarding the giving of medication the administration such as the right dose, right route, right time, right patient so those are that also form background and play an important role when it get to carrying of women with reproductive health care needs … medication is treated under Pharmacology subject in our second year and we apply it in General Nursing Science and in Midwifery and in Community Nursing Science”
“The thing about our course is that there is a lot to do in a short period of time….. you are given two weeks in Midwifery…. then to Madadeni for Psychiatry…. then to other components. However it is also up to individuals to become dedicated and focus on what they want to achieve in order to complete the course ….”
“We need to inform the patients about STI and those diseases so that they should not think that contraceptives will prevent such…. they will think the family planning is taking HIV away”
“I think more information about dual protection, I mean use of contraceptives and condoms must be made available to the youth. Iam saying this because preaching contraceptives only could be interpreted as allowing them to have more sex…. they don’t know about the sickness such as sexual transmitted infections…. if it does not get mentioned…..we forget AIDS is there…. and many more diseases are transmitted through sex.
We need to focus our attention on providing more HIV/AID information at schools….. the pupils must be told that taking contraceptives does not mean that if they use this method now you will not contact HIV infections. Duel protection must be encouraged as well because it is key in the prevention of HIV infections”
“There must be dedicated nurses who have the ability to put in practice what they learned on reproductive health care practice. They should be delegated to do family planning the whole day. These nurses should function within the ethics of the profession and observe the acts and omissions…they are to do the right thing, and adhere to the Code of Ethics and conduct themselves as expected, in this way the rights of women will not be violated, eh.. like forcing women on family planning methods they do not like ”
“rights of women will not be violated, eh.. like forcing women on family planning methods they do not like ”
“….then for practica we are then taken to the local clinics as per allocation whereby when we are in the local clinic at the second year level you get to be delegated to do this family
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|        |        |            |              | planning in the clinic you are expected to prepare a script on giving health education to the public on family planning its effects, side effects, etc and you are expected as well to actually to perform the family planning demo. if it is oral contraceptives you show them you educate them if is injectable."
|        |        | Year level |              | "We are also taught anatomy and physiology of the reproductive system…… function of the systems… in community we do family planning … and midwifery as well, one gets allocated in a RHS unit or one should work in their focus area….I think we should do those courses in detail to can provide better service ….You find that sister M is good in this service, let them be encourage to specialize in that field…. Work where you are more productive to can provide good service" |
|        |        | Module type |              | "At the second year level of study you get to be delegated to do this family planning in the clinic you are expected to prepare a script on giving health education to the public on family planning, its effects, side effects, etc. and you are expected as well to actually to perform the family planning if is oral contraceptives you show them and educate them if is injectable"
|        |        |            |              | "I think the second year level is fine because when you get to the 3rd level where you are doing midwifery you need that background of giving contraceptives and you need to advice the women so you cannot still be learning about them, so it helps because midwifery on its own has a lot of theory information that you still need to acquire or learn thus it is better to have background to inject, that is how we are prepared." |
|        |        |            |              | "And I also agree with him I think second year is the best year because that is where you are exposed to the pharmacology part of it?"
|        |        |            |              | "RHS should be introduced as early as in first year because clients once they see a nurse they want information irrespective of the level of study. The information will also empower students and reduce high level of pregnancy seen around the college" |
|        |        |            |              | "Firstly we are prepared theoretically and practically so and theoretically in the lecture or classroom setting whereby we are given information and education under the Community Nursing Science subject."
|        |        |            |              | "On who teaches reproductive health…..any member of a multidisciplinary health team does the teaching. It is a kind of a cycle because lecturers teach students, students teaches patients, and patients teaches their children. The other health care practitioners continues the cycle of teaching clients during contact with them when need arises. It is also intertwined, but the primary responsibility of teaching the UNS remains with lecturers/preceptors, it also means that if something does not go right with regard to teaching the clients about family planning methods and available services, the nurse will be hold accountable because she/he is the client’s initial contact as well as a primary source of information"
|        |        |            |              | "The nurses in the clinic play a major role in teaching….eh the reproductive services provided and demonstrate how they are administered to the patients"
<p>|        |        |            |              | &quot;Lecturers and health professionals choose what they prefer but a lot more is lecture, self-study and group work&quot; |</p>
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|        |        |            | Teaching methods and activities used for reproductive health | “Any member of a multidisciplinary health team; It is a kind of a cycle because lecturers teach students, students teaches patients, patients teaches their children and even the other practitioners also teach. It is also intertwined it also means if something does not go right the nurse is a primary source of information.”
|        |        |            |              | “The lecturers are teaching us, we had it last year done by the Community Nursing Science 1 lecturer, she is teaching us; the anatomy and physiology lecturers, and pharmacology does the teaching as well.”
|        |        |            |              | “The nurses in the clinic play a major role in teaching….eh the reproductive services provided and demonstrate as well how they are administered to the patients” |
|        |        |            | Teaching materials used | “Demonstrations, formal lecture, in-service training are the most methods used to teach students about family planning methods”
|        |        |            |              | “Other lecturers like, eh... self-study groups, presentations and other activities like role plays because with role play they can learn in a funny way how to go about with family planning”. |
|        |        |            | Assessment methods used | “Commonly used are posters and ah! Another one that students used is role play because with role play they can learn in a funny way how to go about...”
|        |        |            |              | “Pamphlets are also issued……. The school health nurse can also use these when doing school health services; the youth can benefit from this as well as use of magazines on RHS...”
|        |        |            |              | “We have guides from the department…. Stating that we must not force the patient for services they do not want and may have harmful effects to their body.......”
|        |        |            |              | “Pamphlets are issued…… things like teen magazine, the school health nurse can also use these when doing school health services, the youth can benefit from this as well as use of magazines on RHS.”
|        |        |            |              | “The workbooks for Community Nursing Science and Midwifery have aspects of RHS and students are to do practical and complete such as placement at the RHS facilities to use live patients to do demonstrations”
|        |        |            |              | “We have guides from the department and these are also used as teaching materials and the lecturers provide us with such to read relevant information about family planning matters....” |
|        |        |            |              | “Sometimes... after eh! presentation you can have a questionnaire to see if there was understanding of what you were teaching just ask questions random questions about what you were teaching then the client will tell you what they heard or understood”
|        |        |            |              | “And also the preparation of that presentation is important that is why you must have a handwritten copy because the professional nurse that is evaluating you can see if you are able to present and know where you got the information from and whether that information is correct and important.”
|        |        |            |              | “We are evaluated in various ways, like tests, completion of workbooks, feedback demonstrations”
<p>|        |        |            |              | “Sometimes after eh! Presentation you can have a questionnaire to see if there was understanding of what you were teaching just ask questions random questions about what...” |</p>
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<td>“you were teaching then the client will tell you what they heard or understood” “And also the preparation of that presentation is important that is why you must have a copy handwritten because that professional nurse that is evaluating she can see a can know you where you got the information from and whether is right kind of information…” “…and our final examination we are exposed to written examinations, OSCEs and comprehensive evaluations…eh, and you get to write for all you learnt the whole year”</td>
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ANNEXURE H: LANGUAGE EDITING DECLARATION

Susanna Elizabeth Louw
Phone 076 588 8561
Email anzelle@wordfix.co.za

EDITING DECLARATION

DATE: 29/12/2017

I, SE Louw, hereby declare that the thesis *Guidelines for undergraduate nursing students (UNS) to support women to make informed decisions about family planning (contraceptive) methods* by Theira Iulia Maunye, with the exception of verbatim quotes and appendices, has been professionally language edited by me.

If further information is required, please contact me.

SE Louw
Susanna Elizabeth Louw

2017-12-29
Date