University of KwaZulu-Natal

Maternity care in KwaZulu-Natal: towards a grounded theory of adolescent-friendly maternity services

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A Dissertation Submitted to

The Faculty of Community and Development Disciplines

University of KwaZulu-Natal

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In Fulfilment of the Requirements for the Degree

Doctor of Philosophy (Nursing)

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by

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Dissertation Supervisor   Prof. N.O. Adejumo

February 2005

DEDICATION

This work is dedicated to,

My mother, Uma, my father, Chet and,

my sister, Malini.

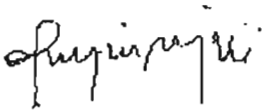Thank you for always being there

for me.

ACKNOWLEDGEMENTS

DECLARATION

Except for referenced citations in the text,

this is the researcher's original work.

Ravani Chetty

Prof Oluyinka Adejumo

ABSTRACT

The issue of adolescent health has steadily grown momentum with people realizing the vulnerability of this sector of the world's population. Within the South African context, the tide had also turned. However, most initiatives aimed at the prevention of problems, one of which was adolescent pregnancy. Extant literature revealed that despite efforts to reduce adolescent pregnancy, adolescent fertility rate in Sub-Saharan Africa remained on the rise. As such, the need for appropriate maternity services for this group became a concern, as extant literature also revealed the costly long term effects to pregnant and parenting adolescents, as well as society as a whole.

Within KwaZulu-Natal pregnant and parenting adolescents use the same maternity services as their adult counterparts. It was not clear if these services were appropriate to the needs of these clients. As such, a Glaser Grounded Theory approach was used to explore the maternity services from the points of view of the various stakeholder groups. Data was collected, using theoretical sampling, by means of semi-structured interviews and focus group interviews. Constructs of adolescent-friendly maternity care were identified from the findings.

The components of the constructs included aspects of (1) Structures and Resources, (2) Attitudes to AMCs, and (3) Services. The resources or structures that either need to exist and/or be improved included policies, the quality and quantity of HCps, formalized support for AMCs, a sensitized administration, community involvement and the educational preparation of HCps. The attitudes that service providers were expected to demonstrate in their interaction with AMCs included those of equality,

empathy and respect. They were also expected to show understanding towards AMCs and provide them with reassurance and support. The third component identified specific services to be provided to AMCs during the antenatal, labour and delivery, and postnatal period.

These constructs can be used by health care planners and providers to strengthen and improve service provision to and utilization by pregnant and parenting adolescents and form the foundation on which a theory of adolescent-friendly maternity care can be based. Recommendations were made with regards to future service and research endeavours.

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ABBREVIATIONS

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For the purposes of the study the following abbreviations have been used:

AIDS   Acquired immune deficiency syndrome

AMC   Adolescent maternity client

DoH   Department of Health

FGI   Focus group interviews

HCp   Health care provider

HCP   Health care planner

HIV   Human immuno-deficiency virus

SSI   Semi-structured interviews

STI   Sexually transmitted infections

WHO   World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

An estimated 15 million adolescent pregnancies are thought to occur throughout the world (Rivera, Cabral de Mello, Johnson and Chandra-Mouli, 2001). In America there are an estimated 900 000 adolescent pregnancies occurring each year and this has resulted in America having the highest rate amongst all developed countries (Lonczak, Abbott, Hawkins, Kosterman & Catalano, 2002). According to Kaufman, de Wet and Stadler (2001), the fertility rate in South Africa is decreasing and is currently amongst the lowest in the sub-Saharan African region. However, despite this drop, there has been no significant decrease in the number of adolescent pregnancies. In South Africa more than 30 percent of 19-year-old girls were reported to have given birth at least once (Kaufman et al, 2001; South African Demographic and Health Survey, 1998). Makiwane (1998) alludes to adolescent pregnancy rates in South Africa being one of the highest in the world. In her study she found that 58 percent of her sample of adolescent females had "experienced some sexual activity by the age of 16 years, and a [sic] 82 percent by 17 years" (Makiwane, 1998, p.43). Less than half of the sexually active seventeen-year-olds in the Makiwane (1998) study had taken precautions to prevent a pregnancy.

A review of the literature surrounding the problem of adolescent pregnancy indicates that the main focus of work in this area has been the prevention of pregnancies and sexually transmitted diseases (Abdool Karim, Preston-Whyte & Abdool Karim, 1992;

Kunene, 1995, Jewkes, Vundule, Maforah and Jordaan, 2001). A lot of work has been done on understanding the antecedents of adolescent pregnancy and the prevention of such pregnancies (Corcoran, 1999; Kellogg, 1999; Arnold, 2000; Coard, 2000). Despite such endeavours, the adolescent pregnancy rate in both developed and underdeveloped countries still remains high (Corcoran, 1999), thus, suggesting that some of the emphasis of future research would need to be directed not only to the prevention of adolescent pregnancy, but also realistically begin to address the issue of care for the pregnant adolescent.

1.2 BACKGROUND TO THE STUDY

Arulkumaran (2001) in his editorial defined adolescents as a vulnerable population group, which faced inequity with regards to health care provision. According to him, "one-fifth of the world's population, are adolescents between the ages of 10 and 19 years, and 85% of them live in developing countries" (Arulkumaran, 2001, p.109). Whilst adolescents are catered for within the South African health service, they are not seen as a specific population with specific needs. "In an effort to decentralize family planning services in the late 1980s, special clinics and programs for adolescents were discontinued (Kaufman, 1996). Although a large number of service-delivery points exist throughout the country, adolescents are often unwelcome" (Kaufman et al, 2001, p.149). Negative and judgmental attitudes by nursing staff (Mngadi, Thembi, Ransjö-Arvidson & Ahlberg, 2002) towards adolescents seeking barrier method contraception was also reported by Abdool Karim et al (1992). Their study focused on whether appropriate care and advice regarding HIV / AIDS was being given to adolescent clients attending family planning services in KwaZulu-Natal.

In South Africa, KwaZulu-Natal has the largest number of adolescents as compared to the remaining eight provinces (National Youth Commission, 1997). The 1998 Demographic and Health Survey revealed that a total of 13.8% of adolescents in KwaZulu-Natal had given birth to a child, while 16.7% had at sometime been pregnant. This information is vital to health service planning. While there is a staggering number of adolescent pregnancy and birth, this category of health consumer is made to use the same services that are primarily designed to cater for the needs of adults rather than the needs of pregnant adolescents.

Available statistics from the Informatics Department of the Department of Health for KwaZulu-Natal (see Appendix 1), for the year April 2002 to March 2003, reveal that out of a total of 144 972 live births a total of 14 290 were to women under the age of eighteen. The under 18 figures do not include women aged 18 years and 19 years, who are part of the adolescent population in which this study was interested. In fact this category of client is included in the statistics that are provided for the woman over 18 years of age, who are delivering. The figures for adolescent pregnancy and delivery may in fact be higher than those represented here, as these are statistics that have been submitted from primary health care facilities and hospitals in the province. It does not indicate those individuals who may be reproducing and delivering without contact with the present health care system. There are also statistics missing for some of the 11 Kwa-Zulu Natal regions for some of the months, which may present an inaccurate picture of the problem of adolescent pregnancy within KwaZulu-Natal. A larger number of adolescent care and deliveries are taking place in hospitals (12 308 births) as opposed to primary health care facilities (1982 births), this is due to the fact

that adolescent maternity clients are considered as 'high-risk' because of their physiological immaturity and are referred to hospitals for care. When one looks at the total births recorded for women under eighteen for this same period, this category comprises 9.85% of the total. While this may appear to be a small percentage in light of the whole, one needs to still consider that there were 14 290 individuals who faced the crisis of adolescent pregnancy, not to mention the offspring that are now 'at risk', due to the circumstances into which they were born.

Currently in KwaZulu-Natal there are no maternity services that are specifically for adolescent clients. Available care in these services may not be appropriate to serve the specific needs of adolescents as attested to by Arulkumaran (2001, p.109).

> "Adolescents share many characteristics with adults, but their health-related problems and needs differ significantly. As a result there is a growing recognition among clinicians and public health workers that approaches used to prevent and respond to health problems in adults have to be adapted to meet the special needs of adolescents"

Treffers, Olukoya, Ferguson and Liljestrand (2001) lend support to the idea of tailoring maternity services to cater to adolescent client's needs by drawing our attention to the fact that the technical care during labour and delivery does not differ between the adult and adolescent client. Their needs are basically the same. However, the difference is with regards to the empathetic support that they may require in labour, with the adolescent needing more supportive care than her adult counterpart. These findings and suggestions raise the question of the type and amount of support the adolescents may be receiving within the current maternity services. According to the World Health Organisation (1990) in Williams and Mavundla (1999, p.59), "prenatal care is usually inadequate as compared to that given to adult women" (Ehlers, Maja, Sellers & Gololo, 2001; Treffers et al, 2001). At the time of this study

no research had been done in this area within the KwaZulu-Natal province, to ascertain whether adolescent clients are having their needs met by the present maternity services that they may use.

For the adult woman, pregnancy is a period for introspection and 'finding ones self' again. Becoming a parent implies great responsibility and it is normal for the expectant mother to feel anxiety as her newfound role approaches. The pregnant adolescent finds herself having two stressful phenomena taking place, namely, identity development superimposed with herself becoming a parent. "The result is often confusing, interfering with both the expectant mother's developmental course, as well as her ability to initiate a relationship with her unborn infant" (Trad, 1999, p.3). Inability to bond with the fetus may prove to have serious negative effects after birth, if this situation cannot be corrected and may result in neglect and abuse of the infant.

> "Every year 15 million children are born to adolescent mothers. Eighty percent of these births occur in developing countries (WHO, 1997). Perinatal and infant mortality rates, especially in developing countries, are consistently higher where mothers are younger than 20 years of age. Perinatal care can substantially reduce mortality and complications from pregnancy and childbirth, especially in very young women" (Mngadi et al, 2002, p.40)

Adolescents may attend antenatal clinic later in their pregnancies than their adult counterparts. Tanga and Uys (1996) found that none of the respondents in their study had commenced antenatal clinic visits in their first trimester of pregnancy, while more than half of the respondents only commenced in their second trimester of pregnancy (Kunene, 1995; Tanga and Uys, 1996). As a result of feelings of shame and embarrassment, adolescents may attempt to hide their pregnancies from people around them. In trying to do this, the nutritional status of the adolescent girl and the unborn fetus becomes problematic and may result in malnutrition with its inherent

complications for the pair (Trad, 1999, Arulkumaran, 2001). Later clinic attendance also results in problems not being detected early enough for solutions to be found or supportive care to be given (Mngadi et al, 2002). Evidence suggests that adolescents seeking reproductive health care may have met with negative attitudes and criticisms from health professionals, (Abdool Karim et al, 1992; Kaufman et al, 2001; Mngadi et al, 2002) and, as a result, may delay attending antenatal clinic for fear of receiving much the same reception. Akinbami, Ghandi and Cheng (2003) found that, where adolescents were expected to use the same services as the rest of the patient or client population, they chose not to seek health care. This highlights the possible need for a specific service for adolescent clients.

According to Ehlers et al (2000, p.44), "adolescent mothers experience higher morbidity and mortality during pregnancy and labour than do adult women". Studies have shown increased incidence of pre-eclampsia, anaemia, malnutrition, cephalo-pelvic disproportion and sexually transmitted infections in pregnant adolescents (Trad, 1999; Ehlers, 2000; Rivera et al, 2001; Treffers et al, 2001; Mngadi et al, 2002).

Within the South African context the HIV / AIDS epidemic has significantly altered the disease profile. In 1998 it was found that 60% of new HIV infections were reported in people under 25 years of age within South Africa (Department of Health, 1998). The infection rate of girls was found to be higher than that for boys, within the same age category, with a ratio of 2:1 for girls and boys respectively. The explanation of this ratio is that girls tend to achieve physical maturation faster than their male counterparts. As a result they are more likely to receive sexual advances earlier and

become sexually active at a younger age, placing them at risk for HIV infection. Another factor that contributes to a higher risk in girls is that their reproductive systems are immature and when commencing sexual intercourse at an earlier age, the system may be unable to defend itself against infection, thus putting the girl at risk for HIV infection (Department of Health, 1998).

Pregnant and parenting adolescents using maternity services have already commenced sexual activity and are therefore at a higher risk for HIV infection. Maternity services can provide education and empowerment to such individuals, to sensitize them to this potential, if not real problem. In 2000 the antenatal sero-prevalence survey revealed that 36.2% of antenatal clinic attendees in KwaZulu-Natal tested HIV positive. The survey also indicated that within South Africa, 16.1% of antenatal clinic attendees under the age of 20 were found to be HIV positive. According to this report HIV prevalence within the teenage population had not increased for the period 1998 to 2000. This was attributed to higher condom usage amongst adolescent females. However, there has been a steady increase in the HIV infection rate amongst women in their twenties. It is postulated that this may indicate that becoming infected may in fact be delayed rather than prevented (Department of Health, 2000). HIV / AIDS has serious implications for adolescents seeking maternity care, in that, in the first instance, these are adolescents who have exposed themselves to unprotected sex.

The postnatal period is also crucial and literature review has shown that adolescents are pre-disposed to many problems during this period. Adolescents face problems with conditions such as anaemia and pre-eclampsia in the postnatal period. Babies born to adolescent mothers are more likely to be born premature and to have low birth

weights (Arulkumaran, 2001, Treffers et al, 2001). Inherent within being born premature are conditions such as respiratory distress syndrome, hyperbilirubinaemia, susceptibility to neonatal infections, anaemia, and hypothermia (Merenstein & Gardner, 1998; Deacon & O'Neill,1999).

Presently in South Africa, all women who attend antenatal clinics are asked to come for an examination for both themselves and their baby at six weeks post-delivery (Mngadi et al, 2002). This is done to ensure that both mother and baby are doing well, and that the woman's body is returning appropriately to its pre-gravid state. After this contact, which may take place at the institution where the woman delivers or at the local community clinic nearest to her residence, there are no further scheduled visits. The woman will make contact with a health setting if she experiences problems. Care is taken over by the community health nurses and mostly relates to carrying out the immunization schedule for the infant as laid down by the relevant health authorities. A dearth of resources has resulted in home visits by community health nurses being reduced to absolute essential clients, if they exist at all. For the adult client who may have the ability to recognize health problems and seek assistance, this lack of service is problematic. In the case of the adolescent mother the situation is dire. When postnatal discharge health education is given, more emphasis appears to be placed on physical care of the baby and for the women (Mngadi et al, 2002). The hardships and realities of caring for a newborn become obvious to the adolescent as time passes and she learns by trial and error. This may add to her already stressful situation.

1.3 PROBLEM STATEMENT

There was no available information on the existence of a special maternity service for adolescent clients in KwaZulu-Natal or in South Africa as a whole. The pregnant 15 year old used the same services as the pregnant 35 year old, who was possibly having her third baby. As a group, adolescents are considered to be a vulnerable population, requiring special attention (Arulkumaran, 2001). A review of the literature surrounding adolescent pregnancy points to this population group as being 'at risk' for both physical and psycho-social problems that may have long term negative effects. It was therefore necessary to find out how the existing maternity services catered for the needs of adolescents.

Within the South African context, where health resources are already stretched to their limits, it was necessary to explore the feasibility of an integrated adolescent-friendly maternity service as part of existing maternity services in the country. Separate services might also add to ostracisation and stigmatization that this vulnerable population group might face. Hence, the idea of making the present maternity services that these clients use adolescent-friendly was an attempt to increase service utilization. Having said this, it was then not clear what would constitute an adolescent-friendly maternity service within KwaZulu-Natal. Extant literature pointed to adolescent-friendly initiatives being applied to general health care services and were not specific to adolescent maternity clients (Finger, 2000; Dickson-Tetteh, Pettifor & Moleko, 2001). Adolescent pregnancy was considered a crisis period in the life of the adolescent; therefore, it might not be appropriate to assume that what was described as being adolescent-friendly for general health services would necessarily apply to maternity services. An attempt to locate information on adolescent-friendly

maternity services in South Africa had shown that no such services exist within this context. While adolescent maternity clients might be better catered for elsewhere in the world, the guidelines for such endeavours might not be transferable to the South African or African context, as each setting is unique with its own ethnicity and relevant culture (McNair & Brown, 1996; Finger, 2000; Heunis, van Rensburg & Ngwena, 2000; Rivera et al, 2001). Thus, models imported wholesale from elsewhere might not serve the purpose of a developing African country.

Hence the need to establish what would constitute an adolescent-friendly maternity service within KwaZulu-Natal. To ensure that the service was practical, feasible and appropriate with increased service utilization in mind, it was necessary to ascertain what stakeholders in the maternity service would consider to be an adolescent-friendly service. At the time of the study there was no documented information from adolescent clients about the maternity services in the KwaZulu-Natal. Adolescents' views about the services they receive and their expectations of care were important in shaping the services to meet their needs. It was therefore necessary to pursue constructs towards a model for action for adolescent-friendly maternity services from the perspectives of all stakeholders involved in adolescent maternity services.

1.4 AIM

The aim of this study was to identify from the data constructs that could be used towards a model of action for an integrated adolescent-friendly maternity service from the perspectives of all stakeholders involved in adolescent maternity services. An understanding of what constituted an adolescent-friendly maternity service would

allow for improved maternity service provision to adolescent maternity clients and would result in increased service utilization by these clients.

1.5 RESEARCH QUESTIONS

In view of the current situation the following research questions were asked:

1. What were the perceptions of adolescent clients regarding maternity services in KwaZulu-Natal?

2. What were adolescent client's expectations of the maternity services in KwaZulu-Natal?

3. What were the attitudes of health care planners and health care providers towards adolescent maternity clients and their needs?

4. What were the strengths and weakness of the present maternity services provided to adolescent clients as perceived by health providers and health planners?

5. What were the suggestions from health providers and health planners on how to improve the present maternity services so that they might more effectively cater for the adolescent client?

6. What did the adolescent maternity clients consider to be an adolescent-friendly maternity service?

7. What did the maternity health care providers consider to be an adolescent-friendly maternity service?

8. What did the maternity health care planners consider to be an adolescent-friendly maternity service?

1.6 STUDY OBJECTIVES

The study addressed the following specific objectives:

1. Described the perceptions of adolescent clients using provincial maternity services regarding the care that they received.

2. Explored the views of health care providers working in provincial maternity services towards adolescent maternity clients.

3. Explored the views of health care providers working in the maternity departments regarding the strengths and weaknesses within the maternity services with regards to adolescent maternity clients.

4. Examined the views of health care planners at local and regional levels who were involved in the planning of maternal and child health services for the province and for institutions, towards adolescent maternity clients.

5. Examined the perceptions of health care planners on the strengths and weaknesses within the maternity service with regards to adolescent maternity clients.

6. Determined the expectations of adolescent maternity clients, health care planners and health care providers, concerning adolescent maternity services.

7. Described what the stakeholders considered would constitute adolescent-friendly maternity services.

8. Identified constructs that could be used towards a model of action for adolescent-friendly maternity services.

1.7 SIGNIFICANCE OF THE STUDY

In the last decade there had been a refocusing of attention in the arena of health care both internationally and nationally. Adolescent health care had come under the 'microscope', with health care providers, health care planners and educationists responsible for the training of health care professionals, turning their attention to adolescent health needs and how best to address these needs. In response to this shift of attention the World Health Organisation (WHO) held a technical meeting in Cairo, Egypt in February - March 2001. The focus of this meeting was the strengthening of adolescent health and development in pre-service nursing and midwifery curricula in an attempt to better serve this vulnerable population (WHO, Annex I, 2001).

Of the total 'youth' population in South Africa, KwaZulu-Natal had the highest 'youth' population from all the nine provinces, with a total of 22%. Of this, male adolescents comprised 20% of the total population in KwaZulu-Natal, while female adolescents formed 22%. As could be seen, females formed the larger group, making it vital to consider them when planning health services. "It has been found by the HSRC in 1994, that 48% of Black women, 17% of Coloured women, 30% of Indian women and 17% of White women gave birth before turning 20 years of age" (National Youth Commission, 1997).

After having examined the changes on the national and international front with regards to adolescent health care, it became obvious that not enough work had been done within the South African context regarding response to adolescent health care needs. The previous focus which concentrated on issues of sexual health needs and

prevention of pregnancy and sexually transmitted infections needed to be re-examined. It is clear that while prevention strategies could help to decrease the incidence of adolescent pregnancy, it was not able to totally eradicate the problem. As such, this study aimed to address the plight of those adolescents who have become pregnant, in an effort to provide more appropriate care to them and their babies during their pregnancy, labour and delivery, and postnatal period.

In light of the world's focus on adolescent health and the provision of services to meet their specific needs, this study was highly significant as, if successful it would help health care providers and planners to deliver relevant maternity services to these adolescents, thereby, increasing utilization of health services by pregnant and parenting adolescents, allowing for early detection of problems and appropriate intervention, application of preventative strategies and ensuring good health promotion within this population and for future offspring. At the time of the study no information had been formally collated outlining the perceptions, experiences and needs of adolescents using the present maternity services. This study added to the current body of knowledge surrounding the problem of adolescent pregnancy and how best to respond to the health needs that this situation created.

The emerging model of action towards a grounded theory of adolescent-friendly maternity services in this study provided a foundation for future researches on adolescent health and adolescent maternity services in South Africa and the rest of Africa in general.

1.8 DEFINITIONS OF CONCEPTS

1. Adolescents: for the purposes of this study an adolescent referred to individuals between the ages of 12 to 19 years.

2. Partners of Pregnant Adolescents: The word 'partner' was used to make reference to the individual who had fathered the pregnancy and subsequent child.

3. Significant others: included all people the adolescent felt was significant to her, such as, parents, grandparents, siblings, aunts, uncles and friends (Tanga & Uys, 1996).

4. Maternity services: included the antenatal clinic, antenatal ward, labour and delivery ward, postnatal ward, neonatal nursery, postnatal clinic and family planning clinic

5. Adolescent specific health services: Referred to health services that are solely for use by adolescent clients and that have been developed specifically for the adolescent client.

6. Adolescent-friendly health services: these were health services that serviced the general population in terms of whatever service they might offer, but at the same time they catered for the adolescent client. "Health services can be described as adolescent-friendly if they have: '…policies and attributes that attract youth to the facility or programme, provide a comfortable and appropriate setting for youth, meet the needs of young people and are able to retain their youth clientele for follow up and repeat visits'" (Senderowitz, 1999 in Dickson-Tetteh et al, 2001, p.161).

7. Stakeholders: for the purposes of this study the term 'stakeholders' was used to refer to adolescent maternity clients , health care providers and health care planners.

8. Adolescent maternity clients: for the purposes of this study this referred to all maternity clients between 12 and 19 years of age, who used the maternity services at the designated research sites.

9. Health care providers: this term was used to refer to midwives who were registered with the South African Nursing Council, and doctors who were working in the maternity services at the three selected research sites. This term also included midwives and doulas in private practice settings.

10. Health care planners: for the purposes of this study the term 'health care planners' referred to three categories of participants. Firstly, it included nursing service managers who were directly responsible for midwifery care at the three selected research sites, secondly, individuals from the local Maternal, Child and Women's Health sub-directorate of the KwaZulu-Natal Department of Health, and thirdly, the heads of Obstetric and Gynaecology departments where appropriate.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

A grounded theory methodology was used in this study, which takes the view that literature should not be read widely prior to the data analysis phase. However, it was essential that the researcher read around the area of adolescent health, in order to arrive at and clearly define the problem statement. That literature review is presented in this chapter, with the hope of giving the reader a clear picture of the South African youth and adolescent population, thus illuminating how the researcher arrived at the area of study that this report is concerned with, namely, adolescent-friendly maternity care.

2.2 VULNERABLE POPULATION

> "Since the 'youth uprising' of 1976 and the subsequent mobilization of young women and men against apartheid policies and racial oppression, the term 'youth' has represented a potent and important element of the political struggle. It has also been used to characterize a segment of the population seen as violent, unruly, undisciplined and underdeveloped" (National Youth Commission, 1997).

The term 'youth' as used in the quotation given above refers to people between 14 to 35 years of age. In an attempt to move away from this negative concept of young people, the South African government commissioned the National Youth Policy. Diversity and uniqueness amongst the young people of South Africa was being recognized. This document brought to the fore the present status of South African youth and their vulnerability as a population within the general South African context.

According to Dickson-Tetteh and Ladha (2000), there is an estimated 18 million people in South Africa below the age of 20. This accounts for 44% of the total South African population. Within the youth cohort there is inequity, with African youth facing the biggest problems in terms of housing, employment, access to health, access to education and exposure to crime and violence, when compared to the White, Coloured and Indian youth populations (National Youth Commission, 1997).

Whilst the adolescent population is at risk for many health related problems, it would appear that the area of sexual and reproductive health behaviours is responsible for the largest proportion of death and disability among young South Africans. An estimated 4 million cases of sexually transmitted infections take place yearly. Of this incidence, a little over half take place in the adolescent population. This is not surprising since the average age for commencement of sexual activity has been found to be 15 years for females and 14 years for males. The 1998 national antenatal sero-prevalence survey demonstrated that 21% of clients attending antenatal clinic in the under 20 year old category were found to be HIV positive (Dickson-Tetteh & Ladha, 2000). This is not surprising in the light of the HIV / AIDS pandemic in South Africa at present, the worst affected province being KwaZulu-Natal (Heunis et al, 2000).

Despite declining fertility rates in the adult population, the adolescent pregnancy rate remains high, especially with regards to the Coloured and rural African female population groups (South African Demographic and Health Survey, 1998). By age 19, an estimated 35% of the adolescent population within South Africa has either been pregnant or has had a child; a concern for the government and researchers in the area

of adolescent health alike (South African Demographic and Health Survey, 1998). Adolescent pregnancy poses many health risks for both the mother and child. "One in eight teenage deliveries are by caesarean section, which indicates complicated births, and highlights the risk that adolescents place themselves at (sic) by becoming pregnant at such an early age" (Dickson-Tetteh & Ladha, 2000). Disruption of schooling adds to the picture of vulnerability. Incomplete school results in low paying jobs and poor socio-economic status (National Youth Commission, 1997).

Governmental amendment to legislation surrounding the issue of termination of pregnancy now makes it possible for women to legally procure abortions. This has translated into less women dying from complications related to illegal abortions. In 1999, an estimated 11% of abortions were done on females under the age of eighteen. This is despite an encouragingly high percentage of contraceptive use amongst sexually active adolescents in the 15 to 19 year age group. Injectable contraception appears to be more popular with adolescent clients, while condom usage is relatively low (South African Demographic and Health Survey, 1998). This is disturbing given the high HIV prevalence amongst adolescents and their susceptibility to the disease as a result of immature body physiology. Commencement of sexual activity earlier will also possibly mean more sexual partners than for those who commence first intercourse later in life.

Within the South African context, violence against women has been seen to have a significant effect on early childbearing. Some adolescents view sexual coercion as a norm and accept being forced into sexual relationships (Chetty, 2000). Dickson-Tetteh and Ladha (2000) make reference to a study conducted in the Western Cape

where a staggering 32% of pregnant adolescents indicated having been forced into having sexual intercourse, which resulted in their pregnancy. An estimated 15% of youth in South Africa are thought to suffer from mental illness that may need diagnosis and hospitalization. Alcohol and tobacco usage amongst young South Africans is high. A reported 80% of adolescents in the 10 to 21 year age category admitted to having used alcohol at least once, with 10% of all adolescents smoking. Adolescent morbidity from injuries (including accidents, homicides and suicides) appears to be high, with a reported 78% of deaths amongst adolescent males and 41% amongst adolescent females. The HIV pandemic has also contributed significantly to the mortality and morbidity rates amongst adolescents in South Africa (South African Demographic and Health Survey, 1998; Dickson-Tetteh & Ladha, 2000).

As can be seen from the information just presented, adolescent health needs attention as the plight of adolescents within South Africa appears dire. Prior to the 1990's youth in South Africa were viewed as part of the population at large and were catered for in the same light. With democratization, a new view of young people also emerged (National Youth Commission, 1997). They were now being perceived as a separate population group with specific needs that had to be specifically catered for. Health care for young South Africans was one of the areas that came under focus. Previously, adolescent health was provided with the general health structure and the individual received paediatric or adult services, based on age.

In 1993, Yach highlighted the need for adolescent health services in South Africa, in the editorial section of the South African Medical Journal. Mention was made of the fact that adolescents as a population are at risk for problems such as substance abuse,

sexually transmitted infections and violence (Yach, 1993). The same facts were corroborated by Richter (2000), and Dickson-Tetteh et al (2001). Yach (1993) emphasized the need for health promoting programmes that aims at lifestyle change, with a view to combating risk factors. The World Health Organisation (WHO) had this to say about adolescents in making a case for strengthening adolescent health in nursing and midwifery curriculum:

> "One in five people in the world today are adolescents aged between 10 and 19 years and 85% of this group live in developing countries. Adolescents have specific health problems and needs, which generally are not adequately met in most countries. Although the perspective on adolescents has tended to be problem-oriented, perpetuating a rather narrow view of adolescent health, this life stage has enormous potential for health promotion and illness prevention."

> (WHO, Annex I, 2001, p1)

The need for adolescent specific health policies and services was also brought into focus by Health Minister for South Africa, Dr. Manto Tshabalala-Msimang, in her address given at the launch of the "Contraceptive Policy Guidelines" and, "Youth and Adolescent Health Policy Guidelines", held on the 26th March 2002. "The Youth and Adolescent Health Policy Guidelines aim at preventing and responding to the needs of young people such as unsafe sexual behaviour, and promoting healthy lifestyles of all youth and adolescents" (Tshabalala-Msimang, 2002). As can be seen by the information presented, the last decade has seen an increase in the awareness amongst health care providers for the need for adolescent specific health care.

2.3 ADOLESCENT HEALTH SERVICES

One area of adolescent health and development highlighted by the working group at the WHO (2001) technical meeting in Cairo was that of adolescent reproductive health. Whilst adolescents are catered for within the South African health service, they are not seen as a specific population with specific needs as WHO would like for

them. In addition, it would appear that the present public health facilities are providing care that is inadequate for and non-specific with regards to the adolescent client (Dickson-Tetteh et al, 2001). There are very few services that cater for the adolescent specifically and when they do exist the focus tends to be education regarding sexuality and safe sexual practices (Kunene, 1995).

When youth health services exist, they have been shown to be very useful to the adolescent client. Finger (2000) indicates that adolescents would like clinics that they can attend to have their health care needs met. Dickson-Tetteh and Ladha (2000) indicate that a large percentage of young people in South Africa feel that they could benefit from health education on issues related to sexuality and reproduction. Kunene (1995) found that ninety-four percent of female users stated that they derived benefit from the education on human reproduction that they received. This enabled them to be able to prevent unwanted pregnancies. In the same study male respondents, a total of eighty-four percent, felt they had gained from the exposure that they had received in the youth health centre. They were slightly different from their female counterparts, in that, prevention of pregnancy was not an issue for them. Instead they benefited from the information on sexual relations and on the dangers of sexually transmitted diseases.

From the sample investigated in the Kunene (1995) study, a total of sixty-one percent felt that it was more appropriate to have adolescent health services separate from the mainstream health services. The reason cited by these adolescents was the privacy afforded by a separate service. They would not be in fear of bumping into their parents or parents of peers whilst attending the health centre. They could then get

information and take action without their parents' knowledge. Akinbami et al (2003) found that issues of confidentiality contributed to adolescents not seeking health care. In general health care practices, where confidentiality was likely to be compromised, it was noted that adolescent patient attendance rates were low. This finding is in agreement with an earlier study by McNair and Brown (1996, p.347) who report a, "reluctance to access mainstream general practice services, particularly for sexual health problems due to confidentiality issues (even if only perceived by the adolescents)".

Adolescents also expressed the view that since their problems and concerns would be different from those of adults, it was better to have a separate service (Kunene, 1995). An idea corroborated by Arulkumaran (2001) and in keeping with WHO philosophy that sees the adolescent as a specific client with specific needs. In the Kunene (1995) study the youth health centre was an environment in which adolescents felt they could express their individual views and determine their own actions. This is significant as it demonstrates the views of the adolescent clients themselves.

2.4 NEGATIVE IMAGE OF ADOLESCENT HEALTH FACILITIES

There are also obstacles that prevent appropriate use of such services when they do exist. A lack of privacy leads to adolescent clients being discouraged from utilizing the service as would be expected. Fieldworkers in the Abdool Karim et al (1992) study reported feelings of discomfort when receiving sensitive information in the absence of privacy. Adolescent health centres appear to be perceived in a negative light, since, as stated earlier, where they do exist, their focus appears to be on reproductive health. Finger (2000) asserts that adolescent female clients may not want

to use reproductive specific health services, due to stigmatization of the facility within the community. Association with such a centre may indicate sexual activity. This brings to the fore difficulties likely to be encountered in developing adolescent-specific services that are meant to be friendly to the adolescents in such a way that they are able to use the services without fear of their personal issues being discovered.

Another reason for poor utilisation of the existing service for adolescent care was its proximity. Respondents in the Kunene (1995) study found that the service was too far away from where they lived. This meant that they had to get public transport, for which they had to pay, to get there. The adolescents themselves felt that it would have been better if it was in the townships where they lived. It would also appear that only one such service existed for the entire Empangeni area. It may be more beneficial and user friendly to have more such services on a smaller scale in an area, so that access is made easier. The 1997 National Youth Policy confirms this problem of access in that almost half of the KwaZulu-Natal province's youth have to travel for an hour or more to reach health services (National Youth Commission, 1997). Findings from the 1999 HST Update (in Heunis et al, 2000) make the picture of access clearer. According to this report, 95% of White and 93% of Indian youth in South Africa are able to access health care within half an hour. However, 61% of African and 84% of Coloured young people are able to access health care within the same time frame. The difficulty of access for African youth is crucial.

The youth health centre in the Kunene (1995) study was open at the same time that adolescents were in school. Hence they were unable to access the service. A similar finding was also reported by Dickson-Tetteh et al (2001) and Finger (2000). From the

information presented it would appear that the adolescents themselves should have been consulted prior to the youth health centre being set up. This would probably have resulted in the service provided being more suited to the client and in better utilization of such an essential service.

2.5 ADOLESCENT-FRIENDLY SERVICES

An alternative approach to adolescent care would be to make all health care clinics adolescent-friendly as opposed to adolescent specific. This is the crux of 'The National Adolescent-Friendly Clinic Initiative' (NAFCI). According to Dickson-Tetteh et al (2001, p.161), "NAFCI has been developed on the premise that stand-alone youth centers may not be cost-effective or sustainable, and cannot be set up, at least in South Africa, in sufficient numbers to provide care to the majority of young people". This removes the preconceptions of past facilities where reproductive health was the focus of adolescent specific clinics.

According to Finger (2000), some of the criteria that contribute towards a health service being considered as adolescent-friendly are as follows:

- The service should afford privacy.

- Confidentiality should be maintained.

- There should be adequate time per consultation to allow for proper interaction between staff and clients.

- It should be affordable to the adolescent.

- It should be easily accessible, both in travelling distance and operating hours.

- The health care providers working in the facility should be sensitive when dealing with adolescent clients.

- The staff working at these facilities should show respect towards their adolescent clients.

As evidenced from the information presented, it would appear that general principles regarding what constitutes an adolescent-friendly health service have been developed. However, these guidelines, when closely examined, could apply to any client population within the health care setting. They are not necessarily specific to adolescent clients alone. Whilst these principles definitely have bearing on this study, they alone cannot provide the answers to the research questions that have been posed. This study, whilst dealing with adolescent health services, focuses on a very specific time in the adolescent's life, namely childbearing. A review of literature will give the reader an insight into the possible problems and crises that a pregnant or parenting adolescent is likely to encounter. Childbearing for adult women is a stressful event, fraught with both psycho-social and physical upheaval. One can only assume that these transitions will have more of an impact on an adolescent female (Trad, 1999). The principles of adolescent-friendly care that are given above, are relevant to adolescent clients attending regular health services as opposed to those going through the 'crisis' of pregnancy and parenting as adolescents. Adolescent maternity clients would be presumed to have different psycho-social needs that require a great deal of exploration in order to establish care that can be said to be friendly to them.

2.6 FACTORS CONTRIBUTING TO ADOLESCENT PREGNANCY IN SOUTH AFRICA

A review of the literature surrounding the problem of adolescent pregnancy indicates that despite interventions to prevent pregnancy during this critical developmental stage, pregnancy rates remain high (Corcoran, 1999; Kellogg, 1999; Arnold, 2000; Coard,, 2000).Within the South African context cultural values may also be responsible for the rate remaining high. Kaufman et al (2001) draws our attention to the fact that while adolescent pregnancies are not condoned by society, babies born out of this situation are taken into the family, with responsibility for care falling onto the parents and grandparents of the adolescent female (Makiwane, 1998; Mngadi et al, 2002). The adolescent, however, does face rebuke from her family (Tanga & Uys, 1996). Where rebuke is perceived to be too strong, negative consequences can result as discovered by Makiwane (1998), where an adolescent drowned her baby after being reprimanded by her father for falling pregnant. This indicates how delicate the problem of adolescent pregnancy becomes for the girl, her family and the child born as a result of the pregnancy.

Within some ethnic groups in South Africa, monetary compensation is expected from the father of the baby. He is to pay 'damage costs' to the parents of the girl (Tanga and Uys, 1996; Makiwane, 1998); hence, admitting his responsibility for the pregnancy. Whilst this is perceived as admittance to paternity, it does not necessarily mean that the father will be responsible for maintaining his child after initial payment (Makiwane, 1998; Kaufman et al, 2001). In effect it serves to 'let the individual fathering the baby, off the proverbial hook'. This leaves the female to deal with the burden of child rearing, and all its related financial and social implications.

Studies done in the early Nineties reveal that proof of fertility is perceived by adolescent females to improve a girl's status within her family and her ability to secure a husband (Preston-Whyte & Zondi, 1992). This resulted in some adolescent girls falling pregnant in order to prove their fertility. However, later studies indicate that this attitude is changing. Richter (1996) found that most of her cohort expressed the desire to complete their education and seek employment before considering a family. One of the reasons for possible pregnancy put forward by Kaufman et al (2001) is that it often occurs against the wishes of the girl herself. The girl is coerced into sexual activity by her partner or may even be raped (Treffers et al, 2001). Given the high statistics of rape and violence against women and children in South Africa, this is not surprising. Heunis et al (2000) suggest that situations of poverty may force young girls into relying on older more financially stable men to support them, resulting in prostitution of sorts. Sex in exchange for material comfort is also thought to contribute to the problem of adolescent pregnancy within South Africa and much of the under-developed and developing worlds.

Another factor that contributes to the problem of adolescent pregnancy is the poor health services available to this vulnerable group (Abdool Karim et al, 1992; Kaufman et al, 2001). According to Kaufman et al (2001) this lack of services can be attributed to the state of administration surrounding family planning services. "In an effort to decentralize family planning services in the late 1980s, special clinics and programs for adolescents were discontinued (Kaufman, 1996). Although a large number of service-delivery points exist throughout the country, adolescents are often unwelcome" (Kaufman et al, 2001, p.149). Negative and judgmental attitudes by

nursing staff (Mngadi et al, 2002) towards adolescents seeking barrier method contraception were also reported by Abdool Karim et al (1992). Their study focused on whether appropriate care and advice regarding HIV / AIDS was being given to adolescent clients attending family planning services in KwaZulu-Natal. Nursing staff were found to perceive condoms as an effective method to prevent sexually transmitted infections but not reliable for the prevention of pregnancy. Hence, their advice to the young fieldworkers collecting data in the study was to rather opt for oral contraception as opposed to condoms since it was, according to them, more effective for the prevention of pregnancy. In their haste to focus on prevention of pregnancy, staff at these clinics did not cater to the needs of the client. As a result they put clients at risk for sexually transmitted diseases and possible HIV infection and subsequent death. In their study done on the piloting of NAFCI, Dickson-Tetteh et al (2001, p.166) found that only four out of a total of seven health service providers gave "information on safer sex practices and STI/HIV prevention" to adolescent clients. Clinic staff in the Abdool Karim et al (1992) study also showed gender bias to female fieldworkers requesting condoms, which they found strange. "In two instances, both at the same clinic, the female fieldworkers were told to 'ask their boyfriends' when they requested more information on condom use" (Abdool Karim et al, p.358). Wood, Maepa and Jewkes (ftp://ftp.hst.org.za/pubs/research/contracep.pdf, retrieved 7th February 2005) found situations where health care providers interrogated adolescents about their sexual relationships and lectured to adolescents seeking contraception on being too young to have sexual intercourse. With reactions such as this, it is no wonder that adolescent pregnancy rates remain high.

2.7 KNOWN PROBLEMS ASSOCIATED WITH ADOLESCENT PREGNANCY

Once pregnancy has taken place, the results for both the male and female adolescent tend to be very negative. As mentioned earlier, low socio-economic status is one of the major predisposing factors to such pregnancy. Once pregnant, many life opportunities become closed off to the adolescent couple. One of the crucial problems is the difficulty these adolescents experience with completing their schooling (Lonczak et al, 2002). This results in them not being in a position to further their post secondary school education and having to take on low paying jobs in order to support themselves and their babies (Trad, 1999; Coard, 2000; Elhers et al, 2000; Kaufman et al, 2001, Rivera et al, 2001). Having a child in the South African context does not necessarily predispose the adolescent to marriage and having more children. The education system in South Africa makes allowance for pregnant adolescents to interrupt schooling to have their babies. In other countries this may not be the case. In Swaziland, pregnant adolescents face being expelled from school (Mngadi et al, 2002). In South Africa pregnant adolescents can resume their schooling as they see fit (Kaufman et al, 2001). However, it has been found that adolescent pregnancy is a major contributory factor to females not completing their schooling (National Youth Commission, 1997). The National Youth Policy document reveals that one in eight young women have had to leave their education because of pregnancy. So despite educational policy adjustments to cater for adolescent pregnancies, many of these adolescents may not return to school and complete their education. The result is poor socio-economic circumstances for the girl, her family and her child. Kaufman et al (2001, p.148) assert the need to understand the factors that prevent returning to school

so that relevant policy changes can be made, "which in turn could enhance postpartum social and economic opportunities".

Young (2001) looked at 'internal poverty' and its link to adolescent pregnancy. Internal poverty was defined as having low life aims in areas of education and vocation, limited self-efficacy and an external locus of control. Self-efficacy in this study was seen as a person's ability to reach certain aims in life. Internal poverty was found to be directly proportional to risk for adolescent pregnancy and repeat pregnancy. Hence, this would mean that programmes directed at already pregnant adolescents should have as one of their foci, the continuation and completion of schooling as well as exposing the adolescent to future vocational opportunities (Young, 2001; Kaufman et al, 2001).

According to Trad (1999), approximately two-thirds of children born to adolescent mothers live below the level of poverty by the time they are six years old. The cycle of the lower socio-economic environment is thus perpetuated and another generation is at risk for adolescent pregnancy. This poor environment can also result in subsequent pregnancies. Coard (2000) gives statistics for repeat adolescent pregnancy in the United States of America, which shows a 30-35% likelihood of repeat within the first year after delivery of the first baby and a 40-50% probability within two years post delivery. These are shocking statistics and should point to the need to focus on the adolescent who is already pregnant so that a bad situation does not become worse. Another worrying factor is that repeat pregnancy tends to be planned rather than accidental, as is the case with the first pregnancy. The educational level of the adolescent female has been seen to directly impact on the possibility of repeat

pregnancy. Where education is interrupted the female is more likely to become pregnant for the second time (Coard, 2000; Lonczak et al, 2002). Kaufman et al (2001, p.156) report that, "the possibility of returning to school and the hope of continuing for some tertiary training prompt many women to wait before having another child".

Adolescent pregnancies have also been shown to be more likely to occur where there are poor family dynamics to begin with. Lack of communication or poor ability to communicate between parents and their adolescent often results in dysfunctional and deviant behaviour in the adolescent. This breakdown within the family structure has been shown to contribute to a higher incidence in adolescent pregnancy, since peer influence has the opportunity to take hold and grow. Hence, adolescents discuss their romantic relationships with peers and get advice from individuals, just as inexperienced as themselves (Corcoran, 1999; Arnold, 2000). Where an adolescent has already become pregnant, it would appear that she is now at risk for another such occurrence. A way of preventing this may be to target the manner in which the family functions.

Adolescent pregnancy is a definite stressor to the functioning of any family. Where a low socio-economic background is pre-existing, its stressful effects may be even more obvious. Adolescent respondents in the Kunene (1995) study appear to be very aware of the stressful effects that a pregnancy would have for them within their families. They cited economic difficulties for the family with the pregnancy and addition of a new baby as their first problem. Other issues were related to family relationships and feelings within the family. There would be anger and disappointment on the part of

the parents, while the adolescents themselves would probably have felt guilt and embarrassment. Embarrassment about their child's situation also applied to the parents of the adolescent (Kunene, 1995; Makiwane, 1998; Kaufman et al, 2001; Mngadi et al, 2002). It becomes obvious that in order to diminish the negative effects of the pregnancy, one of the solutions would be to work on family functioning and communication. This should be done in order to help the adolescents and their family, deal with the problem of the pregnancy and be able to move past the crisis situation into normal functioning.

2.8 PSYCHO-SOCIAL DEVELOPMENT DURING ADOLESCENCE

Adolescence is defined as the transitional stage when an individual moves from childhood to adulthood. It is a time for rapid change, both biologically and psychosocially. This stage of development is further subdivided into 3 phases, namely:

- early adolescence, from 11 to 14 years of age
- middle adolescence, from 15 to 17 years of age, and
- late adolescence, from 18 to 21 years of age.

Erikson (1968 in Ashwill & Droske, 1997) sees the main developmental occurrence during adolescence as being the development of the individual's identity and the striving to gain autonomy. Added to these two developmental achievements are the ability to develop intimate relationships, establishing comfort with one's own sexuality and finding a sense of achievement (Ladewig, London, Moberly and Olds, 2002). The rapid physical growth during this period heralds the arrival of secondary sexual characteristics and exploration of sexuality as well as interest in the opposite

sex (Ashwill & Droske, 1997). Thus begins the potential problem of adolescent pregnancy.

During early adolescence, individuals tend to socialize more with same sex peers. There is a noticeable discomfort with peers of the opposite sex, which is probably attributed to self-consciousness regarding one's body image and the rapid physical changes that are occurring at this stage. During this period the adolescent begins to develop group identity and starts to conform to peer standards (Ladewig et al, 2002). The early adolescent has a tendency towards egocentricity. Whilst becoming self-absorbed there is also a tendency towards thinking that they are also the focus of attention to others that surround them. Elkind (1967 in Ashwill & Droske, 1997) refers to this as a reaction to an imaginary audience. Unfortunately, this phenomenon is usually the basis of adolescent-parent conflict during the expected rebellious phase that begins to occur during early adolescence. Despite an attempt to gain independence from the family environment, the adolescent still bows to parental authority during this phase. According to Piaget (1972), the adolescent who was previously a concrete thinker begins to develop formal operational thought. However, at this early stage of development, the adolescent has only a limited ability of foresight regarding the consequences of his or her actions. For the adolescent the locus of control appears to be external, to one's self, with other people in charge of one's destiny (Wong, 1999; Ladewig, et al, 2002).

With middle adolescence comes much parental frustration. In an attempt to increase one's independence from one's parents, the adolescent becomes more entrenched in his or her peer group. This is coupled with an increased period of introspection and

narcissism, and proves to be a challenge for even the most understanding parent. Frequent adolescent-parent conflict is likely to take place as the adolescent begins to test the limits of this relationship. Since formal operational thought is not completely developed, the adolescent is still unable to see the consequences of his or her actions and tends to see negative consequences as external to himself or herself, that is, 'it only happens to others'. Hence, this inability to reason effectively places adolescents in great danger during this phase of their lives. This lack of foresight is reflected by Dickson-Tetteh and Ladha (2000) who note that despite adolescents understanding of how the HIV infection was transmitted, condom use in sexually active adolescents was in fact low. Middle adolescence with its peer influence is also a time for experimentation with drugs, alcohol and with sex being the centre of every parent's nightmare (Ashwill& Droske, 1997; Wong, 1999; Ladewig et al, 2002). If adolescent pregnancy is to occur, this is the most likely stage. The lack of formal operational thinking and need to rebel makes caring for such maternity clients difficult, not to mention preparation for adolescent parenting.

In the late adolescent period group identity diminishes with the adolescent finding less of a need to conform to peer influences. The development of self identity contributes to the shift away from the peer group, as it causes an increase in the adolescent's self esteem, allowing the adolescent the courage to stand alone. Late adolescence sees the decrease in family friction. Formal operational thinking is developed and the adolescent demonstrates the ability to think abstractly and be able to verbalise his or her thoughts on different subjects. Adolescents are now, also, more able to see the consequences of their actions and are more careful with the decisions that they make and the behaviours that they display. However, they have a tendency towards

romanticized and idealistic thinking regarding issues, a breach in reality which may in fact put them at risk (Ashwill & Droske, 1997; Ladewig et al, 2003). The adolescent maternity client during this stage of development, while more mature than in early and middle adolescence, is still likely to encounter problems in that her perception of her preparedness for this event (childbirth and parenting) may not realistically reflect her ability to cope with the situation.

2.9 IDENTITY DEVELOPMENT AND ADOLESCENT PREGNANCY

"Some developmentalists have even referred to the pregnancy period as a time of crisis during which the woman undergoes not only psychological upheaval, but a revision of self and identity. While these changes are noteworthy for the adult woman confronting pregnancy, their effect is frequently magnified when the expectant mother is an adolescent" (Trad, 1999). Adolescence is a time of major growth both physically and psychologically. According to Rivera et al (2001) physical maturity appears to be taking place faster than in previous generations. Girls are reaching puberty and menarche a lot earlier. As a result, this puts them at risk for pregnancy much earlier. It is a very important period for identity development and a pregnancy at this time can have very negative outcomes for the adolescent in terms of her psychological development.

> "With the onset of pregnancy, the teenager can no longer continue the normative strivings for identity that characterize the behaviour of most of her peers. Instead, a kind of developmental arrest occurs and she is forced to focus on the pregnancy and its consequences. As a result, the pregnant teenager may engage in maladaptive behaviours and inappropriate emotions that affect not only her own development, but may influence her eventual relationship with the infant" (Trad, 1999, p.3).

From the statement above it is obvious that attention needs to be paid to identity development in the pregnant adolescent, for best outcome for herself and her infant.

Parents and significant others of the pregnant adolescent need to be made aware of such needs and taught how to assist the adolescent on the path of identity development. Strategies should be developed to help this category of adolescent to understand and deal with the emotional agitation that they may experience (Trad, 1999; Mngadi et al, 2002).

Adolescence is a time when the individual is trying to gain independence from one's parents (Akinbami et al, 2003). This may not be possible if pregnancy occurs. Since the adolescent will not be able to adequately sustain herself financially, she is dependent on her parents (Rivera et al, 2001). Pregnancy brings on a whole new set of material needs, such as doctors bills, maternity clothes, special foods and medications, and preparations also need to be made for the new arrival. All of these can prove to be very expensive and lead to the adolescent becoming even more dependent on her parents during and after her pregnancy. However, the opposite may also be true. For an adolescent from a troubled home, the pregnancy itself may be perceived as her way of getting independence from her parents (Trad, 1999). Where situations of sexual abuse may be taking place, the adolescent may attempt to get pregnant to escape such awful, unwanted attention (Kellogg, 1999).

2.10 ADOLESCENT PARENTING

Adolescents themselves are immature by virtue of being themselves (WHO, 1993 in Mngadi et al, 2002). Physical maturation at puberty and the ability to reproduce does not necessarily translate into the ability to parent effectively. Once pregnancy has occurred and the decision to keep the pregnancy and resultant baby is made, the adolescent needs to be prepared for the reality of her situation. Parenting for the

mature adult couple in a relationship is always a challenge despite their preparedness

for such a role. Adolescence is a time of great turmoil in that identity development is

at a crucial stage and the adolescent is working hard to discover herself or himself,

separate from the family and community within which they exist. A pregnancy at this

stage can have very negative consequences for the adolescents themselves and the

baby.

Adolescents themselves appear to be conscious of the negative consequences for

babies born to adolescent parents. One of the problems that they highlighted was

"poor growth and development due to parents' unpreparedness" (Kunene, 1995, p.51).

Studies have demonstrated that babies born to adolescent mothers are more likely to

have lower birth weights, which is an indication of maternal nutritional status during

pregnancy. This low birth weight also predisposes the baby to increased risk for

morbidity and mortality. After birth they are also more likely to have delayed growth,

both physiologically and pyscho-socially (Treffers et al, 2001).

Babies born to adolescent parents are more likely to be victims of abuse. As

mentioned earlier, child rearing can prove to be stressful and demanding. The parent

needs to be mature to handle the situation. Tantrums for the adult parent may prove to

be difficult and for the adolescent parent will be even more so (Hanna, 2001). Where

the adolescents themselves have been victims of some form of abuse, they are at risk

for adolescent pregnancy, either to escape the abuse or of acting out. In this situation,

a baby, born to an adolescent couple, has a stronger chance of ending up as another

casualty of abuse. A child born in such negativity has very little opportunity to escape

his or her environment and hence the cycle is perpetuated.

The adolescents in the Kunene (1995) study also had concerns about the long-term effects of the pregnancy on the baby that was born. For them the issue of illegitimacy could be a source of embarrassment for that child when it grew up. Feelings of anger, due to family rebuke, can have very negative consequences for the child as seen in the Makiwane (1998) study mentioned earlier. Adolescent parents may take their frustration out on their children. Newborn infants and children are a stressful factor in the life of any adult parent, and are even more so for developmentally immature parents. It makes sense then that health care professionals play a role in assisting adolescent parents to adjust and develop within their new and demanding roles, towards optimal outcome for both parents and children.

2.11 NEED FOR SPECIALIZED CARE

From the information presented earlier it is clear that adolescent health issues need to be addressed. There is a paucity of information on maternity services for adolescents in South Africa, indicating the possible lack of such services. Lack of maternity services for adolescent clients is not a concern in South Africa alone. A 1993 survey done by the Victorian Advocacy Network in Australia, reported pregnancy to be the second most important health issue for youth at a staggering 88%. This in turn brought about the need for the youth health care centre to aim at providing "continuity of care specifically antenatal and postnatal care" (McNair & Brown, 1996, p.348).

As documented earlier, where adolescents were expected to use the same services as the rest of the patient or client population, they chose not to seek health care (Akinbami et al, 2003). Taking into consideration the perspective by Dickson-Tetteh

et al (2001), making maternity services adolescent specific may not be financially viable for the South African Department of Health. A better solution would be to take the current services and make them adolescent-friendly (Dickson-Tetteh et al 2001), thereby providing "an approachable environment" for adolescent clients where they can receive support (Mngadi et al, 2002, p.41).

Whilst damage to the reputation of health care professionals may already have been done in earlier encounters, the situation is by no means irreversible. Williams, Gouws, Colvin, Sitas, Ramjee and Abdool Karim (2000) show an increase from 10% in 1995 to 16% in 1999 of adolescents between the ages of 15 – 19 attending antenatal clinics in South Africa. This is a considerable increase within a mere four years, indicating the importance of considering the specific needs of the adolescent client within the context of maternity health care provision. Once adolescents begin attending antenatal services, it is essential that the midwives who render care in these services make a concerted effort to be non-judgmental and supportive. They should strive to make the service adolescent-friendly (Dickson-Tetteh et al, 2001; Mngadi et al, 2002) and build partnerships with the adolescent that promote health and prevent disease (WHO, Annex I, 2001). The result should be a well-monitored pregnancy, optimal labour and delivery, appropriate and effective adjustments in the postnatal period and a healthy infant and adolescent mother.

Physical care afforded by midwives to adolescent clients is in effect no different from that given to their adult counterparts (Treffers et al, 2001). However, closer supervision may be necessary in light of the earlier statement by Ehlers et al (2000) regarding mortality and morbidity. Studies have shown increased incidence of pre-

eclampsia, anaemia, malnutrition, cephalo-pelvic disproportion and sexually transmitted infections in pregnant adolescents (Trad, 1999; Ehlers et al, 2000; Rivera et al, 2001; Treffers et al, 2001; Mngadi et al, 2002). Closer supervision will also provide opportunity for adequate health education to ensure good health promotion and possible disease prevention.

The postnatal period is also crucial. Literature review has shown that adolescents are pre-disposed to many problems during this period. As mentioned earlier, they still face problem with conditions such as anaemia and pre-eclampsia during the postpartum period. They require close monitoring to detect problems early so that intervention is possible. To prevent future pregnancies or another pregnancy too close to the present delivery, health care providers need to ensure that the adolescent has a good knowledge and understanding of the need to delay future pregnancy and the methods that can be employed to do this. Regular postnatal follow-up will ensure supervision and monitoring of child spacing. Poverty has also been linked to the likelihood of adolescent pregnancy and implies that resources are scarce. Hence, it is important to have some system to encourage breastfeeding among adolescent mothers, to prevent babies receiving inadequate nutrition (Treffers et al, 2001). These issues make the need for closer follow-up care of the adolescent mother all the more essential.

The area where more emphasis and specialized care needs to be given has been identified to be that of social support. Tanga and Uys (1996) found social support to pregnant adolescents by health care professionals to be lacking. As mentioned previously, pregnant adolescents face many negative consequences. Their families are

usually upset and angry with them for becoming pregnant (Makiwane, 1998). They have had to leave school or may still have to 'cross that bridge'. Hence, they may face rebuke from teachers and peers (Elhers et al, 2000). Female adolescents may have had to deal with boyfriends denying paternity, and the feelings of betrayal that go with this declaration (Makiwane, 1998; Kaufman et al, 2001). Hence, rebuke from the boyfriend's family may also be forthcoming. Suffice to say that by this stage the last thing that the adolescent needs is a health care professional who adds more rebuke and feelings of guilt and shame to an already psychologically painful situation. The job of the midwife here would be to give support and try to aid the adolescent, her partner, both the families involved and the resultant infant towards a positive outcome for all concerned.

The first year of the newborn's life is one of great dependence. For the adult mother this means sacrifice and having to put her baby before herself. A certain level of maturity is expected in order to parent and make the necessary adjustments to this demanding role. For the immature adolescent female, this may prove to be very stressful (Trad, 1999). It makes sense then that supportive care from significant others and health care professionals is vital during this first year post-delivery (Tanga and Uys, 1996). Psycho-social support should begin when the adolescent commences attendance at the antenatal clinic and should be formalized into supportive follow-up care for at least one year post-delivery. The aim of this care is preparation for childbirth and subsequent motherhood, with the idea that adequate preparation of the adolescent for situations that may arise, will result in being better able to cope and overcome problems (Arnold, 2000). The adolescent mother should find in health care professionals a supportive network of people who help her understand what she is

facing and find appropriate strategies for coping and dealing with problems. This would ensure that her life does not become irrevocably derailed by the pregnancy and birth of her baby. If the adolescent learns to cope, she will be more likely to resume her education and be less likely to continue having more children while her situation does not permit (Makiwane, 1998; Coard, 2002; Kaufman et al, 2001).

2.12 CONCLUSION

The literature review that has been presented, attempts to provide the reader with insight into the problem of adolescent pregnancy. It allows for the reader to understand the extent to which adolescent pregnancies are occurring and the possible problems that these adolescents may face. It highlights the need for health care services to cater for this vulnerable population group within the present maternity services in the public sector and suggests possible areas that may need to be improved toward delivery of optimal care for these clients.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

In this research endeavour, the phenomenon under study was adolescent maternity care. A qualitative approach to the study was the preferred choice. According to Polit and Hungler (1999, p.239), some of the characteristics of qualitative research are as follows:

> "1. Qualitative design is flexible and elastic, capable of adjusting to what is being learned during the course of data collection.
> 2. Qualitative design typically involves a merging together of various methodologies.
> 3. Qualitative design tends to be holistic, striving for an understanding of the whole.
> 4. Qualitative design is focused on understanding a phenomenon or social setting, not necessarily on making predictions about the setting or phenomenon."

According to de Jonge (2001) and Hanna (2001), qualitative approaches prove useful when examining an area that affects a population that may not ordinarily be given a voice in society, such as pregnant and parenting adolescents. Hence, this approach was meant to allow this vulnerable population an opportunity to make themselves heard.

3.2 DESIGN

This research was a qualitative, non-experimental study using a grounded theory approach, as the study attempted to explore the phenomenon of adolescent-friendly maternity care from the points of view of the various stakeholders in adolescent maternity health services, so as to provide constructs of an adolescent-friendly

maternity service for the KwaZulu-Natal province, towards a model of action. Polit and Hungler (1999, p.24) describe a construct as "an abstraction or mental representation inferred from situations, events, or behaviours". A grounded theory approach was adopted, Glaser (1998) suggests grounded theory as a way to best research substantive areas that relate to life cycle problems. The aim of collecting this information was towards making the existing maternity services adolescent-friendly, as opposed to creating a separate and new service. Bearing this aim in mind, the study adopted a grounded theory methodology, as it allowed for the researcher to use observations and data collected in order to extract constructs towards developing a model of action (Grbich, 1999).

A grounded theory is inductively achieved from the phenomenon under study. The grounded theory researcher does not have a preconceived theory in mind when setting out with the research. Instead, he or she starts with an area of study and proceeds, allowing all relevant information and ideas to emerge (Babbie, Mouton, Vorster & Prozesky, 2001). Often grounded theory is used to research areas where there is a dearth of knowledge (Grbich, 1999). As the literature review has shown, there is little information on how adolescent maternity clients experience maternity services and on whether these services cater for their specific needs. Even though a grounded theory methodology was used, the intent of this study was not to develop a theory. Burns and Grove (2001, p. 141) define a theory as consisting "of an integrated set of defined concepts, existence statements, and relational statements that present a view of a phenomenon and can be used to describe, explain, predict, or control that phenomenon". They further qualify a theory as being "directly testable" (Burns & Grove, 2001, p.141). Since there have been no studies within KwaZulu Natal

examining what would constitute an adolescent-friendly maternity service, grounded theory was used to extract constructs for a model of action, which could in later studies be tested toward a theory of adolescent-friendly maternity services.

For the purposes of this study, the researcher followed the Glaser (1992) approach to grounded theory. It was necessary to identify the school of grounded theory that this research followed, because, according to Babchuk (1997), this differentiation is essential to one's understanding of grounded theory itself. The school of thought influences how researchers view and use a grounded theory method in research. Glaser's approach to grounded theory was more in keeping with qualitative research approaches, as opposed to Strauss whose focus on grounded theory retaining aspects of replicability, generalisability, and verification, lend more towards quantitative approaches to research. Glaser on the other hand "seems to view grounded theory as a more inherently flexible type of an operation which is guided primarily by informants and their socially constructed realities. To him, the informant's world should emerge naturally from the analysis with little effort or detailed attention to process on the part of the researcher" (Babchuk, 1997). According to Stern (1994), Strauss brings every piece of information, whether in the data or not, into consideration when developing a theory of the phenomenon under study. However, Glaser pays attention only to the data that is obtained and uses the data to develop the emerging theory. Glaser also views the research problem as emergent and ill defined at the beginning of the study (Babchuk, 1997). In his school of thought, the research problem will become obvious as theoretical sampling proceeds, data is collected, coded and constantly compared. As in the case of adolescent maternity care in KwaZulu-Natal, little was known and hence it was difficult to clearly define the research problem. It was hoped, as with this

methodology, that as the study proceeded, the research problem or problems would become more clear and would lead to further questions and information.

A cross-sectional approach was used to collect data at one point in time from participants. According to Polit and Hungler (1999, p.162), "cross-sectional studies are especially appropriate for describing the status of phenomena or for describing relationships among phenomena at a fixed point in time". For this reason, a cross-sectional approach allowed the researcher to explore the phenomenon of adolescent maternity care across the different stakeholder groups with which this study was concerned. For further in depth data collection, a cohort comparison design was used, which entailed each stakeholder group comprising of different cohorts as follows:

- Adolescent maternity clients comprising two cohorts, namely antenatal clients, as well as postnatal clients.

- Health care providers comprising three cohorts, namely midwives, doctors and doulas, working in antenatal, labour and delivery and postnatal areas within the maternity services.

- Health care planners comprising three cohorts, hospital/clinic based nursing service managers, doctors in charge of obstetric and gynaecology hospital departments and regional health care planners working for the department of health.

During data collection, constant comparison was "used to develop and refine theoretically relevant categories" (Polit and Hungler, 1999, p. 248), that emerged from the data provided by the different stakeholder groups.

3.3 POPULATION

The initial target population for this study comprised three categories of participants who were intimately connected with adolescent maternity services, namely:

- Adolescent maternity clients who were attending maternity services at public hospitals (Adolescent Maternity Clients –AMC)

- The midwives and doctors who attended to these clients (Health Care Providers – HCp)

- Nursing service managers overseeing maternity care in public hospitals, doctors overseeing obstetric and gynaecology services in public hospitals, together with those individuals responsible for planning maternity services on a regional level (Health Care Planners – HCP)

Beyond these three stakeholder categories, the researcher attempted to follow the data, in keeping with theoretical sampling. The result was that the following individuals were added as participants:

- Doulas working with midwives in private practice, rendering support during pregnancy, labour and delivery and the postnatal period.

- A midwife working in private practice who worked closely with doulas, who assisted her in rendering support to pregnant, labouring and postnatal women.

- Significant others of adolescent maternity clients who were with these clients at the time of data collection.

- HCps working in the clinical teaching department at the data collection site who were responsible for overseeing the clinical teaching and learning of nursing students doing the four year comprehensive nursing diploma.

3.3.1 Adolescent Maternity Clients (AMC)

As indicated by a review of the literature (National Youth Commission, 1997),

adolescent pregnancy was a problem that was not race or class specific and appeared

to affect both developed and developing countries alike. The 1997 National Youth

Policy divided youth into their racial groups and the results were as follows: 77% of

the total youth population were African, followed by 11% which were White, next

came Coloureds making up a total of 10%, and lastly Indians comprising 3%

(National Youth Commission, 1997). In order that all racial and ethnic groups were

included in the study, it was important to draw respondents from areas that contained

the different concentrations of the identified racial groups. Therefore, adolescent

participants were selected from hospitals serving the eThekwini Metropolitan area, as

this area was more cosmopolitan in nature.

Another reason for data collection being done in this region of the province was that

according to statistics provided by the Informatics department of the KwaZulu-Natal

Department of Health the eThekwini Metropolitan area had the largest number of

births by women under the age of 18 years as compared with the remaining 10 regions

from which they draw their figures. In total, for primary health care facilities and

hospitals combined, the eThekwini Metropolitan area accounted for 27.9% of births to

women under 18 years old (see appendix 1).

A provincial hospital was selected on the basis that it was a public health care facility.

As such, it was subsidised by the government and provided care to masses of South

Africans. Adolescents attending maternity services at private health care facilities

were not included in the study. The researcher felt that private facilities are able to render more individualised care due to the large economic, human and material resources available to them. Pregnant adolescents attending such facilities were in the care of an obstetrician / gynaecologist and were seen on a one to one basis. The public health care facilities however, faced larger patient numbers and were under strain in terms of staffing and resources, and were more likely to render group or standard care.

3.3.2 Health Care Providers (HCp)

To be able to reach a consensus between client expectations and health care services, it was imperative to draw both client participants and health care provider participants from the same pool. Hence, health care providers working in the maternity units where adolescent maternity clients were drawn from, formed the second target population under study. All health care providers were registered with the South African Nursing Council or the South African Medical and Dental Association, as midwives or doctors, respectively. They were also working in one of the following units within the maternity department:

- antenatal clinic

- labour and delivery ward

- antenatal ward

- postnatal ward

In this way, all health care providers who were likely to come into contact with adolescent maternity clients might be included in the study sample.

3.3.3 Health Care Planners (HCP)

The third target population group that this study obtained information from were the people responsible for the planning of maternity health care. As such, the nursing service managers and doctors in charge of obstetric and gynaecology services in the same institutions from which the adolescent participant population were drawn, were approached to participate in this study. They were joined by individuals responsible for the planning of maternal, child and women's health services for the Durban functional region. This category was included, since, without the input of health care planners, any model of action for adolescent-friendly maternity care that was obtained, might prove to be unrealistic and not feasible within the present health care system.

3.4 SAMPLE AND SAMPLING PROCEDURE

According to Polit and Hungler (1999) there are no set rules with regards to sample size in qualitative research approaches. Where populations are homogenous a sample of less than ten may be adequate. With phenomenological studies a sample size of 10 or less has been considered sufficient (Polit and Hungler, 1999). Grounded theory focuses on sampling for saturation and theoretical completeness, rather than for a specific sample size (Glaser, 1998). In keeping with the methodology of grounded theory, theory driven sampling was used. The total number of participants for this study was therefore determined by data saturation, as analysed in the succeeding chapter. Final participant numbers can be found in Chapter Four, accompanying the relevant findings.

For Glaser (1998), theoretical sampling is a means of data collection, which allows for codes to emerge from the raw data collected. As codes emerge, they are used to direct the researcher in further data collection. Questions constantly change, guided by the emerging theory, in the pursuit of theoretical fullness. This in turn leads to saturation and integration of codes into an emerging theory (Gbrich, 1999). Hence, as data was collected at the first research site, the researcher simultaneously analysed the data to detect emerging codes and by delimitation used these codes to determine where next to collect data and from whom. Gaps in information were used to alert the researcher to new informants that had to be approached for further data collection and clarification of emerging codes and concepts. The idea behind theoretical sampling is not necessarily to increase the sample size, but instead to use sampling as a tool to refine ideas for the sake of clarity and an emerging theory (de Vos, Strydom, Fouché & Delport, 2002). Theoretical sampling continued until the researcher was satisfied that no new categories of data were emerging and theoretical saturation had been achieved.

A further snowballing sampling approach was instituted to recruit adolescent participants, with participants being asked to inform people who had had similar experiences of adolescent pregnancy or parenting, of the proposed study. The thinking was that adolescent clients are likely to know other adolescents who were or had been in a similar predicament to themselves. These individuals were then contacted and invited to participate.

As mentioned, sampling commenced at a provincial hospital in the eThekwini Metropolitan area, and data was collected from maternity health care planners

(nursing and medical), maternity health care providers (nursing and medical), and adolescent maternity clients (antenatal and postnatal). Data analysis and coding, lead the researcher to the Department of Health, where data was collected from health care planners (nursing) responsible for maternity care in the Durban functional region. Data collection from the provincial hospital also led the researcher to collect data from individuals working in private maternity services, namely doulas and a midwife in private practice. Analysis from data collected at the Provincial Hospital also revealed the need for further data collection from doctors responsible for community maternity services. Contact was made with the individuals concerned via the necessary authorities and their participation was requested. However, none of the individuals contacted chose to respond to the communication. This added a further limitation to the results of this study.

Data collection at the Department of Health indicated the need for views from outlying maternity services to be included in the study. So data collection then proceeded at a polyclinic's maternity department, where data was collected from health care planners (nursing), health care providers (nursing) and adolescent maternity clients (antenatal). This clinic fell under the jurisdiction of the Department of Health. Another polyclinic was included as a site on the recommendation from the Department of Health. Data was collected here from adolescent maternity clients (antenatal). This clinic was under the jurisdiction of City Health, eThekwini Metropolitan area. Data collection ended here as analysis revealed that data saturation had been achieved.

Data was taken to be saturated when interviews with respondents were found to be

revealing no new information, and a consensus appeared to have been reached from

the content of the data supplied by the participants. Saturation was achieved for the

three stakeholder groups independently, as their views of the phenomenon under

study were from different angles. Each stakeholder group's input was based on a

different experience of the concept of adolescent-friendly maternity services, namely,

that of client, provider and planner. An example of data saturation amongst

adolescent client, can be seen in the statements below:

"They shout when you have got something wrong."

(Antenatal Polyclinic 1 AMC)

"In front of everybody they will shout at us, like you crazy like."

(Antenatal Polyclinic 2 AMC)

"And they scream and they scream and they talk and you know, rude."

(Postnatal Hospital AMC)

*"If you there alone, they are going to run you down, make you look like a fool
because of your age."*

(Antenatal Hospital AMC

As can be seen by the above statements, AMC respondents from all three sites where

data was collected, provided and corroborated information on what they perceived to

be an unfriendly manner in which HCps addressed them. This is an example of how

the researcher made decisions regarding when aspects of the data was found to be

saturated.

3.5 DATA COLLECTION

3.5.1 Data Collection Instruments

A concern in keeping with information provided by earlier literature review was that

the lack of privacy when dealing with adolescent clients might be a deterrent to

participation (Abdool Karim et al, 1992; Akinbami et al, 2003). This might have also

proven to be a problem with data collection using focus group interviews. Individual interviews might have been better as they allow the researcher to obtain deeper information on the subject in question. However, one on one contact with the researcher might have also been construed as threatening, as there appeared to be a balance of power that exists between interviewer and interviewee, which can provide negative results in the data collection process (Burns and Grove, 2001). To achieve a balance, data was collected using both focus group interviews and semi-structured interviews. The number of participants that presented at each data collection time was used as the deciding factor in whether data was to be collect by either focus group interviews or semi-structured interviews.

Focus Group Interview (FGI)

Depending on the number of respondents that presented at each data collection session, focus group interview (FGI) was one of the methods used. According to Burns and Grove (2001), this strategy has been used very effectively in previous nursing research studies for evaluating client's satisfaction and quality of care as well as exploring the value of programmes directed at health care needs. As per the research objectives laid out for this study, all these aspects appeared to be in line with this study. This method of data collection also allowed the researcher the opportunity to collect information on a subject from people within a limited time frame (Polit and Hungler, 1999). Calder (1977 in McLafferty, 2004) asserts that being exploratory in nature, focus group interviews can be pre-scientific in that they can be used to identify constructs that are then further tested using quantitative approaches. This added further argument for the use of focus group interviews as a data collection instrument in this study.

The focus group interviews also appeared to be the choice that might have elicited more information than individual interview with adolescent participants. From previous work with adolescents (Chetty, 2000), the researcher had noticed that adolescents were more inclined to talk in environments where they felt supported and free of judgement (Burns and Grove, 1999). Within any focus group there were always some members who talked more than others initially, depending on their level of comfort. However, as the group session proceeded, one found that the quieter ones became more relaxed within the group and gained the courage to share their experiences. Another possible benefit of using focus groups was that they could help to bring adolescents experiencing the same problem together and form a type of ad hoc support group.

Semi-structured Interviews

Semi-structured interviews were also used as a method of data collection, depending on the number of respondents presenting at each data collection time within stakeholder groups. This method of data collection was selected as it posed fewer logistical problems and allowed the exploration of "greater depth of meaning than can be obtained with other techniques" (Burns and Grove, 2001, p. 422). Response rates with interviews are higher, ensuring that the information gleaned is more representative of the target population and also allows the researcher the opportunity to determine the accuracy of information given by respondents, by a process of feedback for the purpose of verification. Gillham (2000) also advocates the use of interviews by explaining that the research interview allows the researcher to see and comprehend information that may be presented in a more abstract form in other data

sources. Gillman (2000, p.11) further makes a case for the use of semi-structured interviews in this study, by saying that interviews are suitable when the "research aims mainly require insight and understanding", as was the case with this study.

3.5.2 Data Collection Procedure

The process of data collection took place over a period of one year, from August 2003 to August 2004. This included obtaining permissions to conduct the study as well as for entry into data collection sites. Data collection was staggered and done in two rounds. This was necessary due to the availability of the researcher to collect data in person, as well as due to the availability of respondents. It was not possible to predict when adolescent clients would be using maternity services and this meant that the researcher had to spend time at sites waiting for adolescent clients to present themselves. Work schedules for HCPs and HCps also meant that the researcher had to be flexible and make frequent visits to sites before data could be collected. Collecting data in two rounds also allowed the researcher time to analyse data so that it could direct further data collection.

Prospective participants for all stakeholder groups were informed of the study that was to be undertaken and were then requested to volunteer their participation. It was felt that this approach would yield participants who had an interest in the subject under study, therefore, providing richer data. To promote feelings of comfort and freedom from perceptions of prejudice, and to diminish the aspect of fear of reprisal, all categories of participants provided information separately, thereby ensuring homogeneous groups.

Adolescent Maternity Clients (AMC)

After permission to proceed with the study had been granted from the relevant

authorities, the institution was approached for permission to enter the site to collect

data. HCps working in the maternity department were approached to assist with AMC

recruitment. They then identified the AMCs who were using the services on the days

of data collection to the researcher, who then approached the AMCs and briefed them

on the study and requested their participation. The briefing session also allowed

prospective participants the chance to get any questions they might have had,

answered by the researcher.

This method of recruitment and collecting data at the same meeting was used, as

based on the literature review, made the researcher come to the realization that

adolescent maternity clients often commence maternity very late, or not at all, or

default on care. Hence, it was felt that trying to arrange another day for data collection

may result in decreasing AMC participant numbers. To ensure that adequate

information regarding perceptions of maternity care was collected, all adolescents

who showed interest in participating were included and no randomisation was done.

Problems that this might yield are discussed under the limitations of the study.

Health Care Providers (HCp)

The health care providers working in the maternity departments of the designated

hospital and further data collection sites were informed of the proposed study via the

nursing service managers at the sites. All those who showed interest in participating

were selected, as the researcher felt that due to duty scheduling and the participants

having other responsibilities, it might not have been possible to randomly select

participants. Due to staffing constraints, it was not possible to use focus group interviews at some sites, as health care providers could not be freed en mass to attend the focus group interview. Data was also collected from health care providers by means of semi-structured interviews, as permitted by the work allocation and availability of health care providers.

Health Care Planners (HCP)

The nursing service managers involved in maternity care at the research sites were briefed individually on the study and their participation was requested. The same was done for doctors in charge of obstetric and gynaecology services (where applicable at research sites), as well as for individuals from the Department of Health who were responsible for the planning of maternity health care facilities in the Durban functional region. Those who expressed a willingness to participate were included in the study. Semi-structured interviews were conducted at the convenience of each of the health care planner respondents in this study.

Focus Group Interviews

Focus groups were homogenous, allowing for more freedom of expression and increased validity of data provided (Burns and Grove, 2001). Prior to the focus group, members were given an idea of the topics on which the session will focus. This was done during the study briefing when participants were being recruited (Appendix 2.1, Appendix 2.2, Appendix 2.3), to ensure that they were given time to think about what they would like to say in the focus group session. This allowed for more detailed and well thought out information being provided (Burns and Grove, 2001). However,

topic guides were used merely to help the researcher get the discussion started during focus group interviews, at which point the researcher allowed the discussion to guide itself as data was provided and delimited. During the focus group interviews, information was constantly fed back to participants by the researcher to verify that it had been correctly understood and interpreted. As codes emerged, these were also fed back to respondents for their confirmation.

A quiet room was provided at each research site to ensure privacy during the focus group interview. Focus group interviews conducted lasted between one and one and a half hours to ensure adequate and useful data capture. All sessions were tape recorded with the permission of participants. This was done to assist the researcher in making notes and memos and to ensure that no data was lost during the session. Tape recording was done with the permission of group members and was later transcribed into text by the researcher for the purposes of data analysis.

Semi-structured Interviews

Semi-structured interviews were conducted in a quiet room provided by the health care facility where data collection took place. A topic guide (Appendix 2.1, Appendix 2.2, Appendix 2.3) was used to assist the researcher in guiding the discussion during the interviews; however, the researcher was conscious at all times of not over controlling the process and allowed the interview to follow the direction that the discussion took (Burns and Grove, 2001) towards emergence of the constructs. To aid the discussion, where possible, respondents were informed of the topics for discussion prior to the interview. This was done to ensure that the respondents had time to think over the information they wished to share during the interview. All respondents were

briefed on the study and given an opportunity to have their questions regarding the study answered.

During the semi-structured interviews, information was constantly fed back to participants by the researcher to verify that it had been correctly understood and interpreted. As codes emerged, these were also fed back to respondents for their confirmation. Interviews lasted between one and one and a half hours. All interviews were tape recorded with the permission of the interviewees. This was done to aid the researcher in delimiting the data towards the desired emergence of constructs and to prevent any data from being lost. The recording was then transcribed verbatim into text for analysis.

General Data Collection Procedure

According to Polit and Hungler (1999, p. 247) "the primary purpose of the grounded theory approach is to generate comprehensive explanations of phenomena that are ground in reality". Grounded theory shares many commonalities with phenomenology. It allows the researcher to move from merely describing a phenomenon to actually attempting to understand the processes that underpin the phenomenon being studied (Burns and Grove, 2001). In keeping with this approach the emerging concepts were fed back to the participants during focus group interviews and semi-structured interviews so that a discussion of concepts took place, allowing for confirmation of the emerging constructs. With the grounded theory approach, data collection and data analysis go hand in hand. As data was being collected it was simultaneously analysed by the researcher and used to direct questioning towards the honing of emerging constructs.

The principle of data saturation was used for all three stakeholder groups, with regards to conducting semi-structured interviews and focus group interviews. This is "when themes and categories in the data become repetitive and redundant, such that no new information can be gleaned by further data collection" (Polit and Hungler, 1999, p.43). Hence data collection ceased for each stakeholder group when the research determined that no new core categories, sub-categories and properties were emerging (Glaser, 1998).

3.5.2 Data Collection Settings

Data collection took place in as naturalistic a setting as possible. Adolescent clients provided data at research sites, with one antenatal participant opting to be interviewed at her home. Permission was sought from the research sites to use facilities on the premises for data collection. The idea was that adolescents who had attended maternity services at these institutions were already comfortable in the hospital settings. Hence, collecting data from them in a private room on the day that they accessed the services was not thought to be problematic. For antenatal clients, data was collected in the antenatal clinics in a private room provided by the research site. Data was collected from postnatal clients in the postnatal ward, at their bedsides, with permission from both the ward staff and the participants. This variation was also done, so as not to inconvenience respondents, especially those who had recently delivered and were experiencing postpartum pain and who were nursing their infants, and therefore not readily mobile.

For the health care providers, their work environment was considered a natural setting in their day to day lives, as it was a place at which they spent a substantial amount of time. As such, it was assumed that they would feel comfortable within this setting. Hence, data was collected on site in health care facilities from health care providers. Once again, with permission from the site authorities, a private room was allocated for the collection of data amongst health care providers. For health care providers working outside the health care facilities, data was collected at either their place of business or their homes, according to their requests.

Nursing service managers, doctors and health care planners were interviewed in their offices, so that they felt comfortable and were able to readily participate since they were not kept away from their work for a very long period of time.

3.6 ETHICAL CONSIDERATIONS

The study first gained permission (Appendix 4) from the research ethics committee of the Faculty of Community and Development Disciplines at the University of Natal (now University of KwaZulu-Natal), Durban. Once this permission had been granted, further permission to conduct the study was sought from the KwaZulu-Natal Department of Health (Appendix 5) and from the administration of the designated research sites.

Adolescent Maternity Clients

Nursing staff in the various maternity departments provided assistance in identifying the adolescent clients who fitted the profile for this study. These clients were then approached by the researcher, who, after introducing herself to the prospective participants, briefed them on the study, either individually or in a group. Once they

agreed to participate, a written informed consent form (Appendix 3.1) was filled, indicating their understanding of the study taking place and the role they would be expected to play, as well as their willingness to participate. Though no expectations of monetary reward was given at the beginning of the interview, the adolescent participants were thanked and given a sum of twenty-rands (R 20.00) each for refreshments and transportation costs back home from the health care facility. This also served as compensation for their time.

Health Care Providers and Health Care Planners

These categories of participants were first informed of the study by the management at the health care facility. Prospective participants then met with the researcher who verbally informed them of the proposed study and the roles they would be expected to play. They were allowed the opportunity to have any questions they might have regarding the study, answered. Once they gave verbal agreement to participate, they signed an appropriate written informed consent form depending on whether they were health care providers (Appendix 3.2) or health care planners (Appendix 3.3), indicating their understanding of the study taking place, their role in the study and their willingness to participate.

General ethical considerations

All participants were informed, prior to their participation, about the nature of the study and the roles that they were expected to play. They were notified that participation was completely voluntary and would in no way compromise them as individuals. Participants were free to withdraw their participation at any given stage of the research, without having to justify this course of action and without fear of

reprisal. An informed written consent was taken from all participants and they were also provided with written information regarding the details of the research as well as with contact details should they wish to contact the researcher at a later date with questions or queries regarding their participation and the research results. Confidentiality was maintained at all times, and, within the focus groups, participants were free to use an alias if so desired. No original names were attached to the data in the written report nor will any names appear in any related publications that may arise from the study. The focus group interviews and semi-structured interviews were tape recorded so that no data was lost during the sessions. These recordings were only heard by the researcher and transcribed into text for analysis. The information that they provided was used for the sole purpose of the research and once the study was completed and the report was written, the original data was destroyed by the researcher.

3.7 DATA ANALYSIS

The study attempted to use the 'editing analysis style' proposed by Crabtree and Miller (1992) during data collection. According to Polit and Hungler (1999, p.574) the following is true of this approach to data analysis:

> "The researcher using the editing style acts as an interpreter who reads through the data in search of meaningful segments and units. Once these segments are identified and reviewed, the interpreter develops a categorization scheme and corresponding codes that can be used to sort and organize the data. The researcher then searches for patterns and structure that connect the thematic categories".

Given the nature of the study and the proposed methodology, it appeared to be the appropriate choice as it fitted snugly within the areas of phenomenology and grounded theory (Polit and Hungler, 1999). This style of data analysis allowed the

researcher to feedback to participants during focus group interviews and semi-structured interviews, thereby ensuring verification of the information provided and the way in which it was interpreted. Examples of this can be seen in the excerpts below of data from an interview with an antenatal AMC:

Example 1:

Respondent: *"Ya, they hurt you and when you say you know, 'it's sore'. 'Oh, relax, relax, relax'. And most of the time they tell the patient, like anybody, 'oh when you were having sex it was nice, now you are complaining'."*

Interviewer: *"So when you complain about something that is done to you, then the response is, 'you didn't complain when you were having sex'?"*

Respondent: *"Yes, yes."*

(Antenatal AMC)

Example 2:

Respondent: *"The first time I came there to make an appointment to come to the antenatal clinic and thingy, they were like.....that nurse I spoke to, she was like, 'oh, you so young and blah, blah, blah, and you coming so late for clinicing and everything'."*

Interviewer: *"You sound like they made you feel uncomfortable?"*

Respondent: *"Ya."*

(Postnatal AMC)

The approach to data collection also allowed for the researcher to constantly compare information obtained, and delimit data in a bid to enhance the emerging of concepts towards the final constructs. It also helped the researcher in theoretical sampling, by giving more direction in what to ask next and of whom to ask.

The following schematic representation explains the 'editing analysis style':

Figure 1: Editing Analysis Style

Interpreter
(Editor)

Report ◄——— TEXT ◄———

Identify units

Develop categories

Interpretively
Determine Connections

Verify
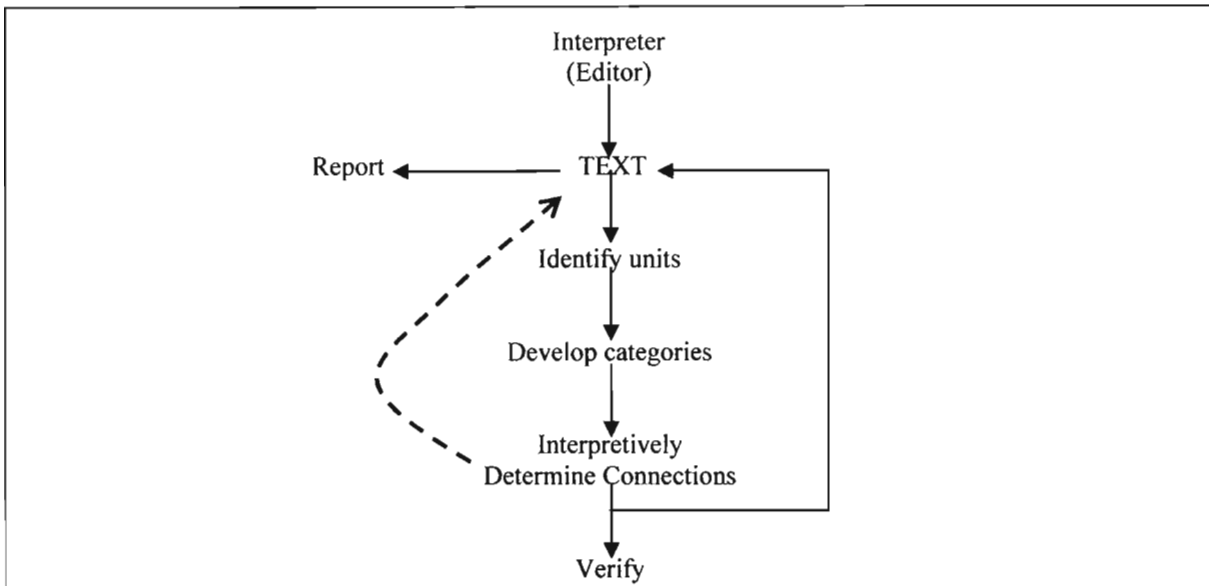
(Crabtree and Miller,1992, p18)

In terms of this study the schematic representation was as follows:

Figure 2: Adapted Editing Analysis Style

Researcher

Report ◄——— Participants (AMC, HCp & HCP) ◄———

Identify units related to perceptions / improvements of care, ie. whole statement

Emergence of categories and themes

Feedback to participants
to verify

Determine relationships that exist between categories / themes

Done by feedback to
participants

Verify relationships observed
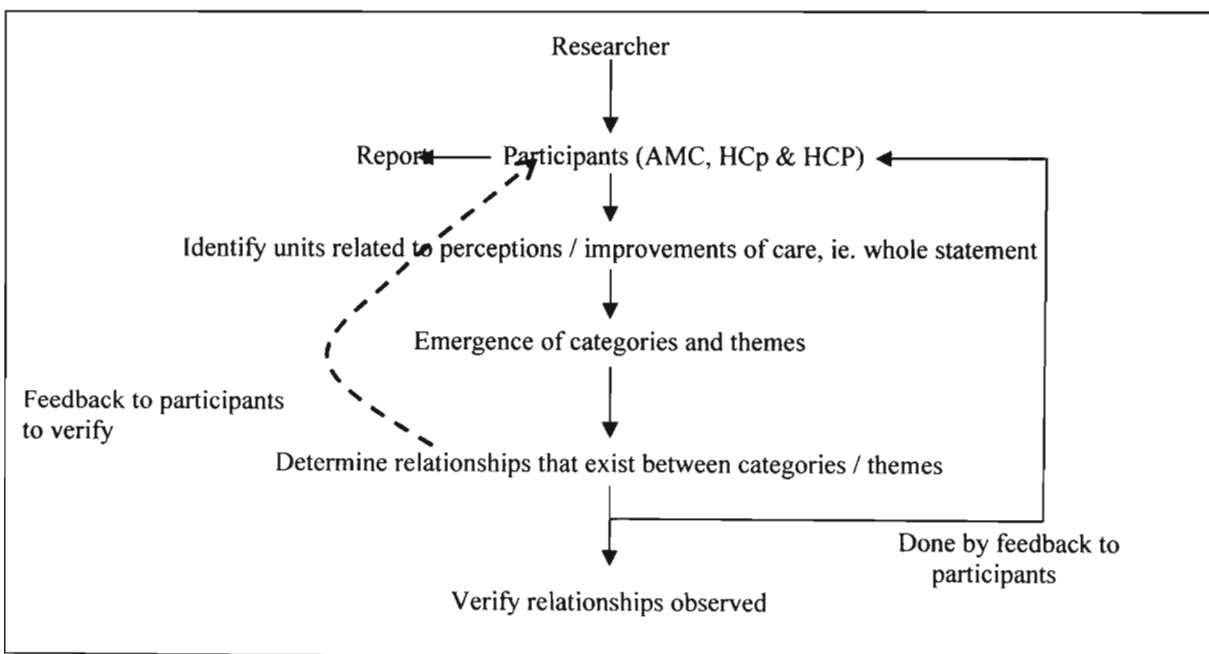
(Adapted from Chetty, 2000, p.54)

As can be seen from the above diagrammatic representation, during data collection

from participants, the researcher began simultaneous analysis, by carrying out a

process of data reduction, attempting to attach "meaning to elements" in the data that was being collected (Burns and Grove, 2001, p. 596). Units of information relating to perceptions of adolescent maternity care as it stands, and what the care should ideally be, were identified by the researcher in an attempt to bring to the fore emerging categories and their properties. Once this was done, the researcher focused attention on trying to determine relationships that may exist between the core categories and sub-categories. To ensure that the researcher was clear about the information that participants were providing, this information was fed back to participants during the focus group interviews and semi-structured interviews to verify correctness and allow for constant comparison. An example of this is found in the following excerpts from the data. In the first statement an AMC respondent alluded to the age of the HCp invoking a different response from her.

" No some of them that's old I just ignore them. The young ones make me cross because they know what they do. "

(Antenatal AMC)

The researcher then followed this trend in thought to ascertain how other members of this focus group interview felt about the age of the HCp. The researcher then decided to see if other stakeholder groups verified this information.

Interviewer: *"Is there a specific age category you think the person should be? "*

Respondent 3: *"It would help, but if you are knowledgeable you shouldn't have a problem being 20 or 30. "*

Respondent 2: *"But I suppose it would be easier for them to talk to a person who is more or less their age, if possible. "*

(Postnatal HCp)

Areas of consensus amongst stakeholder data were used to construct the requirements and components of adolescent-friendly maternity services.

In keeping with the directions from Glaser (1998), data analysis was done manually, allowing the researcher to immerse herself in the data by way of memoing and developing categories with its related properties, and drawing thematic connections between categories. Once interviews were transcribed into text, the researcher began the process of reading through the data, coding (substantive and theoretical), analyzing, making memos, and arriving at categories. With further surveillance and constant comparison, categories which appeared to be linked to more than one category became visible. Hence, core categories were arrived at, linked to sub-categories and their properties.

A category is used to succinctly catch fundamental patterns that appear in the data and is at a higher level than a property. Since a property is defined as "a concept about a category", every category will have related properties (Glaser, 1998, p. 135). Categories can also be used as properties of other categories. Within Glaser's grounded theory, categories are arranged according to their conceptual levels. Core categories are the highest level, followed by sub-core and categories towards theoretical comprehensiveness. "The core category relates to most other categories and their properties, since through these relations the core category accounts for most of the ongoing behaviour in the substantive area being researched" (Glaser, 1998, p. 135). For the purpose of this study, a slight deviation from what Glaser purports was used, with the findings being arranged into core categories, sub-categories and properties.

Thus emerged the latent structure of the model for action (Glaser, 1998), which by constant comparison of data, was grounded into a modifiable model for action. This

process took place using a four level conceptual perspective analysis. Firstly, the data was scrutinized and coded. Secondly, the data was conceptualized into categories and their related properties, which is presented in Chapter Four. At the third level of this process, the categories were arranged into constructs based on their thematic patterns and links, as demonstrated in Chapter Five. Finally, these constructs were formalized into a model for action by the use of literature from the substantive area under study and presented as a discussion in Chapter Five (Glaser, 1998).

3.8 PROOF OF PRODUCT

According to Glaser (1998), grounded theory is concerned with product proof, rather than the usual credibility, confirmability, transferability and dependability of other qualitative approaches. Glaser defines this proof as located in the outcome of a study, namely:

> "Does the theory work to explain relevant behaviour in the substantive area of the research? Does it have relevance to the people in the substantive field? Does the theory fit the substantive area? Is it readily modifiable as new data emerge?" (Glaser, 1998, p. 17).

If the produced theory meets these requirements, then it can be legitimized. Grounded theory uses four criteria by which to evaluate results and the presented theory, these are fit, workability, relevance and modifiability.

Fit is a synonym for validity within the grounded theory methodology. It begs the question, "does the concept adequately express the pattern in the data which it purports to conceptualize?"(Glaser, 1998, p.18). The act of constant comparison results in the honing of fit. Within this fit, constant comparison was actively done during semi-structured interviews and focus group interviews as a means of verifying

information from participants, individually, within and between stakeholder groups. This allowed for confirmation of the data as initially analysed and reduced by the researcher during these data collections sessions, as well as establishment of agreement between stakeholder groups towards validity of the findings. Apart from this, during further data analysis, emerging concepts were constantly compared within and between stakeholder groups so that core categories, sub-categories and their related properties could emerge with clear thematic connections between them.

Workability examines whether the concepts and their relationships to hypotheses "sufficiently account for how the main concern of participants in a substantive area is continually resolved" (Glaser, 1998, p.18). Categories and properties that emerged from this study were grounded in the data and emerged as a result of constant comparison between segments of data. The emerging constructs with their thematic patterns, were based on areas of consensus amongst participants relating to their concerns and views surrounding the idea of an adolescent-friendly maternity service.

Relevance of the study was highlighted by the literature review presented in Chapter Two, which clearly indicated that adolescent pregnancy was worldwide a problem. Whilst much research has been undertaken in the area of adolescent pregnancy prevention and the social implications that face parenting adolescents and their infants, there was a paucity of information on maternity care for pregnant and parenting maternity clients. As such, this study appeared to have relevance well beyond the research location of KwaZulu-Natal. This relevance was further highlighted by the findings presented in Chapter Four, which showed that all stakeholder groups agreed that adolescent maternity clients could not simply be

combined with their adult counterparts as their needs were different and needed to be specifically addressed. "Relevance makes the research important, because it deals with the main concerns of the participants involved" (Glaser, 1998, p.18). Thus, the constructs towards a model for action that are put forward in this report have been extracted from the points that participants considered key, when providing maternity services to adolescent maternity clients.

Modifiability translates into the emerging theory not be 'cast in stone'. Whilst verification was done during data collection to ensure that the data was correctly understood by the researcher and that participants agreed on the codes that emerged within and between stakeholder groups, the constructs themselves were not verified. Instead, what is produced is based on participant consensus and is open to modification as new data becomes available, with new researches in the field of adolescent maternity care. In the discussion presented in Chapter Five, new data from literature review was also used as a means of adding to the presented model for action rather than simply confirming or denying findings of this study. Hence, the constructs and the resultant model for action were open for modification from literature, moving it beyond the findings.

3.9 LIMITATIONS OF THE STUDY

Since volunteer and snowballing sampling was used, participants were those who were interested in the subject under study. Their opinion might only represent the thinking of the enthusiastic group, and not necessarily those of the adolescent population at large. Since adolescents attending private health care facilities were not included in this study, it would be appropriate to assume that the findings of this study

might not be transferable to them and might not reflect their perceived health care needs. However, it is believed that the constructs of adolescent-friendly maternity care resulting from this study is still applicable to adolescents receiving such services either in private or public health care facilities. The results also do not include the views of doctors rendering community maternity services, as they omitted to participate by not responding to the communication that was sent, requesting their participation. Hence certain aspects of obstetric care presented here, may be more applicable to central hospital settings rather than rural ones.

3.10 RESEARCHER'S ROLE

In the spirit of transparency and to prevent or explain any possible subject bias that might have occurred in the process of this study, it is necessary for me, the researcher, to reveal my stand within this area of study. I worked as a midwife in a maternity department at a public hospital for two and a half years. After that I taught midwifery for a further eight years, at diploma, post-basic, undergraduate and post-graduate levels. During these years I have had contact with adolescent clients attending maternity care in the various maternity departments of public health care facilities around the Durban functional region. I have observed how adolescents have been treated in maternity settings, and have always wondered how these clients felt and what they thought of their care. From my experience, I believed that for the most part, midwives tend to add more discomfort to the already desperate situation these adolescents face by scolding and taunting them. I have always felt that health care providers should use the opportunity of adolescents seeking maternity services to assist them get over their crisis towards a better future for themselves and their babies.

Having said that, I, the researcher has attempted to keep in mind the words of Glaser (1998, p. 49), which caution that, "in studying an area of life cycle interest, the researcher must always keep in mind not to force the data with particularism". Rather, I tried to discover what needed to be done in the area of adolescent maternity services with regards to its necessary inputs, process and outcomes by talking to as many concerned stakeholders and being vigilant for emerging patterns.

3.11 CONCLUSION

A Glaser Grounded Theory qualitative approach was used to explore the phenomenon of adolescent maternity care towards the development of constructs of adolescent-friendly maternity services for KwaZulu-Natal. Data collection was done by means of focus group interviews and semi-structured interviews amongst the various stakeholders in the rendering of maternity services. Theoretical sampling was used and data was followed until theoretical completeness and saturation were achieved. In the pursuit to this end, every effort was made to protect participants and preserve ethical standards by remaining within ethical parameters laid down for human research subjects. Data analysis took place in tandem with data collection, with the researcher delimiting by coding, memoing, analyzing and developing categories with their related properties. This also helped to guide the theoretical sampling, leading to the formalization of the emerging categories and properties into a model for action based on constructs of adolescent-friendly maternity services.

CHAPTER FOUR

FINDINGS

4.1 INTRODUCTION

As mentioned in Chapter Three, a Glaser Grounded Theory methodology was used to identify constructs of adolescent-friendly maternity care which can be used as the foundation of a model for action for the provision of adolescent-friendly maternity services for KwaZulu-Natal. This chapter represents the first two levels of conceptual perspective analysis. During level one conceptual perspective analysis, the data was manually analyzed by the researcher, by close examination for the emergence of codes. This process began as the data was collected by semi-structured interviews and focus group interviews, using theoretical sampling. As codes began to emerge, the researcher began level two conceptual perspective analysis, which involved arranging the codes into appropriate categories with their relevant properties. This arrangement which is presented in this chapter forms the latent structure for the constructs of adolescent-friendly maternity care (Glaser, 1998).

Extant literature indicates that qualitative methods suit this type of research, as they help to give a voice to populations that might otherwise not have one (de Jonge, 2001; Hanna, 2001). With this in mind the researcher decided to present the findings for stakeholder groups individually, so that they are not lost in the mix and have a voice. Respondents have been arranged into three stakeholder groups, namely: adolescent maternity clients (AMCs), health care planners (HCPs) and health care providers (HCps). This arrangement will also benefit future researchers who might pursue a

theory of adolescent-friendly maternity services based on the constructs presented in Chapter Five.

4.2 ADOLESCENT MATERNITY CLIENTS

A total of eighteen (18) adolescent maternity clients participated in this study. Their demographic information is as follows:

Type of client:

- 10 were antenatal clients

- 8 were postnatal clients

Age Distribution:

- 8 were 19 years old

- 5 were 18 years old

- 2 were 17 years old

- 1 was 16 years old

- 2 were 15 years old

Distribution according to race:

- 15 of the respondents were Black

- 2 of the respondents were Coloured

- 1 of the respondents was Indian

Apart from the respondents mentioned above, a mother of one of the antenatal AMC also agreed to be interviewed.

- Mother of an AMC

The following research questions guided the data collection amongst adolescent maternity clients.

1. What were the perceptions of adolescent clients regarding maternity services in Kwa-Zulu Natal?

2. What were adolescent client's expectations of the maternity services in Kwa-Zulu Natal?

3. What did the adolescent maternity clients consider to be an adolescent-friendly maternity service?

As such the findings are presented with these research questions in mind.

4.2.1 Adolescent Client's Perceptions of the Maternity Services

The perceptions of the adolescent maternity clients are put into two main themes, namely perceived friendly care and perceived unfriendly care. Within these two themes are various categories with their accompanying patterns of health provider behaviours and possible adolescent maternity clients' responses that characterize friendly or unfriendly care.

4.2.1.1 Perceived Friendly Care

The following table contains the emergent sub-categories and properties of AMC perceived friendly care that emerged from the data:

Table 1: Subcategories and Properties of AMC Perceived Friendly Care

Core category	Sub-categories	Property
Perceived Friendly Care	HCp behaviours that demonstrate caring	Being addressed in a polite manner. Being physically handled in a gentle way. Being listened to.
	HCp behaviours that demonstrate support	Being helpful. Being friendly. Providing reassurance. Demonstrating understanding. Non-judgmental.
	Clients' needs	Having one's needs anticipated. Having one's needs responded to. Birth companion.

For reader clarity, each of the sub-categories in table 1 will be discussed individually.

4.2.1.1a HCp Behaviours that Demonstrate Caring

The first sub-category to the core category 'Perceived Friendly Care' is 'Behaviours that Demonstrate Caring'. The table below contains the properties of this sub-category, as well as resultant AMC behaviours/feelings:

Table 2: Properties of ' HCp Behaviours that Demonstrate Caring'

Sub-category	Property	Resultant AMC behaviour / feeling
HCp behaviours that demonstrate caring	Being addressed in a polite manner. Being physically handled in a gentle way. Being listened to.	Feeling safe. Being able to seek assistance. Feeling respected. Being seen as an individual.

Addressing clients in a polite manner

A health care provider with a caring attitude was essential to the adolescent client

perceiving care as being 'friendly'. For many of the respondents, care was perceived

as being friendly when the health care provider spoke to them in what they described

to be a 'nice' way.

*"They don't shout. They are just nice. You talk to them and you tell them your
problem, and they understand."*

(Antenatal AMC)

"She won't shout at us, treat us well because we are human beings."

(Antenatal AMC)

This way of interacting with them made the adolescent clients feel more comfortable

with the health care provider and more able to communicate their problem or need, as

they perceived the health care provider to be understanding.

Being Physically Gentle

The manner in which physical care was given also conveyed caring or non-caring to

the adolescent client. When asked to describe health care providers with whom they

were happy, a postnatal respondent described the health care provider who took care

of her during labour and delivery as follows:

"She was very gentle with me. She didn't rough handle me."

(Postnatal AMC)

This client saw kindness or tenderness in how the nurse carried out physical
procedures.

Another respondent described the way the doctor who examined her conducted the

abdominal palpation.

*"He just felt the correct places not pull this down or pull that up or something. You
know he just checked my stomach and he was gentle with me."*

(Antenatal AMC)

More than one client mentioned that care was perceived as being friendly when health care providers were physically gentle with them. Gentleness on the part of the health care provider conveyed caring to the adolescent client.

Being listened to

Caring was also conveyed to clients when they perceived that health care providers had listened to them and acted in accordance with the information that they in turn supplied.

"Yesterday there was a white lady there and I went to the toilet yesterday, and I came and told her you know, 'I went to the toilet and here's my card, I am after this person'. She was, she made it that I was after that person."

(Antenatal AMC)

In this situation, the respondent felt that the health care provider had been good to her by listening to her when she informed her of her place in the queue and by seeing to it that she was able to take up her original place, rather than being expected to go to the back of the queue.

This sentiment was also expressed by another respondent who described her idea of a 'good' HCp as someone who listens and responds:

"You tell the nurse and she must understand you and she must tell you what's it about and how to treat it."

(Antenatal AMC)

4.2.1.1b HCp Behaviours that Demonstrate Support

'HCp Behaviours that Demonstrate Support' is the second sub-category of the core category 'Perceived Friendly Care' for AMC. The table below contains its properties as well as resultant AMC behaviours/feelings:

Table 3: Properties of 'HCp Behavious that Demonstrate Support'

Sub-category	Property	Resultant AMC behaviour / feeling
HCp behaviours that demonstrate support	Being helpful. Being friendly. Providing reassurance. Demonstrating understanding. Not focusing on age.	Feeling significant. Not being dismissed. Having one's needs met. Feeling understood. Feeling accepted.

Being helpful

Respondents also seemed to relate better to HCps who were not dismissive of them, but who were instead perceived as being helpful. The respondent below describes a situation where she was almost turned away from the antenatal clinic because she did not have her birth certificate with her.

"And that white woman walked in and she said, 'no send her, if she don't (sic) have her birth certificate', you know, 'we can still see to her'."

(Antenatal AMC)

When asked to recall a health care provider with whom she had had a good experience in the antenatal clinic, the respondent remembered the health care provider who had rescued her from being sent home for not having her birth certificate with her. She found this person to be helpful towards her and thus caring, as opposed to the health care provider who almost turned her away from the clinic.

Being Friendly

For many respondents the issue of the health care providers being friendly seemed to be linked with the concept of providing support.

"I found it was very nice because the nurses were very supportive and they are very friendly compared to other clinics."

(Postnatal AMC)

"She must be friendly."

(Antenatal AMC)

Friendly health care providers were perceived to be 'nice' and clients appear to feel more favourably about the care they then render. The care is also then perceived to be more supportive.

Providing reassurance

Health care providers who appear to give reassurance were also perceived to be supportive. When asked to describe instances of care with which adolescent clients were happy, a postnatal respondent described the support that she received while in labour from the nurse who looked after her.

"I was like in pain and I was very uncooperative and she was like ....even though she was screaming at me. She was only screaming at me like reasonably. Telling me, 'okay fine, don't do this, don't do that'. "

(Postnatal AMC)

She felt that this nurse was very supportive to her by reassuring her and telling her what not to do, despite her being uncooperative. Another postnatal respondent had a similar experience and said that the health care providers had been good to her. When asked to describe exactly what they had done to make her arrive at this conclusion, she said the following:

"They don't just shout at us like....they just tell you that you mustn't scream when you are in labour. And they attend you, tell you to keep quiet, it will be okay. "

(Postnatal AMC)

She saw the attention the health care providers had paid to her during labour when she was in pain as supportive and reassuring.

Demonstrates Understanding

When the health care provider showed understanding towards the client, he or she was perceived as rendering 'friendly' care.

"She was like okay fine, understanding even though she got irritated at some point. She still was like, okay fine understanding and doing her job. "

(Postnatal AMC)

"I mean they must be more understanding towards young girls because most of them don't know what to expect and you know, exactly what they are supposed to do."

<div align="right">(Postnatal AMC)</div>

This respondent describes the health care provider who took care of her during her labour as not being affected by her behaviour, but tried to do what was needed in the situation, despite the client's behaviour. This made the respondent feel that even though the health care provider did get 'irritated' with her, the health care provider was still able to be understanding and render appropriate care to her.

Non-judgmental

When health care providers were non-judgmental they were perceived to be more caring and supportive by the clients. A good example of this is when they did not criticize adolescent clients for becoming pregnant at a young age.

"They were so patient. And they don't bother about how to...maybe when you are a young lady. They don't treat you as you are mistaken."

<div align="right">(Postnatal AMC)</div>

This respondent felt that the health care providers did not make her feel as if she had made a mistake by falling pregnant. Instead, she found them to be very patient in their dealings with her, which made her very pleased about the care they rendered. Another respondent felt that even though the health care provider who attended to her did not say anything positive about her being pregnant, he did not bring up the issue of her age.

"He never mentioned my age, he was just nice to me."

<div align="right">(Antenatal AMC)</div>

In doing so, the health care provider was perceived as being 'nice' by the adolescent respondent. Hence, health care providers who did not focus on the client's age were seen as non-judgmental and therefore, deemed to be more caring.

4.2.1.1c Clients' Needs

This is the last sub-category in relation to the core category of AMC 'Perceived Friendly Care'. The following table contains properties related to 'Clients' Needs', together with resultant AMC behaviours/feelings:

Table 4: Properties of Clients' Needs

Sub-category	Property	Resultant AMC behaviour / feeling
Clients' needs	Having one's needs anticipated. Having one's needs responded to. Birth companion.	Being understood. Feeling respected. Feeling significant. Ability to access care / information that is needed. Feeling supported.

Anticipating the needs of the client

Health care providers were also perceived to be 'friendly' when they were able to anticipate the needs of clients and respond to them without the client having to ask.

"I didn't even have to ask him questions. He told me about when you are giving birth this is what you would see, what do you expect. He was very nice with me."

(Antenatal AMC)

In the statement above, the client was very pleased with the care she received because the health care provider gave her health education, without her having to initiate the discussion by asking a question. The respondent also felt more comfortable with the health care provider because he wanted to hear from her.

"He even asked me, 'what are you expecting to see'. You know it was....you feel comfortable."

(Antenatal AMC)

In this situation the health care provider did not simply give her information. Instead, he wanted to know what she was expecting to see when she went into labour. This made the client feel like the health care provider was interested in what she had to say. The result was that she immediately felt comfortable with the health care provider because she perceived him to be caring.

Responding to the needs of the client

When clients felt that health care providers responded to their needs they appeared to

be more satisfied with the care they received.

"When I am feel (sic) pain, they help me."

(Postnatal AMC)

A good example of this is when they received pain relief during labour after telling

health care providers that they were experiencing pain or after health care providers

noticed that they were in pain. This made the client feel that the health care providers

were aware of them as a person and as such responded to their needs.

Another example of where a health care provider responded to the needs of the client

is evidenced below:

"Like last week, they wouldn't allow him (referring to the boyfriend of the client) to come in the room. Yesterday, we asked the doctor, is he allowed to come. He said, 'yes, you are allowed, come in'."

(Antenatal AMC)

This adolescent client was accompanied by her boyfriend when she went to the clinic

for her antenatal appointments. On previous occasions the health care providers had

not allowed her boyfriend into the consulting room while she was being attended.

However, the respondent persevered and at the last visit enquired if her boyfriend

could remain with her during the consultation. The health care provider allowed the

boyfriend to be part of the consultation and this decision made the respondent feel

more comfortable with this particular health care provider.

Birth companion

Being supported by a significant other was perceived to be of great benefit by the

adolescent maternity clients. Some antenatal clients felt that they wanted to have

someone, other than the nursing staff, with them when they were in labour. Postnatal

respondents on the other hand were glad that they had someone with them during labour. While some of the antenatal respondents wanted their boyfriends to be with them during labour, many showed a preference for a female birth companion.

"My brother's girlfriend came."

(Postnatal AMC)

"I will go home and take my mother."

(Antenatal AMC)

"I wouldn't have made it without my mother."

(Postnatal AMC)

"My mum and my aunty."

(Postnatal AMC)

Irrespective of who the adolescent client chose to accompany them, the need for extra support was clear.

4.2.1.2 Perceived Unfriendly Care

Under the theme of perceived unfriendly care, the adolescent maternity client data revealed four main categories, with their emerging patterns, as shown in Table 5 below:

Table 5: Sub-categories and Properties of 'Perceived Unfriendly Care'

Core category	Sub-categories	Property
Perceived Unfriendly Care	HCp behaviours that invoke fear	Reprimanding. Shouting. Facial expressions or looks. Possibility of Retribution. Shouting.
	HCp behaviours that invoke negative reactions	Focusing on client's age. Reprimanding.
	Feeling of being punished	Sarcasm. Ridicule. Curtailed freedom to express one's feelings. Unwillingness to render care.
	Disdain or lack of respect	Unnecessary exposure. Needing to be accompanied by an adult. Being perceived as a child.
	Routinized Care	Un-individualized care. Non-caring attitude. Lack of privacy. Long clinic waits. Hurried consultation. Not anticipating the needs of the client. Lack of health education.

4.2.1.2a HCp Behaviours that Invokes Fear

This is a sub-category related to the core category of 'Perceived Unfriendly Care'.

Table 6 below contains its related properties, together with resultant AMC

behaviours/feelings:

Table 6: Properties of 'HCp 'Behaviours that Invoke Fear'

Sub-category	Property	Resultant AMC behaviour / feeling
HCp behaviours that invoke fear	Reprimanding. Shouting. Facial expressions or looks. Possibility of Retribution.	Inability to seek help. Embarrassment. Inability to seek health education. Feeling shy / ashamed. Being silenced.

Reprimanding

Patterns of behaviour of health care givers that invoke fear in the adolescent maternity

clients include reprimanding the adolescents because of their pregnancy and wearing

looks that the adolescents claim scare them. Adolescent maternity clients would

perceive care that reprimands them, because of their pregnancy, as unfriendly. The

adolescent maternity client interviewed described her fear of being reprimanded.

"I was afraid to tell them to (sic) got a pain there and all that there because how they told us before the treatment, if you don't want to get pregnant, you must use condom and all that there (sic)."

(Antenatal AMC)

This fear of reprimand may prevent adolescent clients from seeking health care in the

first instance, which may prove to be possibly detrimental to their health status.

Shouting

Some respondents gave the impression that they were not treated well.

"Sometimes they treat us well. But others they don't treat us well."

(Antenatal AMC)

When asked to provide examples of not being treated well, the adolescent respondents

made reference to the manner in which health care providers reacted to (shouted at)

them.

"They shout when you have got something wrong."

(Antenatal AMC)

The following excerpt further reinforces the above claim as another respondent

described how the health care providers reacted to her during labour because she was

crying out in pain.

"Everybody in the ward was screaming at me. Telling me, 'shut up' and, don't scream' and, 'don't do this and, don't do that'."

(Postnatal AMC)

Intimidating Facial Expressions

Adolescents interviewed expressed concern about the type of facial expressions sometimes put up by the HCps. When asked about whether they approached health care providers with their health education needs, they responded as follows:

"You scared of them."

(Antenatal AMC)

"The way they look at you, you feel shy."

(Antenatal AMC)

From this response it would appear that adolescent clients do not feel free to approach health care providers because of their perceptions on what is conveyed in the expression on the faces of the health care providers.

Possibility of Retribution

Respondents perceived that health care providers would take negative action against them if they were in disagreement with them.

"They shout , they treat you like a dog. I know they treat people like that, my mother is a nurse too."

(Antenatal AMC)

When asked if they responded to things that health care providers said to them, which they perceived to be negative, a respondent said the following:

"You can't say anything because like they'll just ill treat you. You know if you are giving birth and he is seeing to you, like they remember your face and they punish you for saying what you were saying or doing what you were doing. That is how they are with you. So you must just keep quite to them."

(Antenatal)

The fear of retribution caused the adolescents to remain silent about aspects of care that they were unhappy about.

4.2.1.2b HCP Behaviours that Invoke a Negative Reaction

This is a sub-category of the core category 'Perceived Unfriendly Care'. Table 7 that follows, contains its related properties with resultant AMC behaviours/feelings:

Table 7: Properties of 'HCp Behaviours that Invoke Negative Reactions'

Sub-category	Property	Resultant AMC behaviour / feeling
HCp behaviours that invoke negative reactions	Focusing on client's age.	Anger. Feeling demeaned. Embarrassment. Defaulting clinic appointments.

Focus of Attention on Age

Adolescent clients consider unnecessary attention to their age by the HCp as

unfriendly. AMCs that were eighteen years and under reported that the nurses in the

maternity departments and clinics drew attention to their ages, and referred to them as

being too young to have babies.

*"They asked why did I fall pregnant when I am so young, why I am having that....then
I was cross. I didn't come for three months. So when I came back, they said, no, they
were just shouting at me to tell me that it's wrong."*

<div align="right">(Antenatal AMC)</div>

The adolescent in the statement above reacted with anger towards this focus on her

age and perceived this interaction to be a reprimand. The result was that she got angry

with the nurses at the clinic and did not attend her antenatal appointments for the next

three months. Even when health care providers were perceived to be giving 'friendly

care' the issue of the client's age still loomed.

*"They treat me normally like other people. But they were always saying that I was too
young to have a baby."*

<div align="right">(Postnatal AMC)</div>

This respondent felt that the health care providers in the antenatal clinic that she

attended treated her in the same manner that they would any other antenatal client.

However, they did tell her on many occasions that she was too young to have a baby.

This did not appear to go well with this respondent.

Adolescent clients also reported overhearing health care providers discussing the issue of their ages.

"Every time I go to … … (name of facility removed), there was the same nurse yesterday there and she is asking me my age. I said, 'it's on my file'. In front of everybody they will ask you your age, just to embarrass you because you are 15. And I must keep telling them, 'I am 15'."

(Antenatal AMC)

This client found that even though her age was written on her file and the health care providers at the clinic had attended to her more than once, they persisted to enquire about her age; an action that would appear to be deliberate in the opinion of the adolescent maternity client.

"They scream, 'oh you 15, you 15, she's 15', they telling everybody."

"I feel embarrassed in front of everybody, you know. Girls also will ask, 'oh, you're fifteen', you know."

(Antenatal AMC)

This drawing of attention to her age made the client feel embarrassed, as often it was not done privately but in full view of other health care providers and clients in the waiting room.

4.2.1.2c Feelings of being Punished as Part of Care

This is a sub-category of the core category 'Perceived Unfriendly Care'. Table 8, that follows, contains its related properties with resultant AMC behaviours/feelings:

Table 8: Properties of 'Feelings of Being Punished'

Sub-category	Property	Resultant adolescent behaviour / feeling
Feelings of being punished	Sarcasm. Ridicule. Curtailed freedom to express one's feelings. Unwillingness to render care.	Feeling demeaned. Feeling embarrassed. Being silenced. Inability to protect one's self. Inability to obtain needed information. Feeling judged.

Sarcasm and Ridicule

In other instances the fear of reprimand goes beyond being a perception with adolescent clients actually experiencing being ridiculed by the health care providers.

"They hurt you and when you say you know, 'it's sore'. 'Oh, relax, relax, relax'. And most of the time they tell the patient, like anybody, 'oh when you were having sex it was nice, now you are complaining'."

(Antenatal AMC)

In some situations when clients did tell health care providers that they were not happy with what was being done to them, they found that they were met with ridicule and sarcasm. Adolescent clients were made to feel that they should not complain because they had got pregnant of their own accord and had therefore brought this on themselves.

Other adolescent respondents also experienced some health care providers being unhelpful and choosing to ridicule them instead. The following respondent describes an interaction that she had with a health care provider, when she forgot to bring her birth certificate with her to the antenatal clinic.

"And she says to me, 'oh you forgot it. It's something so small, how did you forget it, why didn't you forget yourself?'"

(Antenatal AMC)

Instead of being helpful and explaining to the client why it is important to bring her birth certificate to the clinic, the health care provider used this situation to ridicule the client, conveying an attitude of non-caring by this interaction.

Curtailed freedom to express one's feeling

As mentioned earlier, in order not to incur any reprisal from health care providers, adolescent clients made the decision to keep quiet about aspects of the care that they were unhappy about.

"You know like if they do something wrong to you or hurt you, and you tell them you know, 'you're hurting me, that's not right what you are doing'. They tend to treat you badly."

(Antenatal AMC)

While receiving care, adolescent respondents are afraid to be open with health care providers, out of fear of reprisal, especially if they want to criticize the care. This perception does not help to foster a relationship of trust between client and health care provider, as it serves to silence the client.

Unwillingness to render care

There were reported feelings among the adolescents that they were not taken care of by the HCps. One respondent put it in the following way:

"They didn't .....because of my age they felt that I was too young to have a baby so they didn't actually take care of me."

(Postnatal AMC)

This particular client was fifteen years old. From her interaction with the health care providers, she felt that they were judging her because of her age and as a result were not prepared to care for her because they did not agree with her being pregnant at this young age. The adolescent was asked to concretize this perception that she had of the health care providers' that made her feel she was not taken care of.

"Like they weren't interested and if I asked something, they won't give a straight answer or things like that."

(Postnatal AMC)

This unwillingness to engage in dialogue with the client led her to feel that the health care providers were not interested in her and that she was being judged for falling pregnant. Hence, the health care providers withholding of information actually resulted in the client feeling that they disapproved of her becoming pregnant

4.2.1.2d Disdain or Lack of Respect

This is a sub-category of the core category 'Perceived Unfriendly Care'. Table 9, that

follows, contains its related properties with resultant AMC behaviours/feelings:

Table 9: Properties of 'Disdain or Lack of Respect'

Sub-category	Property	Resultant AMC behaviour / feeling
Disdain or lack of respect	Unnecessary exposure. Needing to be accompanied by an adult. Being perceived as a child.	Inability to protect one's self. Feeling vulnerable. Losing one's rights. Being dismissed.

Unnecessary exposure during the consultation

Respondents perceived care as being unfriendly when it appeared that health care

providers did not respect them.

*"Last week a male doctor saw to me. I went to get examined. And like he told me to
pull my shorts down, to check my stomach, but he told me I must pull it....he is pulling
my shorts right down, you can see my private parts. Okay at that time I didn't know
whether it was right what he was doing."*

(Antenatal AMC)

The client was at that time unable to judge for herself if what the health care provider

was doing was correct or not. However, when she was examined a week later by

another health care provider, the respondent found that this individual did not over

expose her when performing an abdominal palpation on her.

"He respects your body."

(Antenatal AMC)

When she compared the two incidents, she came to the realization that she had been

over exposed during the earlier consultation. This comparison and conclusion made

her feel that the previous health care provider had been disrespectful of her, while the

second health care provider's consideration for her body made her feel respected.

Needing to be accompanied by an adult

In order to be accorded some respect, a respondent felt that she needed to be

accompanied by an adult to the antenatal clinic. Referring to her experience in one of

the antenatal clinics, she reported:

"They won't say anything to you because if they see an elderly person, then they are not going to say anything. They are going to keep quite. If you there alone, they are going to run you down, make you look like a fool because of your age."

(Antenatal AMC)

From her experience she had come to the conclusion that health care providers were

more critical of adolescent clients when they were not accompanied by an adult.

Being Perceived as a Child

The respondent felt that the health care provider's perception of the client being a

child caused the health care provider to disrespect the client.

"If you want to make a suggestion, like why don't .....you know, they won't listen to you because you are a small child. You know, 'who you?' 'Go and sit down', or something. They don't listen to you or anything. They just push you one side."

(Antenatal AMC)

The respondent felt that the health care providers did not give adolescent clients a

hearing because of their perception that these clients were children, and, therefore, did

not know what they were talking about.

4.2.1.2e Routinised Care

This is a sub-category of the core category 'Perceived Unfriendly Care'. Table 10,

that follows, contains its related properties with resultant AMC behaviours/feelings:

Table 10: Properties of 'Rountinised Care'

Sub-category	Property	Resultant AMC behaviour / feeling
Routinized Care	Un-individualized care. Non-caring attitude. Lack of privacy. Long clinic waits. Hurried consultation. Not anticipating the needs of the client. Lack of health education.	Losing one's individuality. Feeling inconsequential / insignificant. Feeling vulnerable. Feeling embarrassed.

Un-individualized care

Respondents commented about the interaction that took place between themselves and the health care providers at each visit to the health care facility. Many felt that the health care provider rendered only routinised care to the client. A postnatal respondent said the following:

"Nothing was good, I mean they just did what they were supposed to do, that's it. Just check if the baby is okay and give you those tablets, those iron tablets."

(Postnatal AMC)

In her opinion, the health care providers appeared to do only the necessary within routine consultations. However, from the statement, it would appear that the respondent expected more of the health care providers, otherwise she would not have come to the conclusion that there was nothing good about the care.

Another antenatal respondent remarked that she felt the job of the nurses was an easy one, based on her observations in the antenatal clinic.

"You know I was even saying if I was a nurse, it's just easy. Take the pregnant person, sleep there and just feel the baby, and just write it down, 'you feeling okay?' and all that."

(Antenatal AMC)

Another respondent described this type of routinised care as follow:

"They sit there and you get up there and they ask you if you feel the baby is fine, okay then its fine, see you next week."

(Antenatal AMC)

This pattern of lack of personalized care was continuously reported by the adolescent

mothers. Another postnatal client related a similar experience:

"..., they don't do much. The only thing they do for you is, you just go there, they
check that whatever they have to write down, that's what they do, that's all."
<div align="right">(Postnatal AMC)</div>

This client felt that the health care providers only attend to things that need to be

written on the chart and don't do anything beyond this.

Non-caring attitude

A postnatal client described how health care providers demonstrated a non-caring

attitude towards her when she came to the labour ward of the hospital thinking that

she was in labour and was diagnosed as being in false labour.

"I thought I was in labour but I wasn't and I came here round about 12 o'clock in the
night. I was admitted at 5 past 12 and discharged at 1 o'clock in the night."
<div align="right">(Postnatal AMC)</div>

This client did not have any transport of her own and was brought into the hospital by

ambulance. She was unsure of how to get back to her house at this time of the

morning. She described the reaction of the health care providers when she sought their

assistance to resolve this problem.

"If you ask them, 'now what I'm going to do because it's late in the night I can't go
now?' They tell you, 'oh, not our problem, do whatever you think you can do for
yourself'. That's it."
<div align="right">(Postnatal AMC)</div>

From the description of what transpired it would seem that these health care providers

were not concerned with this adolescent client's safety and expected her to find her

own way home in the early hours of the morning. This led the adolescent client to the

conclusion that the health care providers did not care for her.

Lack of Privacy

Many respondents commented about the lack of privacy in the clinics.

"In the rooms there is no privacy, only when you are getting examined. But other than that, you are out in the open, in front of everybody like that. So everybody hears what is going on, it's not private."

(Antenatal AMC)

They felt embarrassed especially when discussing sensitive issues with health care providers. This lack of privacy meant that other clients in the clinics' waiting rooms could hear what was being said. Apart from the physical layout of facilities decreasing privacy, adolescent clients also reported health care providers not making efforts to maintain privacy and confidentiality.

"They stand and scandal. They talk about certain patients."

(Antenatal AMC)

This respondent observed health care providers openly discussing clients in full view of other clients who were waiting to have their vital signs taken in the waiting room of the antenatal clinic. Respondents felt that health care providers should be aware of this constraint and therefore, should make efforts not to discuss their confidential matters at a high volume, thus preventing other clients from over hearing.

Long Clinic Waits

Respondents at all three sites where data was collected complained about the long hours that they had to sit in the antenatal clinics to receive care.

"It's only that we have to wake up early in the morning when we come up from where we stay."

(Antenatal AMC)

Many clients had to leave home early in the morning in order to get to the clinic on time and then had to wait many hours before being seen, so they ended up going home really late in the afternoons. They attributed the long queues in the clinic to the nurses working at a pace that was too slow.

"The things that I am not happy with, is that the nurses are slow."

(Antenatal AMC)

The clients attributed this slowness to the socializing in which the nurses engaged.

"They take their own time if you want to go there. They start chatting and when you want to go home, they don't attend us."

(Postnatal AMC)

"They like to chat, you see the nurses standing around not working."

"The nurses, they stroll in the passage, they start talking their own thing."

(Antenatal AMC)

This perceived lack of consideration for the clients, demonstrated by the health care provider's socializing left the clients feeling as if the focus had been shifted from them to the health care providers instead.

"It's like they are having the babies, that's how it is."

(Antenatal AMC)

Hurried Consultation

As seen in the information presented above, respondents complained that they had to wait long hours before being attended. However, once they were seen by the health care providers, another complaint was that the interaction then appeared hurried.

"Well at the clinic they expect you to be like....they never have time. They just want you to like, okay be fast in whatever you do."

(Postnatal AMC)

In the excerpt above, a postnatal client perceived the health care providers as wanting the client to be quick about all things that needed to be done in the clinic. After spending time waiting to be attended, clients expected that the consultation should then not be hurried. From the information presented in the section above it would appear that time taken up by the reported socializing of health care providers was then compensated for by making the consultation hurried. Another antenatal respondent commented that she did not feel like she could approach health care providers with

her health education needs. When asked what stopped her from doing so, she

responded as follows:

"They look like they haven't got time to sit and chat, you know."
<div align="right">(Antenatal AMC)</div>

This perception of the health care providers being hurried in their work may be a

barrier to the adolescent clients seeking health education.

Not anticipating the needs of the clients

One of the antenatal respondents felt that health care providers did not empathize with

the situation of the pregnant clients and were thus unable to anticipate the clients'

needs.

"You know when you are pregnant, you get hungry often and you get very tired. And then I say to myself, they making us wait here so long, not understanding we need to eat, we want to go home and sleep, you know. They don't understand that, they just think for themselves."
<div align="right">(Antenatal AMC)</div>

In the opinion of this respondent, health care providers should be more understanding

and try to make every effort to increase the speed within which clients are attended

within the antenatal clinic, so that they are able to finish earlier and return home to eat

and rest.

Lack of Health Education

Tied to the hurried nature of the client – health care provider interaction was the issue

of health education. Many respondents felt that they had received very little health

education, if none, while in contact with the maternity services.

"Like the other doctor that I saw last week. He didn't explain to me, what am I (sic) going to see. You know, he didn't explain what's going to happen before I do give birth."
<div align="right">(Antenatal AMC)</div>

"It's not the care that taught me anything, it's just me, myself and I. I mean it's more like I had to tell myself, okay fine, I have done the deed and I am pregnant and I am going to have a baby and ya, I'll take good care of her, so that's it."

(Postnatal AMC)

As can be seen from the statements above, respondents reported receiving no health education from the health care providers. One came to the realization that she would have to learn how to care for her baby by herself.

Many clients said that they were going to learn how to take care of their babies from family members, especially from their mothers who had raised them.

"My mother, she will teach me a lot."

(Postnatal AMC)

Another respondent had a similar experience. She had received no instruction from the health care providers; instead she was waiting until she went home to learn from her mother.

"I am going to listen to her, how to look for a baby when it's sick."

(Postnatal AMC)

When she went home, her mother was going to teach her what to do in the event that her baby got sick.

4.2.2 Adolescent Clients' Expectations of the Maternity Service

Findings from adolescent respondents on their expectations of the maternity service fell under four main categories within the theme of friendly care, namely:

- the qualities that they expect the health care provider to possess
- the interaction with the health care provider that conveys caring
- the maternity system itself, both physical set-up and procedural aspects
- health promotion and illness prevention

As such, findings for this research question will be presented under these four main headings as listed in Table 11 below:

Table 11: Subcategories of AMC Expectations of Friendly Care

Core category	Sub-category	Property
Friendly Care	Qualities that HCp's should possess	Qualified within the profession. Experienced within the profession. Egalitarianism. Supportive. Understanding. Empathetic. Maternal disposition.
	Interaction that conveys caring	Respect. Privacy. Confidentiality. Creating a comfortable atmosphere.
	The maternity system, both physical set-up and procedural aspects	Decrease clinic waiting times. Increase physical comfort within the clinic. Orientation to the health care facility.
	Health promotion and pregnancy prevention	Health education needs. Peer support programmes.

4.2.2.1 Qualities that the Health Care Provider Should Possess

An Experienced HCp

While AMC's were ambivalent about the age of the health care provider who would make them feel comfortable, they were very clear about expecting the health care provider to be experienced within the profession, and, as such, be someone who could render optimal care as a result of their level of experience. This is evidenced by the statement below of a respondent who was asked what she expected from the health care provider.

"Somebody experienced."

(Postnatal AMC)

Governmental health care facilities are used as clinical sites for the training of student nurses. This appeared to pose a problem to respondents, as evidenced by the statement below.

"But the bad thing is there is (sic) student nurses there, they don't know what they are doing, like with injections, they don't know where to poke."

<div align="right">(Antenatal AMC)</div>

This respondent did not like to be attended by student nurses. She felt that they did not know what they were doing, and, as a result, it took them longer to accomplish a task. This caused clients to spend more time in the clinic. She felt that if the health care providers were more experienced they could render care at a faster pace.

Egalitarianism

Respondents wanted health care providers to respond to them in the same way they would to any other pregnant client.

"Treat me like I am, like other pregnant women."

"Treat me equally like how you treating everybody else. And like with my age, don't put me down."

"Bring me up. You know not always degrade me, tell me about my age and all that."

<div align="right">(Antenatal AMC)</div>

Health care providers should not make an issue of their ages and use this to discriminate against them and 'degrade' them. Instead health care providers had a role to play in uplifting the client.

Supportive HCp's

All respondents emphasized that health care providers need to demonstrate support when caring for them.

"I just feel that we need support from them. If the nurse is supportive, then that's all I need her to have."

<div align="right">(Postnatal AMC)</div>

When asked to describe what they meant by support, respondents had different

perspectives on what they defined as supportive behaviour. Some respondents saw

support as a tangible entity.

"Like they take good care of you if you in pain, then they will be there to support you. Or if you are not feeling well then they give you advice and they encourage you."
(Postnatal AMC)

For this respondent support meant ensuring adequate pain relief or pain control,

encouragement and health education.

Understanding Hcps

Respondents felt that while they were aware that they were too young to be having

babies, the health care providers should realize that it had been a mistake and should

not keep harping on this issue or continue to demean them because of it.

"I mean, we know that okay fine at a young age we are not supposed to be having babies and everything. And if it happens, okay fine, it's happened. It's a mistake. We actually, especially if you like having the baby, you are prepared to face the consequences and you don't expect anybody to be like looking down on you or putting you down. You expect them to be supportive and more understanding."
(Postnatal AMC)

They expected the health care providers to be more understanding about the fact that

it had been a mistake and provide them with support that could build them up rather

than break them down. Part of understanding the client was the ability to anticipate

health education needs and give proper explanations when needed.

"You don't know and you come and they like, instead of telling you nicely or treating you nicely, they tell you, 'oh, you rushing things up, it's not yet your time', this and that and everywhere. They shouldn't do that. They should be like at least, explain to you what to expect. And more or less, what are the signs you are going to get."
(Postnatal AMC)

The respondent felt that the health care providers should understand that these

adolescent clients are young and have no previous experience with labour and

delivery, so do not know what to expect and may in fact be wrong in their self

diagnosis. Instead of being 'harsh' the health care providers should rather explain in a

polite manner, what is happening and teach the client how to anticipate the signs and symptoms of labour.

An Empathetic HCp

The health care providers should also be broadminded in their attitude. Respondents also wanted someone who could empathize with them and their situation. In doing so, the health care provider would be someone who could anticipate their needs and make allowances for them in the care rendered or go that bit extra to overcome the adolescent client's lack of knowledge and experience. For respondents being empathetic meant being able to understand that adolescent clients lacked experience and had specific health education needs that should be addressed.

"Just that they must be more caring, I mean they must be more understanding towards young girls because most of them don't know what to expect and you know, exactly what they are supposed to do. Instead of shouting at them when they want to get something across, they should just tell them properly."

(Postnatal AMC)

Rather than reprimanding clients, health care providers should provide information in a manner that implies caring and an understanding of the client's predicament.

Maternal Disposition

Tied into the HCp's ability to be empathetic was the respondents' request that the HCp treat them as they would their own child.

"You must talk like, the person is your child. You mustn't just treat the person anyhow."

(Antenatal AMC)

Some of the adolescent respondents felt that female HCps should respond to them in a more maternal fashion, treating them as if they were their own children.

"When we leave home we come to here to our mothers, so they must take the place."

(Antenatal AMC)

They should extend to them kindness that they would naturally afford their own children.

4.2.2.2 Interaction that Conveys Caring

Respect

All adolescent respondents felt that it was the health care providers' duty to make them feel comfortable with the maternity service. There were many aspects of interaction that conveyed a feeling of comfort. Essential to feeling comfortable was the knowledge that the health care provider respected them (AMC's). When asked how they would act towards the client, if they were the health care providers, an adolescent antenatal respondent said the following:

"I must treat that person with respect. I would make them feel comfortable, so they come again."

(Antenatal AMC)

It would appear from this statement that when adolescent clients perceive they are not being respected, they begin to feel uncomfortable. This in turn may lead to them not returning to the health care facility and defaulting on their care. So making adolescent clients feel comfortable by respecting them is a way to ensure that they will have good compliance with the care given.

A concrete way in which respect was conveyed to the adolescent client was the manner in which the health care provider greeted them.

"To greet me right (sic)."

(Antenatal AMC)

If adolescent clients were firstly greeted by the health care provider and secondly, greeted in what they considered to be a pleasant manner, then they felt that the health care provider respected them. Respondents also wanted health care providers to maintain this atmosphere of respect by speaking to them in a proper manner.

"She won't shout at us, treat us well because we are human beings."
(Antenatal AMC)

Health care providers are expected to remember that AMC's were in fact human

beings and as such deserved to be treated with respect and not be shouted at.

As part of being respected and being treated like other adult clients, adolescent clients

wanted to be taken seriously by their care providers. When they gave information

relating to their state of health, they wanted to be believed by health care providers.

"If you tell them the baby is coming now, they don't believe you at first. Because they say, 'okay fine, you don't know, it is your first time, so what do you know'."
(Postnatal AMC)

According to the respondent above, she expected the health care providers to believe

her when she told them that her baby was about to be born because she was a

primigravida and had no previous experience with childbirth.

Privacy and Confidentiality

Privacy and confidentiality came up regularly as an issue that contributed to the

perception of being respected or not. Adolescent respondents felt that the health care

providers should be understanding and try to assist them with their problems.

"Ya, you know I must talk about everything that I have got, if I have got problems. You know there are some kind of problems these girls have, you need somebody to talk to, you need to say something that is private. You tell the nurse and she must understand you and she must tell you what's it about and how to treat it."
(Antenatal AMC)

The adolescent client expected to feel safe to approach the health care provider and

discuss sensitive issues with them and rest assured that information shared would be

kept confidential.

"Ya, we must discuss, you and her, not to go out. Maybe I am telling her something and she goes into the passage and she screams for me, 'you know that thing'. And everybody now, the whole passage know that I got that thing. (sic)"

<div align="right">(Antenatal AMC)</div>

The AMCs expect the health care provider to keep the information strictly between

the client and himself or herself.

Creating a Comfortable Atmosphere

Adolescent clients were asked what health care providers could do to make the client

feel more at ease and more comfortable during the routine antenatal.

"She must smile."

"And she must start the conversation. She must ask you how you feel."

<div align="right">(Antenatal AMC)</div>

It would appear that the adolescent clients are very conscious of facial expressions

and a 'smiling' nurse would make them feel more relaxed.

Another gesture that would make them feel relaxed and give them direction as to how

to proceed in the routine visit, would be if the health care provider was the one who

started the conversation, opening the floor for questions.

"Ya, because if I start the conversation and she looks at me like (indicates unfriendly expression on the part of the nurse), like that you know, then aye, it makes you scared."

<div align="right">(Antenatal AMC)</div>

The adolescent in the scenario above feels that if the nurse reacts negatively to what

she is saying, then she will not be able to open up to the nurse about her problems and

needs. Hence, the health care provider initiating the interaction, allows the adolescent

client the opportunity to anticipate how she will be perceived and to decide how to

behave or what to say in the situation.

Another respondent described a situation where the health care provider was the one that initiated the discussion and how she felt about this interaction.

"He is open, he talks to you and you can talk to him, you know. Like you can confide in him, you can tell him personal things that happened and he would, you know, do something about it."

(Antenatal AMC)

In this situation, the adolescent client felt like the health care provider was 'open' because he talked to her and this made her feel like she could talk to him and rest assured that any information that she shared would be kept confidential. In short, this opening by the health care provider served to make the client feel safe with him.

4.2.2.3 Health Care Facilities and Systems

Decrease Clinic Waits

Respondents felt that efforts should be made to increase the pace of work in the antenatal clinics, as they felt that they had to wait for a long time in queues in the antenatal clinic before being seeing.

"I think you must find more nurses to work there."

(Postnatal AMC)

A suggestion was that more health care providers be employed so that many clients could be seen at any given time. This would allow for them to finish whatever they had to do in the antenatal clinic at a faster pace and return home earlier.

Another suggestion to decrease long clinic waiting times was to ensure that the health care providers start their work on time.

"I like that the nurses start at the time."

(Antenatal AMC)

"We have to wait for them to come to us. They said the clinic start at 7 o'clock, but they don't clinic us at 7 o'clock."

(Antenatal AMC)

Even though clients were being told to come to the clinic at 7 o'clock in the morning, at the start of the clinic day, respondents found that the health care providers did not start attending to them immediately. Instead, they were made to wait for a long while before being attended. The result was that they ended going home quite late in the afternoon, tired after sitting in the clinic for a better part of the day.

Increase Physical Comfort Within the Clinic

As seen from the information presented above, respondents felt that they waited for a long time before being attended in the antenatal clinics. As a result, the issue of physical comfort within the health care facility became another issue of importance.

"There is (sic) only two benches there and they get full. Yesterday, I was standing. Even yesterday when I came back, she (referring to her mother) said see my feet, they had blue veins (referring to her swollen feet from standing in the queues)."
<div align="right">(Antenatal AMC)</div>

Respondents expect health care facilities to provide adequate seating so that they can wait to be seen in comfort, rather than standing in a queue for a long time.

Orientation to the Health Care Facility

Some respondents spoke about being unfamiliar with the hospital physical layout and system.

"And queues are always long when you get to the hospital. Like yesterday I went....but the first time I went, I didn't know where to go. I didn't know I was supposed to get a number."
<div align="right">(Antenatal AMC)</div>

"There is no one to tell you, like, okay there is (sic) lines there."
<div align="right">(Antenatal AMC)</div>

The mother of one of the AMC respondents suggested the following:

"They need to be informed at this clinic. Once they get to the clinic, the clinic needs to inform them. This is the process, this is how it works because that is where it starts."
<div align="right">(Mother of AMC)</div>

She felt that when adolescent clients begin at a health care facility the health care

providers there need to give them an orientation to the system. They need to advise

the clients on what the processes are and what procedures to follow and where to

physically find the departments that they may need to access. This respondent gave

the example of a banking institution and the efforts they make to assist customers.

"You always find a consultant walking around, 'what are you here for?' Then she will send you to the right place, so you don't stand in a long queue, when you get to the front, you are in the wrong queue, oh it's an awful thing. I think somehow the other with the pregnant mothers somebody should just or the receptionist should just ask, 'who is here for the first time? You go to that queue', you know?"

(Mother of AMC)

The mother of the respondent suggested that health care facilities make use of a

similar system of having a designated person whose main function is to ensure that

clients receive information and directions, so that they are able to access services

appropriately and at a more efficient pace.

4.2.2.4 Health Promotion and Illness Prevention

Health Education Needs

When asked how the maternity service could be improved so as to better cater for

adolescent clients, a postnatal client's response was:

"I would say, when you are going to the clinic for the usual care that you are supposed to go for to check if the baby is alright, they are supposed to tell you...because you don't know nothing, it's your first baby and you are still young and everything. They are supposed to tell you what to expect, what to do when the time comes. You know teach you those few things, those few basics."

(Postnatal AMC)

This respondent felt that health care providers should recognize that adolescent clients

were young and had no previous experience on which to draw. As a result, efforts

should be made to better prepare them for the changes that are taking place during the

pregnancy as well as those to come in the future. Hence, the health care providers

should be able to assess the educational needs of the adolescent clients and cater for them.

Many adolescent clients expressed a need for health education that would help them better understand what they were going through, physically and psychologically, and be able to prepare themselves for the role of being a parent.

"I would like to know more about my body and all that there. I always read my book."

<div align="right">(Antenatal AMC)</div>

The book that the respondent is referring to is a book on pregnancy and childbirth that she borrowed from a friend. When asked if they would benefit from reading material to take home, a respondent said:

"It will help us too much, yes."

<div align="right">(Antenatal AMC)</div>

Adolescent clients would like reading material that they could take home and read at their leisure, in order to overcome their knowledge deficits.

Peer Support

Some respondents felt that the whole experience of being pregnant and of delivering their babies had been a difficult one and that they had in fact learned from the experience. These respondents felt that they would like to use their experiences to educate other adolescent females.

"It was painful but a very educational experience, which I won't forget. And will go out and teach other girls."

<div align="right">(Postnatal AMC)</div>

When this respondent was questioned about what she would tell other adolescents, she responded as follows:

Respondent: *"Teenage pregnancy is not right, it is not good."*

Interviewer: *"You feel that it would have been better if you had waited?"*

Respondent: *"If I waited for the right time and the right age. Then maybe....because it was too painful."*

<div align="right">(Postnatal AMC)</div>

Another client also said that she would advise other adolescents to wait until after they got married before having babies.

"I can say they wait until they are married. They don't get babies before they are young."

<div align="right">(Postnatal AMC)</div>

She cited pain as being a reason to wait, as the experience of delivery had been too painful.

"I see it's so painful to get a baby when you are young."

<div align="right">(Postnatal AMC)</div>

However, this respondent also went beyond the physical aspect. According to this respondent, sometimes families were disapproving of the pregnancy and were then not supportive and often such pregnancies interrupts one's educational progress.

"Maybe you broken into (sic) school so you feel painfully about your education."

<div align="right">(Postnatal AMC)</div>

These respondents felt that they would like to use their own personal experience to educate other adolescent girls, who in turn could use this knowledge to prevent pregnancy.

4.2.3 AMC Perceptions of an Adolescent-friendly Maternity Service

Constituents of an adolescent-friendly maternity service were extracted from information provided by adolescent maternity clients on their perceptions and expectations of the maternity service.

4.2.3.1 Friendly Health Care Providers

According to data from adolescent maternity clients, for maternity care to be adolescent-friendly they expect that health care providers be:

- Knowledgeable

- Skillful

- Broadminded

- Understanding

- Friendly

- Open

- Supportive

- Non-critical

- Non-judgmental

- Empathetic

4.2.3.2 Friendly Interaction

In keeping with the characteristics that they expect health care providers to possess,

adolescent maternity clients have certain expectations about their interaction with

these health care providers for maternity care to be considered as adolescent-friendly.

During this interaction, adolescent maternity clients expect:

- To be respected as people.

- That they not be judged.

- That they are treated like any other client using the service.

- Not to be shouted at or scolded.

- That they not be ridiculed.

- To be spoken to in a pleasant manner.

- To be understood as a person.

- To have their needs understood.

- To be handled in a gentle manner, both physically and emotionally.

- To be supported when going through a difficult experience, for example labour and delivery.

- To be reassured by HCp's when experiencing a difficult situation, for example during labour and delivery.

- Not to be treated in a dismissive manner.

- HCp's to assist them to develop strategies to cope with difficult situations.

- To be put at ease within the health care interaction.

- That Hcp's initiate any discussion in an effort to put them at ease.

- That their privacy be maintained.

- That their confidentiality be maintained.

- That Hcp's not make an issue of their ages and discriminate against them based on their ages.

- That they are not made to be embarrassed in the presence of others.

- HCp's to assess their level of knowledge, anticipate their educational needs and to provide them with health education to bridge gaps in knowledge as a result of inexperience.

- HCp's to be ready to engage in dialogue with them, when they have learning needs.

- HCp's to take them seriously and believe them when they are expressing what they feel or are experiencing.

- That their age and its implied inexperience or lack of maturity should not prevent HCp's from trusting the information that they give.

- HCp's to focus on them as people during consultations, rather than focusing on the client's chart.

4.2.3.3 Friendly Maternity Services

For the service itself to be considered as adolescent-friendly, AMC's have the following expectations:

- There should not be long waits in the facilities before they are attended.

- Efforts should be made to ensure physical comfort in the facility, so that they may rest while waiting to be attended.

- The consultation itself should not be hurried, with adequate time being allowed for them to have all their needs addressed.

- Directions relating to the physical layout and procedural workings of the health care facilitation should be made clear to them.

- There should be someone available at all times within the health care facility to handle queries and give directions to clients.

4.2.3.4 Role of Clients

Adolescent respondents felt that they had a role to play in making the service adolescent-friendly. From the findings presented for the first two research questions, they saw their role as assisting to provide:

- Peer support programmes, for other adolescents who were in a similar situation.

- Peer education programmes, to educate other adolescents so as to prevent them from falling pregnant.

4.3 HEALTH CARE PLANNERS

A total of six health care planners agreed to participate and provided data towards the findings that will be presented in this chapter. Their details are as follows:

- Three health care planners (nurses) from the Department of Health

- One health care planner (nurse) from the provincial hospital's maternity department

- One health care planner (nurse) from the polyclinic's maternity department

- One health care planner (doctor - registrar) from the provincial hospital's Obstetric and Gynaecology department.

Individual interviews were conducted with health care planners to elicit information on the issue of adolescent-friendly maternity care. Discussion during the interviews was based on the research questions that guided this study. These were:

1. What were the attitudes of health care planners towards adolescent maternity clients and their needs?

2. What were the present strengths and weakness within the maternity services provided to adolescent clients as perceived by health care planners?

3. What were the suggestions from health care planners for improvements to the maternity services so that they might more effectively cater for the adolescent client?

4. What did the health care planners consider to be an adolescent-friendly maternity service?

Manual analysis of the data using the constant comparative technique advocated by Glaser (1998) was done to elicit categories, emerging themes, categories and patterns within the data. The findings of the analysis are presented according to the research questions for clarity.

4.3.1 Attitudes of HCPs Towards AMCs and Their Needs

From the data presented, it was clear that HCPs felt that AMCs had special needs that had to be considered when designing an adolescent-friendly maternity service. Table12 that follows, is a summary of the HCPs' Attitudes towards AMCs and their needs:

Table 12: HCP Attitudes Toward AMCs and Their Needs

Core category	Sub-Category	Property	Result
Adolescents as having special needs	Different from their adult counterparts	Physical immaturity. Psycho-social un-preparedness.	Pre-disposed to obstetric complications. Need more emotional care Inability to deal with consequences of action. Feelings of anxiety and isolation.
	Vulnerable group	'At risk' population. Lack of support.	Increased maternal morbidity and mortality. Default care. Inability to bond with their babies. Feelings of isolation.

4.3.1.1 Adolescents seen as having special needs

All health care planners who participated in this study felt that adolescent maternity clients could not be grouped together with their adult counterparts. Instead, it was felt that their health care needs whilst having some similarities to those of adult maternity clients, were in fact very different.

"Definitely, their needs are different."

(Nurse HCP)

"They are immature physically, psychologically and all this, so they need....they do have special needs."

(Nurse HCP)

Hence, any adolescent-friendly service should attempt to identify, cater for and target

these needs.

4.3.1.1a Different from their adult counterparts

Physical immaturity

A chief difference between adolescent and adult maternity clients was that adolescent

clients were physically immature.

"These, they are young, some of them they have not even started menstruating, they got pregnant without menstruating."

(DoH HCP)

The respondent felt that adolescents' bodies were not physically ready for pregnancy

and childbearing. The medical HCP concurred with this view, as these clients end up

having many obstetric complications.

"It is a known fact that these patients in labour, majority of them land up having caesarean sections because their pelvises are small, they are not very well developed and they have babies that are pretty huge. Maternal fatigue is the other problem that they commonly have. So these patients land up having Caesars either for CPD or maternal exhaustion or things like that."

(Medical HCP)

Psycho-social Non-preparedness

Another respondent felt that while there might be no difference in the physical care

that adolescents would need within the maternity services, there was in fact a

difference in the emotional care.

"I think there is an emotional difference and that is probably the key issue. I don't think there is a physical difference but the emotional difference."

(DoH HCP)

"In the first place, adolescents by virtue of their age, they are young and inexperienced, and they are venturing into a new zone. So there will be uncertainties in their minds, there will be fear of the unknown."

(Nurse HCP)

The main aspect of the difference between adolescent clients and their adult counterparts that all HCP's mentioned was the fact that the adolescent was immature and therefore, not fully able to appreciate the situation in which she was. According to a service HCP, the first difference is that the adolescent client is very aware of the fact that she should not have fallen pregnant and be accessing the maternity services. The HCP went on to explain that this belief is conveyed in the way her family, peers and health care providers react to her and her situation. Another respondent clarified this response as follows:

"Because even your friends in the township, are going to neglect you. Your parents are going to scold you. Nurses are scolding you. Then what is it. You tend to be psychologically deranged because you are not prepared. And when you are young, you are not prepared for all this."

(Nurse HCP)

In the view of a service HCP, a certain amount of risk taking behaviour is expected during adolescence. However, the resulting pregnancy is still not supposed to happen and this becomes a source of great anxiety for the adolescent.

"What's happening now because they are neither teenager now, they're really not an adult to be a parent. So they find themselves in nowhere land. I think they are not prepared for the responsibility or for the experience, both."

(DoH HCP)

Hence, the adolescent finds herself somewhere in between. Not quite an adult but no longer just an adolescent like her peers. It is this 'nowhere land' that makes her very different from her adult counterparts and becomes a source of fear. This 'nowhere land', together with the response from those surrounding her may leave the adolescent with a feeling of isolation.

4.3.1.1b Vulnerable Group

At risk Population

As mentioned earlier, adolescent clients were pre-disposed to obstetric complications,

which placed them in the 'at risk' category. According to a service HCP, it would

appear that there was an increase in the number of AMCs using the maternity

services. The respondent said that while the health department's data collection

methods were still problematic, she concluded, from data gathered by different means,

that the number of deaths among the AMCs were on the rise. Of note were the

statistics for maternal deaths:

"I see that with our maternal death investigations, we find that we have got a high number of mothers, of deaths, of women below 18 years of age."

(DoH HCP)

This respondent had noticed that maternal deaths were on the increase in the

adolescent maternity population. As such she viewed adolescent maternity clients as

an 'at risk' population, who needed special attention.

Another factor which puts these clients into the 'at risk' group is that they tend to

default health care during their pregnancy, or else seek care when the pregnancy is

quite far gone.

"They are coming from outlying clinics, some of them when they are told you are being referred to Addington, then they default and only come here in established labour."

(Nurse HCP)

When questioned further on this topic, the respondent offered the following to explain

why adolescent clients default on their antenatal care.

"I think not wanting to confirm the pregnancy, hiding the pregnancy or denial, you know and I think a lot to do with our coloured mums because it is the Wentworth and Newlands area. I think in their minds they think someone out there in the labour ward might know me, you know."

(Nurse HCP)

The fear of being identified within their respective communities results in adolescent clients missing out on much needed care and health education, thus increasing their 'at risk' status.

Adolescents as needing Support

One of the nurse HCP respondents mentioned that from her observation many of the adolescent clients did not appear to have support, especially when they come to the hospital to deliver. This lack of support further compounded their vulnerability.

"When they come in there is no birth partner with them. It is the saddest thing. There seems to be a tendency a lot of Coloureds coming in, no birth partners. So there is a lot of anger. They express a lot of anger, just before second stage."

(Nurse HCP)

This anger in turn affected the relationship between the adolescent and her baby in the postnatal period.

"It's very difficult for that teenage mum. Very, very difficult, you will find a lot of them post-delivery, not wanting to see the baby at all."

(Nurse HCP)

She remarked that adolescent clients appear to be traumatized by the experience and this in turn affected their ability to bond with their babies. To overcome this, the adolescent mother would need a lot of counselling during the postnatal period to help her accept and bond with her baby.

Another respondent had observed that adolescent clients at her facility did receive support from their boyfriends during labour. However, similar support during pregnancy was not evident.

"Not antenatally, and even in postnatal, it's rarely that you see them being accompanied by a person."

(Nurse HCP)

Also of note was the absence of support people during the postnatal period, where the respondent had observed that many of these clients, on discharge, were

unaccompanied from the health care facility. According to the respondent in this case, it is also sometimes not possible for the adolescent to turn to the health care provider for support.

"Sometimes they cannot turn to the nurses. Sometimes, I am very sorry to say this, because our attitudes are not the same. There are those who are sympathetic, others are not."

(Nurse HCP)

The respondent felt that health care providers should be a source of support to these clients, as they may not be receiving it from their significant others.

"She goes home, she is being scolded by the parents. Probably the boyfriend said, 'no, I don't know your pregnancy'. So she is left in a deep sea now, doesn't know where to go."

(Nurse HCP)

4.3.2 HCP Perceptions of Strengths within the Present Maternity Services

Data from HCPs was analyzed and their perceptions of strengths within the present maternity services with regards to adolescent clients were extracted. One core category emerged, namely 'Perceived Friendly Care'.

4.3.2.1 Perceived Friendly Care

HCP perceptions of what constituted adolescent-friendly care within the present maternity services was further subdivided into its sub-categories and their relevant properties, as indicated in Table 13 below:

Table 13: Sub-categories and Properties of 'Perceived Friendly Care'

Core category	Sub-category	Property
Perceived Friendly Care	Policies	Existence of the maternity service. Accessibility of the service. Extant policies on adolescent health.
	Services	Availability of the social worker. Availability of contraceptive services.
	Resources	Skilled health care providers. Physical layout affords support.

4.3.2.1a Policies

Existence of the Service

HCP respondents were asked to identify strengths within the existing maternity services with regards to adolescent clients. One of the respondents felt that the very existence of the maternity service was a strength in its itself.

"Well it's there, that's a strength, there is a service."

(DoH HCP)

A strength was that adolescent clients had somewhere to go for maternity care, should they fall pregnant. Another view was that the service was accessible to clients.

"I think mostly they are accessible and I think that is a good thing, especially for antenatal care."

(DoH HCP)

So, apart from the service existing, it could also be accessed by adolescent clients.

According to a service HCP, 'on paper' there are strengths within the maternity service for adolescent clients.

"Well, on paper, yes there is. Probably, we haven't started addressing their needs in terms of the actual practice."

(DoH HCP)

"We have policies, people simply don't implement the policies. Or people, you know, know that there is policies but they have no idea what's in the policy or what is the implication of the policy or they have no resources to implement the policy."

<div align="right">(DoH HCP)</div>

However, she was not certain if these strengths actually existed in reality, as seen in the statement above. Another reason for this view was that while there were policies laid down by the government for adolescent health in general, no specific policy existed for adolescent maternity health and even when policies do exist, one of the respondents believes that they may in fact contradict one another.

"Many times it really is you know, when you look at policies and you know policies contradicting each other, not talking to each other."

<div align="right">(DoH HCP)</div>

4.3.2.1b Services

Availability of Social Work Services

In the opinion of the hospital based nurse HCP, a strength within the current service with regards to adolescent clients was the referral pathway to the social worker. This did depend on whether the client herself agreed to be seen by the social worker or not; but a social worker was always available for consultation with the client. The medical HCP who was interviewed at the same hospital also mentioned the availability of the social worker as a strength with regards to adolescent maternity services. According to this respondent the social worker carried out the following function:

"The second strength that we have is that when they come to us pregnant, we've got a social worker that speaks to them and they are consulted with a social worker to see what their social circumstances are. Whether their parents know that they are pregnant, whether they have informed them? What is the support structure that they have?"

<div align="right">(Medical HCP)</div>

In addition to exploring the social environment of the adolescent and of her extant

support structures, the nursing HCP planner said that during the interview with the

client, the social worker's main focus was the financial status of the adolescent.

"Financially if there is....if mum and dad, I am talking about mum and dad is working, the social background, siblings at home. Basically if mum, the biological mum of the child is working but we like sort of focus around that. But there is nothing really done for them, excepting well the grant that is available for them. Otherwise there is nothing else. And there is no follow-up for them."

(Nurse HCP)

Social workers would obtain information about whether or not the adolescents'

parents were employed and if she had financial support. The social worker would also

assist the adolescent to apply for a governmental grant, for which she was entitled.

However, respondents felt that there was no actual social work 'follow-up' system in

place.

"Where they just come in, deliver, they haven't had any follow-up or any social work intervention, you know. They just come, deliver and that's it."

(Nurse HCP)

The intervention of the social worker did not go beyond the hospital stay of the client.

Availability of Contraception Services

According to the medical HCP who was interviewed, a strength within the present

maternity services is the availability of contraception.

"The first strength that we have is that we are providing contraception for our adolescent age groups, which is very good."

(Medical HCP)

As part of the postnatal care in the hospital, all clients are seen by the family planning

nurse who comes up from the polyclinic adjacent to the hospital on week days.

"She is from the family planning clinic. She comes up every morning, comes up from about 9 – 12 daily."

(Nurse HCP)

Her job is to help clients decide on an appropriate family planning which can be

followed at home. Over the weekends, this function is carried out by the nurses in the

postnatal ward. They have a stock of contraceptives for clients discharged over the

weekends.

4.3.2.1c Resources

Skilled Health Care Providers

One of the strengths identified by a nurse HCP was the level of skill that health care

providers possess.

"Our strengths in the...I think, we do have advanced midwives, who are able and capable of attending to these adolescents. That is our strength, we do have trained midwives. They are at night and even during the day."

(Nurse HCP)

According to this respondent, the maternity department in the polyclinic that she was

employed in always had midwives on duty who had undergone the post-basic

midwifery programme. These midwives possessed a greater level of skill and

knowledge by virtue of their extra training and education, and, as such, were available

to care for complicated or high-risk clients.

Physical Layout that allowed for privacy in labour

The medical HCP cited the physical layout of the labour ward as a strength within the

present maternity service at the hospital. According to this HCP, the structure allowed

for individual labour rooms. This meant that the woman in labour could be

accompanied by a support person. The room afforded privacy and did not

compromise that of the other labouring women.

"Which is a good support structure that we offer these little girls. But at the same token, we never ever see their boyfriends standing with them. It is only the mother or the sister who is with the patient all the time."

(Doctor HCP)

As can be seen by the comment above, the HCP considered this facility to be

supportive because of its physical layout.

4.3.3 HCP Perceptions of Weaknesses within the Present Maternity Services

In response to the question of whether there were strengths within the present maternity service with regards to the adolescent client, a nurse HCP said:

"Nothing, absolutely nothing. We don't cater for them at all, at all."

(Nurse HCP)

According to this respondent, while there were no identifiable strengths that she could see, there were in fact many weaknesses within the present maternity service when it came to catering for the needs of adolescent maternity clients. Thus analysis of the HCP data revealed one core category with regards to the perceived weaknesses, namely, 'Perceived Unfriendly Care'.

4.3.3.1 Perceived Unfriendly Care

The core category of 'Perceived Unfriendly Care' further revealed three sub-categories with their relevant properties as can be seen from Table 14 below:

Table 14: Sub-categories and Properties of 'Perceived Unfriendly Care'

Core category	Sub-category	Property	Result
Perceived Unfriendly Care	Structure and components of the maternity services	Vertical systems. Deficiency in postnatal care.	Lack of continuity of care. Early detection of problems not possible.
	Resources within the maternity services	Misusing health policies. Staff Shortages. Lack of privacy. Limited access to aspects of the service.	High staff turnover. Inexperienced health care providers. Lack of support to labouring clients. Early detection of problems not possible. More emphasis on curative aspects of health care. Lack of health promotion. Poor pain control during labour and delivery. Services not available 24 hours a day. Poor transportation facilities.
	Characteristics of Health Care Providers	Immature staff. Non-caring attitude. 'Production line' approach. Lacking the necessary skills to render appropriate care.	Inexperienced health care providers. Care lacked compassion. Care lacked empathy. Punishment given as part of care. Judgmental attitudes towards adolescent clients. Missing the opportunity to provide counselling. Excluding significant others from care. Decreasing support systems that may be available to the client.

4.3.3.1a Structure and components of the maternity services

Vertical systems

A weakness that HCPs identified within the maternity service was the vertical manner

in which the antenatal services were rendered, thereby, resulting in a lack of

continuity of care within an individual clinic visit.

"A weakness of antenatal care is that we have broken it down into little components and everybody has their little component you know. If I am in urines today, I stand and test urines today and in the end, nobody actually has seen the women as a holistic person and I think that is bad for the mother..."

(DoH HCP)

As a result, the client did not receive holistic care as she was seen by a different health

care provider for each aspect of antenatal care that she required. This could result in

the health care provider not being able to detect or piece together important

information.

"... but it is doubly bad for the health workers because their work, they can't, they get no gratification from their work. No person to person contact, they have no idea of who they have dealt with and you know the caring just goes out the window."

(DoH HCP)

According to the respondent above, this approach could also result in the health care

providers stagnating and feeling no personal reward. Adolescent clients may also have

difficulty establishing a relationship of trust with health care providers when they are

seen by a different person at each visit.

"So I mustn't come today and be the one who is providing health education and examination, and tomorrow it is somebody else and tomorrow it is somebody else. They do need to sort of have contact with the same people so that they can build that trust, because unless we have got mutual trust, the provider and the consumer, the adolescent girl, they are not going to open up, we won't reach them."

(DoH HCP)

This could result in the client being reluctant to share information, and the problem

going undetected. The consequence of vertical systems would be decreased caring and

less than optimal care given to clients.

Deficiency in Postnatal Care

According to a service HCP, there is a deficiency in postnatal care, not just for

adolescent clients but for all maternity clients. The respondent felt that what was

needed was a proper postnatal service.

"A proper development of the postnatal system because in fact our postnatal system is poorly developed."

(DoH HCP)

Due to the HIV pandemic, many postnatal clients were experiencing fatal

complications during the puerperium.

"The puerperal sepsis has increased dramatically."

"When you look at when the mothers are dying, the mothers are actually dying at the postnatal phase."

(DoH HCP)

A medical HCP who was interviewed felt that adolescent clients in particular needed

more attention during the postnatal period.

"We know the postnatal period is very delicate where a little girl has to take care of a child and when she herself is a child. So it causes a lot of problems."

"So these patients land up having Caesars either for CPD or maternal exhaustion or things like that. The thing that adds to the whole scenario is the fact that these patients after having Caesars, postnatally need more support."

(Medical HCP)

These clients tend to have more obstetric complications, such as anxiety, maternal

fatigue during labour and prolonged labours as a result of cephalo-pelvic

disproportion, resulting in the increased incidence of caesarean sections.

In the present situation, the hospital constantly experiences a shortage of beds.

"The sadness there is when we are pushed for beds, some of these mums are seen up in the labour ward, seen and discharged, sent down to postnatal ward to collect the baby card and the immunization is done and they are sent home."

(Nurse HCP)

Due to the shortage of beds, maternity clients who have no post-delivery

complications, spend a total of six hours in the postnatal or labour ward, and are then

discharged with their babies. For the client who had undergone caesarean sections, the

hospital stay was also short.

"We only keep them for 3 days because of constraints of time, constraints of bed and because of the whole system itself. But we are not in a position to keep these patients for up to 7 days."

(Medical HCP)

The result is that the nursing staff spent almost no time with them. This resulted in no

health education and preparation for parenting taking place.

Inadequate follow-up services

According to the medical HCP, those clients that were from the hospital's referral

areas, could access postnatal follow-up at the hospital.

"So the patients that come from our referral areas, that belong to our referral areas (sic), are seen by us in the postnatal clinic. But those who live in their own communities, we write letters and they go to their own communities."

(Medical HCP)

However, for those clients who lived in other areas not within the hospital's

catchment zone, a letter was written detailing their care during their hospital stay and

they were transferred to a facility closer to their area of residence to commence

postnatal follow-up.

"Really I can't think of a lot of strengths as far as youth is concerned because there's no follow-ups, there's no preparation of this child for motherhood. There is no special attention to what's going to happen to the rest of her life if she left school at 14 or 15."

(DoH HCP)

However, no follow-up system is in place to check whether these clients from

outlying areas actually seek postnatal care. This lack of follow-up also means that

little is done to prepare the adolescent client for motherhood.

4.3.3.1b Resources within the Maternity Services

Misusing health policies

A service HCP felt that one of the weaknesses with the present maternity system was that health care providers did not always use health care policies as they were designed to be used.

"Because we have policies, people simply don't implement the policies. Or people, you know, know that there is policies but they have no idea what's in the policy or what is the implication of the policy or they have no resources to implement the policy."

(DoH HCP)

According to this respondent, there were two causes for this. Firstly, they may not be aware of the existing and appropriate policies. Secondly, if they are aware of the policy, they may not fully understand it or appreciate its value. The respondent attributed these two reactions to the fact that, in her belief, health care providers were often not adequately prepared for changes taking place within the health care system or that they don't understand the thinking behind the change. She gave the example of when the government introduced free health care for women and children:

"It's like free health care for women and children, it was introduced like on Monday we start and nobody knew what was happening. So there was no preparation in saying to health care workers you know, this is the idea, this is what you can do, this how you can make it work. And I think the value of health promotion you know, was never emphasized in any case."

(DoH HCP)

The HCP felt that health care providers had a curative approach to clients when what was needed, was in fact, a health promotive approach.

"I think all of us are very geared towards curative services and we wait for the crisis first, before we respond to it."

(DoH HCP)

The respondent felt that health care providers had a tendency to wait until a problem presents, which they then treat, as opposed to preventing the occurrence of the problem by using health promotion strategies embedded within health care policies.

Shortage of Staff

Staff shortages were cited as a weakness by more than one respondent in the HCP

stakeholder group.

*"The other weakness is the shortage of personnel. We are so short staffed. I
remember in 5 years or 10 years ago, we used to have 21 midwives in our maternity
department. Now we are only running with 14 midwives. There's a lot of shortage and
there's a lot of turn over."*

<div align="right">(Nurse HCP)</div>

"I think that our labour wards are very badly staffed."

<div align="right">(DoH HCP)</div>

Apart from units being short staffed, with fewer health care providers trying to render

care to the client population, staff turn over was also high. This meant that new staff,

were continually being introduced to the unit while older, more experienced staff

were leaving for alternate placements. This served, in effect, to decrease the quality of

care rendered, in the opinion of the respondent.

Another HCP respondent felt that while physical care during labour and delivery was

good, there was a deficiency in the psycho-social care, especially with regards to

support. She put this down to a shortage of nursing staff available to give individual

care to these vulnerable clients, because they were too busy attending to many clients

who were in labour at the same time. She concluded:

"So it's like the birth partner ends up being the registered midwife."

<div align="right">(Nurse HCP)</div>

Unfortunately, not all adolescent clients were accompanied by a support person while

in labour.

"When they come in there is no birth partner with them. It is the saddest thing."

<div align="right">(Nurse HCP)</div>

So, in effect, many of these clients end up having no support during labour and

delivery, apart from the little that the health care provider can provide. This is due to

the client-provider ratio brought on by the staff shortages.

This lack of time with the client resulted in adolescent clients who were particularly at risk, not being detected early enough for something to be done to help them. The HCP respondent gave the example of adolescent clients who abandon their babies.

"We have had like 3 or 4 for this year, where babies have been abandoned, either in the toilets of 7a or left in the crib and our last one was left in the toilet of casualty."

(Nurse HCP)

The respondent in question felt that had there been more health care providers available, these clients would receive closer supervision and care. This in turn will help to identify those who are experiencing problems bonding with their babies and who may be at risk for abandoning their babies. This will prevent a situation as described in her statement above.

Lack of Privacy

Lack of privacy in some settings has been identified as a weakness in the existing maternity service towards creating an adolescent friendly maternity care. A nurse HCP cited a lack of privacy within the service.

"We do have weaknesses, you know because we don't have privacy. If you don't have privacy there is no confidentiality. And because of the space, we cannot even bring the companions in. We have some weaknesses in that we cannot attend to the adolescents without their spouses or boyfriends, or even relatives, because of the space issue."

(Nurse HCP)

The labour ward in the facility being referred to in the statement above was very small, made up of one big room with labour beds separated by curtains. This did not allow for privacy, as the beds were quite close together. The result was that client confidentiality could not always be assured. The other downside to this lack of privacy and space was that clients could not be accompanied by a support person. For one, there was no space for them and they would be in the way, and two, their presence would then compromise the privacy and confidentiality of other labouring

clients. So this lack of privacy compromised the amount of support that labouring

clients could receive from significant others.

Limited Access to Aspects of the Service

A respondent drew attention to the obstetric risk that adolescent clients pose.

"It is a known fact that these patients in labour, majority of them land up having caesarean sections because their pelvises are small, they are not very well developed and they have babies that are pretty huge."

(Medical HCP)

In view of the potential obstetric complications that adolescent clients are predisposed

to, the medical HCP listed the lack of epidural services as a weakness in terms of

adolescent maternity care.

"The disadvantages is that we do not offer epidural services because we are a district level hospital. So we don't have that facility with us but we do have sedation that we give these patients in labour."

(Medical HCP)

While other methods of pain relief and sedation were available, epidural services were

not. The result was that pain could not be adequately controlled for this category of

client who entered labour already very afraid, with added physical disadvantages, due

to their bodies being immature.

Another perceived weakness within the present maternity service was noted when it

came to delivery services.

"For delivery, I think that perhaps the situation isn't as good. Mostly because we don't have very good 24 hour systems. And where we do have good 24 hour systems, we don't have very good transport between them and receiving hospital. So if something does go wrong and an adolescent might be more likely to have a Caesarean, then obviously we will be in trouble."

(DoH HCP)

So, while the services did exist, not all aspects of care were available 24 hours a day.

So, access to them was limited, with clients having to travel to other facilities

especially for delivery services. Transport between peripheral services and the bigger

referral hospitals was not efficient. This made accessing services difficult and as seen

from information given earlier, it is a known fact that adolescent maternity clients are

more at risk for complications during labour and delivery, and may require transfer to

the referral hospital for operative procedures such as Caesarean sections. This lack of

transport predisposed these adolescent clients to poorer outcomes.

4.3.3.1c Characteristics of Health Care Providers

Immaturity of the health care provider

One of the respondent felt that the shortage of experienced health care providers

resulted in maternity units being staffed with inexperienced young nurses.

"We've got very, very immature midwives. I mean these are girls that are 21, 22. The bulk, I'm being quite honest, ... There's no compassion at all. They would be told, 'in the first place why did you open your legs? You should have known what you were doing.' Secondly is, 'don't call for me, call for the one who made you pregnant'. And even as far as smacking them on their thighs."

(Nurse HCP)

The effect of this type of staff behaviour was that care tended to lack compassion and

empathy. The HCP also commented that the ages of the medical interns were no

better than that of new qualified nurses.

"And of course on the other hand we have got a lot of young interns, very, very young, 22, 23."

(Nurse HCP)

As such, she felt that they were also immature and lacking in valuable life experience,

which could aid them in rendering optimal care to adolescent maternity clients.

Lack of compassion

Tied to the concept of lacking compassion and immaturity was that health care

providers sometimes passed information relating to the client's behaviour from one to

another.

"If that patient walks into the admission room, whatever the outcome is in the admission room and maybe they might have had a problem with the relative or with the patient. That information is also passed on to the next who is going to take over."

(Nurse HCP)

As a result, health care providers may ill treat clients based on information from a colleague, and not in response to an actual encounter that they themselves had with the client.

Another component of lacking compassion was the need to punish adolescent clients for falling pregnant.

"I think you know, although many of our nurses were adolescent mothers themselves, there is this little hidden thing that you need to give a little punishment every now and again, or a little moral chat. Or just by my non-verbal... show you that it is not alright to be pregnant at 16. You know it is just those kinds of things and how we get rid of them, I don't know."

(DoH HCP)

According to the above respondent, health care providers dealt out punishment either verbally or non-verbally to adolescent clients, letting them know that they were opposed to them being pregnant. The respondent felt that this should not be the case and something needed to be done to stop health care providers reacting in this manner towards adolescent clients.

It was also felt that health care providers apart from meting out punishment to adolescent clients, also had a tendency of pre-judging them.

"We seem to pre-judge them, as health workers."

(Nurse HCP)

This lack of compassion, coupled with meting out punishment and being judgmental, contributed to adolescents not using the maternity services.

Production Line

Another evident weakness that HCPs reported was the 'production line' nature of care

that can sometimes occur.

"It's just that there is not much time spent as far as the medical staff is concerned
because it is also like a production line."

(Nurse HCP)

A respondent noted that this was especially relevant to the way in which some of the

medical staff conducted their consultations. She described the care as follows:

"Hello, how are you, is baby moving, stick out your tongue, have you got enough iron
tablets, okay you can go, next."

(Nurse HCP)

This approach meant that the onus was on the client to report any problems, should

they occur, and, if not reported, could result in many problems going undetected with

dire consequences.

A respondent felt that health care providers were not approaching the situation with

the correct mindset.

"I think what people also don't understand, if you render a quality service in the first
place, clients will not come back with a problem that was not addressed the first visit.
So you actually save on man hours in the end if you do quality work."

(DoH HCP)

The respondent felt that if health care providers handled the situation properly during

the first contact with the client, allowing adequate time for a full examination and

proper interview, many problems would be resolved and the client would have the

necessary information to take care of herself. As a result, the number of repeat visits,

dealing with complaints, would decrease.

According to respondents, this 'production line' approach also resulted in a missed

opportunity to conduct health education with clients.

"So it's a situation were you've come, I have done what I have to do, and move on.
There is no counselling, there is no proper antenatal care given."

(Nurse HCP)

"You can walk into whatever antenatal clinic you like, there is very little education going on. It's more become sausage machine kind of stuff."

(DoH HCP)

There is diminished dialogue between client and health care provider, with little or no

opportunity to give health education.

Lacking skills necessary to render appropriate care

One of the weaknesses within the present maternity service with regards to adolescent

clients is that health care providers are reported to be missing the opportunity to

counsel these clients when they commence antenatal care.

"A young woman has just had her first child, yes she might only be 17, but there is important reproductive issues that we need to discuss with her. I don't think that we have particularly a lot of skill to be able to handle that kind of counselling. Yes, I think it is a golden opportunity that we miss."

(DoH HCP)

The respondent felt than once the adolescents access the health care system, every

effort should be made to counsel them on reproductive issues such as sexually

transmitted infections and repeat pregnancies.

"I am not sure if our community health workers are trained adequately to look at the special needs of a woman who has given birth."

(DoH HCP)

However, this opportunity is being neglected, with health care providers failing to

provide the necessary counselling. The respondent felt that this oversight was due to

the lack of appropriate training and skills amongst health care providers.

Reluctance of HCps to allow AMCs to be accompanied by boyfriends

One of the weaknesses identified within the present maternity system was the

reluctance of health care providers to allow adolescent maternity clients to be

accompanied by their boyfriends. According to one of the HCP respondents, there

appeared to be reluctance amongst health care providers to allow the adolescent client to be accompanied by her boyfriend to the antenatal clinic or for the birth of the child.

"But I certainly think in terms of the health service there is a great reluctance. It is fine for the girl to have her mum, but it is not fine for the boyfriend to be there."

(DoH HCP)

While the health care providers did not mind the adolescent's mother accompanying her, they did seem to mind the presence of the boyfriend, conveying a judgmental attitude in this preference. A service HCP felt that this issue should be addressed.

"If we are thinking about creating a family, then maybe that is actually the way to go, to have the father beside the mother and to make sure that the father also bonds to the child for continued care throughout the child's life."

(DoH HCP)

According to the respondent, health care providers had a duty to help foster good relationships between family members. Keeping the father of the baby away would interfere with bonding between him and his child, and with his ability to support his partner. Thus it is imperative to include the father of the baby in the care that is given, whenever possible.

Another respondent confirmed this belief that health care providers were responsible for discouraging the involvement of significant others in the care. The respondent related the following anecdote about her experience of young men sitting in the waiting room at a family planning clinic:

"So I asked them, 'are you here for information, or are you here to collect anything or are you here with somebody?' And they said, no they actually came with their girlfriends. So I couldn't believe it you know and I said, 'I am so impressed actually with them, but why you sitting here, where are they?' And they said no, they are in the consultation rooms. So, you know to me it was very sad because I asked them why, you coming with them to the clinic, you should be in there to listen, you know. And they said, no the sister said they must wait outside. You know so to me the whole idea going to the clinic, that they are willing to accept responsibility and that the health care staff then separated the two."

(DoH HCP)

The respondent felt that capacity building towards an adolescent-friendly service would need to encompass changing the attitudes of health care providers, enabling significant others to play a fuller role in the care of the adolescent client.

4.3.4 HCP Suggestions for Improvements towards Adolescent-friendly Maternity Services

Health care planners had many suggestions on how to improve the current maternity services so that they may become adolescent-friendly. Hence the core category that emerged was 'Constituents of Friendly Care'.

4.3.4.1 Constituents of Friendly Care

This core category was further analysed and divided into its sub-categories, with their relevant properties. However, to assist in concretizing friendly care, strategies that HCPs recommended were also extracted from the data. These are presented in Table 15 below.

Table 15: Sub-categories, Properties and Strategies related to HCP 'Constituents of Friendly Care'

Core category	Sub-category	Property	Strategies
Constituents of Friendly Care	Capacity Building	Raising awareness. Changing attitudes.	Retraining health care providers in an adolescent-friendly approach to care. Include communities in all ventures.
		Putting systems in place.	Improve communications between services. Selecting people who are adolescent-friendly to fill positions at all levels in the service. Educating health care providers on applicable policies and how to use them effectively.
		Midwifery and Medical Curricula	Strengthening adolescent components within current curricula. Providing more opportunities for working with adolescent clients. Post-basic programmes focussing on adolescent care.

	Services	Separate services	Provide specific care. Provide specific health education. Approached as 'high-risk' clients.
		Continuity of care	Seen by the same health care provider Establish health care provider-client rapport. Enhance feeling of confidence within adolescent.
		Fostering support systems	Help client to identify support person. Include support person in the care. Include the family in the care. Initiate peer support programmes.
		Postnatal Care & Long-term follow-up	Extending postnatal stay. Training community health workers t provide follow-up. Extending care to put more emphasis on the woman. Need constant follow-up whenever they access health care.
		Health Education and Counselling services	Health education should cater to the specific needs of adolescent clients. Counselling services to be part of the long-term follow-up system. It should be presented in a way that is attractive to adolescent clients.
	Health Care Providers	Knowledgeable	Understand the client. Be able to cater for the client's specific needs.
		Attitude of caring	Be approachable. Show compassion. Be nurturing. Instil trust. Be empathetic.
		Communication skills	Good listener. Be able to read unspoken cues. Use positive body language. Use non-judgmental tone. Keep information at appropriate level for client.

4.3.4.1a Capacity Building

Raising Awareness and Changing attitudes

A respondent felt strongly that in order for an adolescent-friendly approach to be

successful, capacity building had to take place amongst all levels of people who

would be involved in caring for and supporting these adolescents.

"I think to raise awareness of the issue, I think this is where to start."
(DoH HCP)

*"Because if she has got a friend, she has got an aunt, any trusted body in her
community, somebody she trusts in the family, she must be given, you know, that
opportunity to bring that person."*
(DoH HCP)

Raising community awareness was also seen as potentially increasing support to

adolescent clients. Another respondent felt in the present situation most health care

providers did not truly understand this type of client and their special needs. To some

of the care providers:

"If they are pregnant, they're a pregnant person, they are not a teenager."
(DoH HCP)

The adolescent clients were being seen as part of the general client population and

their needs were being satisfied in the same way.

Another aspect of capacity was the need to retrain existing health care providers, so

that they would become acclimatized to the idea of adolescent-friendly care.

*"You know we need to have more value clarification training so that we don't impose
out own values to these adolescents. I mean, some got pregnant not of their choice,
but as woman we just go and bomb and bomb, making the child feel more guilty. And
at the end she cannot cope up with the child after the delivery. So we need to have
retraining, reorientation, reinforcement about the adolescent care to our health
professionals."*
(Nurse HCP)

The respondent felt that health care providers may require more current training and

education that was specific to the adolescent client, so that they would be able to

understand this category of client better and therefore be able to render more appropriate care.

"Our attitudes I mean, they do play a role in the care of the adolescents."

(Nurse HCP)

This re-education would help to change the attitudes of health care providers towards adolescent clients, which, if not changed, had the potential to negatively influence the interaction between client and health care provider. The respondent also felt that this re-education should include all members of the health care team, who may come into contact with the adolescent client at some point, to ensure a consistent adolescent-friendly approach.

To bring about a change in attitudes, respondents felt that the health care provider needed to understand this category of client well.

"You know I think another thing which needs to be addressed, the health care providers, the majority of us are from that group, you know, of the group who have been brought up culturally of....in that environment of being submissive, and take what you are given, yours is to, do and die, not reason why. And now we are serving a changing society. Our children for instance now are beginning to question each and everything that is said to them, they see."

(DoH HCP)

According to the respondent in the above statement, a generation gap existed between the client and the health care provider. Misunderstanding between the two were fuelled by being raised with a different mindset. The respondent felt that many health care providers had been raised in an environment where they were passive, following orders and instructions laid down by adults. However, adolescents today were being taught to question things and, as a result, were more assertive. The respondent saw this as having the potential for a disharmonious relationship.

Raising awareness among the community was essential for an adolescent-friendly service to be successful.

"But I think society needs to be taken with us in this and I think it cannot happen without an outreach component, where you also actually change the attitudes of society."

(DoH HCP)

After all adolescents clients came from these very communities, and on discharge

would be returning to these communities.

"Because these young people will go home with their children and if we only change the health care system, nothing will change... they go back to the very same community with the same judgments and non-support. Nothing will really change."

(DoH HCP)

To achieve continuity of care and support for these adolescents and to assist with long

term follow-up, the entire community would need to be educated and be part of

helping these adolescents back onto their feet. Included in the community are the

health care providers, who often hail from the communities for which they care.

Putting Systems in Place

A respondent felt that nothing new needed to be put in place. At present the health

care system what was needed to render adolescent-friendly maternity services.

"We're talking about communication systems, follow-up systems, consultation if you consult, how to give feedback, so that kind of feedback system, communication system, should be set up."

(DoH HCP)

However, she felt that the communication systems between existing services needed

to be improved in order that continuous and effective care is given. To assist with this,

it was suggested that there should be someone to coordinate this endeavour.

"There should be definitely a person to coordinate it, so if it's implemented in an institution, there should be a driver of this process to coordinate it in the hospital itself, in the institution. And this person should be able to also then link with the community person doing community health."

(DoH HCP)

This individual could then see the system as a whole and rectify possible glitches that

could not be seen at individual or site level.

Apart from a person to coordinate the programme, appropriate people who are already in agreement with the philosophy of an adolescent-friendly endeavour need to be selected for management positions.

"I think put in place the management understanding the need for that, because I think without that it would never work. I think once that is done, I think there needs to be a system conducive to developing beyond the maternity ward."

(DoH HCP)

It was also felt that any system that is put in place should not stand alone with the focus only on maternity care. That care should go beyond labour and delivery service and the adolescent-friendly maternity programme be linked to other existing programmes, thereby, giving continuous care and support to the adolescent and her baby, long after discharge from the hospital.

Another aspect to look at are the policies that govern practice. According to the respondent, often there are policies in place but people in the service do not follow them, either because they are not convinced of what the policy proposes or they are in fact unaware that the policy exists.

"I think you know people developing policies, really don't look at ways, how to integrate so that one policy can speak to the whole range of services for that."

(DoH HCP)

It was suggested that when health care planners were developing policies, an attempt should be made to see what is currently in place and how the new policy fits within the present system, as sometimes policies may contradict one another, making it difficult for health care providers to implement them.

Midwifery and Medical Curricula

All health care planners interviewed felt that while adolescent health care was

addressed in the curriculum of nursing and medical pre-service programmes, not

enough emphasis was given to it.

"You know there is no emphasis on that you might have the very young client and you might have the very old client. Both really at risk and they need special care."

(DoH HCP)

"Yes, in the curriculum, putting emphasis on, in fact all the age groups. But pay more specific to the adolescents because they are still growing. If they are not growing up nicely or healthy, we won't have good communities."

(Nurse HCP)

"I think it would be better and I don't think they have much periods, you know in college to do with the adolescent. I don't think there is much there at all."

(Nurse HCP)

The result was that the health care providers did not come away from the programme

with an understanding of the unique needs of such a client and therefore, were unable

to care for this particular client holistically.

Respondents felt that medical and nursing curricula focused on the adolescent clients

in terms of them being high risk clients and on preparation for complications. Health

care providers were not adequately trained in how to deal with normal adolescent

maternity clients. A respondent felt that while many adolescent clients were high-risk

and ended having many obstetric complications, many also had no problems during

pregnancy, labour and delivery.

"The curriculum touches the adolescents in as far as high risk pregnancies, but not all of them are high risk. Yes they are high risk by virtue of their age but there is a normal adolescent pregnancy that we need to sort of look at the emotional side of it."

(DoH HCP)

The emotional side of getting pregnant and having a baby was very neglected in the

education and training of health care providers.

"You know, and life skills, not in terms only of this pregnancy, but look once she gets pregnant, her life will never be the same. She has to prepare herself now for this new phase of herself, because even if that baby, even if she loses that baby, still she wouldn't be the same, nulliparous women."

(DoH HCP)

Therefore, the curricula should have a more holistic approach and also include how to care for the normal adolescent maternity client who is free of obstetric complications, but who will definitely have many life changes with which to cope.

Need for specialised training on adolescent maternity care

The expected outcome of nursing education programmes was thought to be a contributing factor to the inadequate preparation that health care providers receive with regards to adolescent clients.

"You know because we are trained as generalists, I think you know that we all come out, although we come up with a yellow bar, a green bar, but in actual fact they train us as generalists."

(DoH HCP)

"I don't think they have much periods, you know in college to do with the adolescent. I don't think there is much there at all."

(Nurse HCP)

A respondent felt that at present nursing curricula trained generalists and while it may be necessary to increase the emphasis on the adolescent clients, it may be more appropriate to have specific training for those working with adolescent clients at a post-basic level.

In a bid to strengthen the extant training programmes, a respondent suggested that opportunities should be created within the clinical training of student nurses to work with the adolescent clients - such as involving student nurses in programmes for adolescent maternity clients in the afternoons when the routine ward or clinic work was finished.

"The other thing, you know it is only on a Tuesday that the student midwives stay in the antenatal clinic, because of the classes. And instead of bringing them up to work in the wards, they can also help, you know if we do have this adolescent clinic open."

(Nurse HCP)

Both the clients and the student nurses would benefit from this interaction. The

adolescent clients because they would get more individual attention and the student

nurses, who would be inculcated with a client-centred approach and be more effective

in their ability to care for the adolescent clients' individual needs when they returned

as registered midwives.

One of the HCP respondents felt that a solution would be to develop a programme to

train nurses to work specifically with adolescent clients, since the regular education

and training curricula did not cater for this category of client. She also suggested that

the programme be hospital-based, so that it would have more meaning in the clinical

setting.

"Hospital based because when we looked at the curriculum, I am just giving you an example, for the Kangaroo mother care and we thought we would like incorporate it and we went down, we sat with the college staff. But when they come out of block and you ask them anything about the KMC programme, they know nothing."

(Nurse HCP)

In her opinion, in the past, when certain aspects of care, (and she gave the example of

Kangaroo care) were included in the curriculum at college, student nurses still did not

appear to have the necessary knowledge and skills when put into the ward situation.

Running the programme at the hospital for nurses, who work specifically with

adolescent clients, will help strengthen and add onto whatever knowledge with which

the nurse qualifies.

4.3.4.1b Services

Separate Services

Respondents were ambiguous about whether a separate service should be created for

adolescent clients. A service provider felt that in an ideal world, there should be

separate maternity services for adolescent clients.

"I think our total lack of resources, including physical and human resources just
simply, you know it will never be possible."

(DoH HCP)

However, realistically this was not possible within the present South African context

of large populations and poor resources. The respondent felt that the existing systems

should be made more 'client-friendly' or 'youth-friendly'. Another respondent

concurred with this idea, stating, firstly, the lack of physical space as a reason for it

not being possible to provide a separate and specific service for adolescent clients.

"But I think that the main reason being the physical structure of many of our
facilities. We haven't got space where we can say we will divide them and put them in
such and such a way in this corner and serve them from that corner, separately from
these."

(DoH HCP)

Secondly, the respondent stated that the way in which the service was provided

prevented adolescent clients from being seen separately because clients used the

service on a daily basis, irrespective of special circumstances or considerations.

"If we say first visits, it is first visits regardless of age or parity. As long as they are
coming for the first time to our service, then we all group them together."

(DoH HCP)

The respondent was also not sure that separating the adolescent client from the rest of

the client population would be a good idea, even if resources were available to do so.

"On the other hand, because if you do that, you say, you come in the morning, you
come in the afternoon, you still separating people and you still develop this divide
between giving support to these young people, give them role models to learn from."

(DoH HCP)

This respondent felt that adolescent clients could benefit from interaction with adult

clients by receiving support and having role models to emulate. Another respondent

raised the issue of stigmatization that may result if adolescent clients were separated.

"The other thing, I don't know if it will be stigmatization or what, but it will be better if we have special days for this, at least even if it's only one day. Special day for the adolescent. That we can see them at least and see their problems and focus on them."

(Nurse HCP)

But the respondent still appeared to hold the view that these clients did in fact need

special attention.

Another respondent made a case for separate services, based on the educational needs

of adolescent clients.

"Our programme should accommodate them and I think we can only say we are adolescent-friendly if we do not mix them with the adult women. They must be, they must have, you know, their own time schedule and the information given to them, should be information that is relevant."

(DoH HCP)

The respondent felt that combining adolescents with adult clients often meant that

their health education needs were not attended to.

"You know, I will give you an example, when we are giving health education, you know, we usually talk in general and we usually talk in general, we usually talk about when you bleed you come right, those are the things that are okay for all the mothers, the danger signs are applicable to anybody. But now when you reflect, when your health education is reflecting previous experiences of the client. They haven't got experiences as far as child birth is concerned."

(DoH HCP)

Therefore, health education should be tailored to meet the specific needs, as well as

cognitive processing of the adolescent client, recognizing that they have no previous

experience and that all that is happening to them is totally new. Thus the focus of

health education should be to build experience, as opposed to reflecting on past

experiences, that they do not have by virtue of their immaturity and lifespan.

While it was not feasible to physically separate adolescent clients from other clients, a medical HCP felt that these clients should be seen and dealt with as a category on their own.

"They are not the kind of patients that we say fall under the normal reproductive age group. You take it physically, you take it mentally, you take it psychologically, you got to cater for them separately."

"Well I think to have a separate service for them would be asking a bit too much of the government and it can be incorporated in the maternity services. But you obviously have to treat them different, as in fact I would probably treat them as high risk patients."

<div align="right">(Medical HCP)</div>

It would be a mistake to consider them as part of the general reproductive health population that accessed the maternity services. The first step in catering for them separately would be to categorize them as 'high risk' clients and approach them as such.

"So I think the doctor has to have some kind of capabilities of handling these high risk patients."

<div align="right">(Medical HCP)</div>

In the opinion of the medical HCP, all doctors working in the maternity department should be trained to identify and manage 'high risk' clients.

Continuity of Care

Respondents felt that continuity of care needed to be improved for the maternity service to be adolescent-friendly. The present system meant that there was no special service for adolescent clients as seen in the information presented below.

"So I mustn't come today and be the one who is providing health education and examination, and tomorrow it is somebody else. They do need to sort of have contact with the same people so that they can build that trust, because unless we have got mutual trust, the provider and the consumer, the adolescent girl, they are not going to open up, we won't reach them."

<div align="right">(DoH HCP)</div>

Adolescent clients used the same service as their adult counterparts. This was a busy service with many clients and a shortage of health care providers. As a result clients

were seen by different care providers at each visit, making it difficult for health care

providers and clients to establish and maintain a relationship.

"They will sit there and listen to you and not even respond and all that, they just shut up."

<div align="right">(DoH HCP)</div>

The respondent felt that this rapport was essential to caring for these vulnerable

clients, as they tend to be 'closed up', and do not respond to what is said or done to

them. Therefore, one cannot gauge how effective care has been, and what needs to be

done to either enhance the strategy or rectify it.

Another respondent gave the example of her facility where they were trying to initiate

a youth programme.

"She (referring to the health care provider) is the only one, she sees all the adolescents."

<div align="right">(Nurse HCP)</div>

The initiative was still in its infancy, but the idea was to have one health care provider

who was responsible for adolescent clients. This would mean that at each visit the

adolescents would see the same health care provider, ensuring continuity of care. This

would also enhance the client-health provider relationship.

"Well like I said the continuity because if it's going to start out in antenatal clinic by the time she gets to postnatal, she is confident enough and she can go out there."

<div align="right">(Nurse HCP)</div>

As a result the client will develop more confidence in her ability to care for herself

and her baby, and therefore, on discharge would be more prepared for her parenting

role.

Fostering Support Systems

A service respondent felt that one of the first things that should be done for an

adolescent client who is seeking maternity care is for the health care providers to sit

down with her and determine what support systems she currently has in place and who provides the support to her.

"... we need not prescribe who this person should be. "

(DoH HCP)

Respondents also felt that health care providers should not choose the support person, but simply help the client to identify the appropriate person, with the final decision resting with the client herself.

Once the support person has been identified by the client, she should be encouraged to bring this individual with her to all her consultations so that this support could be formalised and strengthened.

"Because if she has got a friend, she has got an aunt, any trusted body in her community, somebody she trusts in the family, she must be given, you know, that opportunity to bring that person. That person, when we empower that teenager, we also empower that person to look after her, you know, to provide support. "

(DoH HCP)

This empowering of the support person would also mean that this individual could give ongoing support to the adolescent, beyond the contact with the health care system, not to mention to other members of the community who could benefit from the knowledge and skills with which this person has been empowered.

Apart from identifying an individual to provide support, respondents also felt that efforts should also be made to include the family of the adolescent.

"We do not leave the family behind, we need to bring the family in. So this is very important for an adolescent because the family will be her strong support in it, ya. So we cannot afford not to empower the family. "

(DoH HCP)

"I mean the antenatal care, I don't know how can we bring about, even the mothers, their mothers from home, to come, the parents to be part and parcel of the programme. "

(Nurse HCP)

"...the best way of providing humanized childbirth is also to provide a family orientated maternity service."

<div align="right">(DoH HCP)</div>

The respondent felt that parents, especially the mothers of these adolescent client would play a pivotal role in offering support throughout the pregnancy and once the baby was born. In an effort to 'humanize' childbirth, it is necessary to provide a 'family orientated maternity service'. This will help the family cope with the crisis situation that the adolescent pregnancy may have thrown them into, and help to foster ongoing support amongst family members.

Special mention was also made of how to improve intra-partum support.

"The one thing I would say for intra-partum care, I would make sure that no adolescent ever entered labour by herself. That there was always a birthing companion, either her mother, the boy in her life, some kind of care giver. Because the midwives are just not able to give the back rubbing, sipping of little hot bits of tea, they are not able to give that."

<div align="right">(DoH HCP)</div>

The respondent felt that adolescent clients need to have someone with them during labour and delivery, to give them some support and extra care. Being alone with the midwife was not enough since the respondent felt that the midwives were not able to provide this extra bit of support. When asked why this was so, the respondent offered staff shortages as the reason.

"I think that our labour wards are very badly staffed."

<div align="right">(DoH HCP)</div>

Another suggestion for increasing support to adolescent clients was to use this opportunity to train them to give support to others in a similar situation in the future.

"Okay, postnatal. I wish, you know there is a programme called 'M to M', mothers to mothers to be, that is what it is called and that, especially for HIV but I think it could work for adolescents as well. That HIV positive mother who has gone through the whole HIV thing and the Nevirapine thing, choosing to breastfeed or to formula feed, all that kind of thing and be supported by somebody for the first year of her baby's life, either to correctly formula feed or to exclusively breastfeed and she comes out of that and basically the baby is then checked at one year, positive or negative, it doesn't

make a difference. She then is given a mentoring job to take somebody else and I think you could probably do that with adolescents."

<div align="right">(DoH HCP)</div>

At present there is a programme called 'mothers to mother to be', whereby HIV positive clients receive long-term follow-up postnatally. The respondent felt that this idea could be adapted towards the needs of the adolescent client, who would then receive support, so that she was better able to care for herself and her baby. The same adolescent could then be trained to give support to other adolescents who were in a similar position, thereby creating a system of peer support. However, the respondent identified a possible flaw with this suggestion, in that adolescents may not have time available to carry out this task.

"One has to remember that adolescents are very busy and they are too busy to help anybody else. Maybe, we could use the same concept with maybe a young adult. You know an under 30 year old to go through that adolescent in pregnancy and if she doesn't have a birthing companion, then that could be the person who stays with her."

<div align="right">(DoH HCP)</div>

So the concept can be refined to get a young adult, who had previously delivered, to carry out this role of being a support person.

Postnatal Care and Long-term follow-up

Many respondents felt that postnatal follow-up was inadequate. One of the first suggestions for improvement was to increase the postnatal stay within the health care facilities from the present six hours.

"Like we felt even if they stayed for 48 hours, you know, so at least we have touched bases with them."

<div align="right">(Nurse HCP)</div>

A HCP respondent suggested that this time period should be extended to at least forty-eight hours post-delivery.

"I mean you are not even doing that height of fundus anymore, you barely just rubbing up that fundus, you know there is just no time spent with these youngsters."

<div align="right">(Nurse HCP)</div>

This would give the nursing and medical staff the opportunity to give appropriate and much needed health education. The other benefit would be that this would also give the health care providers more time to observe the client and her baby, so that actual and potential problems could be detected early and interventions commenced to rectify the situation.

HCP respondents also felt that postnatal care should continue after discharge from the health care facility and should involve members of the community from the adolescent hailed, especially older people.

"But use this opportunity, you know to make young people learn from the older people, and learn to....you know Ubuntu (spirit of sharing) is not there anymore."
(DoH HCP)

The respondent felt that these clients could benefit from the life experience of older members of the community.

"But it will be somebody popping in, you know, saying "how are you doing with your baby"."
(DoH HCP)

She felt that there were many people in the community who would be willing to be part of this endeavour and who could be trained to carry out this important supportive role. Hence people from the community could be trained as community health workers.

"They could go in, the community health workers for instance, they could go in and be retrained how to help them with the breastfeeding."

"Yes, especially breastfeeding and re-educating them on oral rehydration, these small things you know. Because the little ones are really battling."
(Nurse HCP)

These community health workers could provide assistance with breastfeeding during the postnatal period and conduct health education on how to deal with minor disorders so that problems could be averted.

A respondent had the following vision of what an effective postnatal follow-up system should be:

"The first thing is to put a policy in, which is a lot of work, but anyway it does need to be done. We want to go for 6 hours, 6 days, 6 weeks, so that the mum and the baby need to be seen by some health worker and in some of that instance it would have to be the community heath worker, if she has had to go home before the 6 hours has occurred and to check, just very salient things. And then 6 days, it doesn't have to be precisely 6 days, just sort of goes nicely if you talk about 6's. Then between 7, maybe 7ᵗʰ day, at least within that first week that she is seen, that the baby is reassessed, feeding is assessed, that the mother's discharge is reassessed and involution of the uterus is going, and that at least the mother has her temperature and pulse taken, to make sure that we aren't looking at any infectious processes. Then again at 6 weeks, again going for sexual information, reproductive control or family planning, whatever you want to call it."

(DoH HCP)

The feeling from the respondent was that currently, the six week postnatal check-up is focusing on the baby, and the woman is being left out. Hence any effective postnatal follow-up system should focus on the health and wellbeing of both the mother and the baby.

A service HCP felt that a weakness within the present maternity service is the lack of long-term follow-up.

"There's no follow-ups, there's no preparation of this child for motherhood. There is no special attention to what's going to happen to the rest of her life if she left school at 14 or 15. What's going to happen to the rest of her life, you know because she is going to have to balance her education, motherhood, relationships, all of that and nobody cares about that, and I think that's why many of them drop out."

(DoH HCP)

The HCP saw the potential role that the health care provider could play in assisting the adolescent make the transition to being a parent, as well as continue on her life's path.

Another idea introduced by a service HCP was the idea of continuous follow-up of the adolescent mother and her child, irrespective of which component of the health system they accessed.

"Yes, exactly and say you know, these were the issues that this patient came in with, this 15 year old. Please at her 6 week follow up, follow-up on a,b,c. You know and from the 6 weeks postnatal, to then go to the well baby clinic and to say, you know, watch out for this. To go to, you know, the community health component and to say, you know when you do IMCI, when you do a community component, watch out, you know I have so many teenagers or older women or whatever the case may be with young children."

(DoH HCP)

This would mean that health care providers working in the different components would need contact with one another for this to work. Once the adolescent is discharged with her baby from the hospital, the health care providers there would need to get in touch with those working at the community clinic that this adolescent is going to attend care be it for her postnatal check-up, contraceptive services or immunization for her baby. At each visit the health care provider attending to her, should remember that she is an adolescent mother and during the consultation make an effort to find out how she is coping.

Health Education and Counselling services

Respondents saw adolescent clients as having very different health education needs compared to adult maternity clients. As such, health education should be tailored to cater for these special needs.

"So they go through this whole phase being treated as just another client. So they are coupled with the adult client. And like I said you know, it's a big shock for these young people to realize that they are not a woman. They really still a child and nobody is reminding them of that. And in a kind way, you know not reprimanding them or moralizing about it. But you know explaining to them, exactly about development and pregnancy, you know and the risks they put themselves through. So I think there is a lot of emphasis on the moral side of being sexually active before marriage, and not so much on the physical risks you take as far as development. You know so, people are not balancing the information and I think this is why young people is (sic) also not very open to what happen, even during delivery."

Health education should focus on explaining to clients what is happening to their bodies and how to prepare themselves for their parenting role, rather than sermonising and moralizing on sex before marriage.

As part of long-term follow-up services, it was felt that there is a need to have a counselling service available to adolescent clients, so that they may receive advice and counselling on reproductive issues.

"I don't particularly think it has to be a professional nurse. We have lots of lay counsellors for VCT (refers to voluntary counselling and testing) now."

According to the respondent above, this position of counsellor need not be filled by a registered nurse. Instead it could be a lay person who has been trained for the task, as is done with HIV counsellors who attend to the issue of voluntary counselling and testing (VCT) within the community. Another respondent concurred with the idea of having a trained counsellor available to the adolescent clients.

" Probably the first thing that I would do is make sure that there was one provider that was a very good counsellor available for adolescents. I think that our health information isn't particularly understandable for adolescents and I think it need to be portrayed in a much more fun, sort of funky way for them to catch on. You know, that kind of stuff. I think that the health education that does occur which is very little is too one sided for adolescents, then they get bored, then they don't actually listen to it."

The function of this counsellor would be to make the health education more appealing to the adolescent client, by delivering it in a more understandable and fun way. The respondent felt that education within the maternity services did not cater specifically for this category of client and tended to be more adult oriented, resulting in adolescents becoming bored and not taking in the information that is given.

4.3.4.1c Characteristics of Health Care Providers

Knowledgeable

There were certain characteristics that HCPs considered essential for health care

providers working with adolescent clients.

"The most important thing, she must have more knowledge about the adolescents themselves. Their plight, the fact that they are immature, physical problems, their psychological problems, the peer pressure they are having outside. She must be knowledgeable and have an insight on that."

<div align="right">(Nurse HCP)</div>

An effective health care provider is one who understands the client with whom she is

dealing. If the health care provider is able to understand the developmental stage of

the clients and how this might affect them, then he or she would be more equipped to

assess them and identify actual and potential problems that need to be addressed.

"So I think the doctor has to have some kind of capabilities of handling these high risk patients."

<div align="right">(Medical HCP)</div>

This also included the knowledge to deal with high-risk maternity clients, since

adolescent clients fall into this category.

Attitude of Caring

In the opinion of one of the respondents, adolescent clients entered into the situation

already scared.

"They've already closed up, they are scared and I think that they would just go that whole process, not even talking or saying anything."

<div align="right">(Nurse HCP)</div>

She felt strongly that the reception the nurses gave them was essential in allaying their

anxiety and allowing them to open up and make them easier to care for them. As such,

health care providers need to be people with whom adolescent clients feel

comfortable.

"She must be a person who is approachable. She must not just be high up there so that the adolescents cannot reach."

(Nurse HCP)

"Compassionate, they need to be compassionate."

(Nurse HCP)

The health care provider should also demonstrate compassion when dealing with

adolescent clients. One of the respondents felt that the health care provider needed to

convey a maternal attitude, which would convey caring and compassion to adolescent

clients.

"If I had to choose people, I would be looking at the motherly type of person, because that is what these clients need."

(Nurse HCP)

Part of feeling comfortable with the health care provider was the issue of trust.

"They must be able to give of their time."

(Nurse HCP)

Adolescent clients should be able to relate with the health care providers and feel free

to approach them with their problems or needs.

"She must be honest. Maintain confidentiality and privacy as well. They must be able to trust her."

(Nurse HCP)

If the health care provider demonstrated honesty when dealing with adolescent clients,

they would be more inclined to trust him or her and this would contribute towards the

development of good rapport.

"I think a health care provider serving adolescents must be somebody who is flexible, who is able to get out of her shoes into the shoes of the adolescent and understand them. You know, because they are there with fear, as I said and they are ready to protect themselves from whatever is hurting them. So we need to have a provider who cares for the adolescents, should have love in the first place, warmth and she must be approachable. They must be able to approach you and ask questions and you must exhibit a relationship of trust."

(DoH HCP)

If adolescent clients felt that health care providers understood them and empathised

with them, they would be more inclined to trust the health care provider. As such the

health care provider should be perceived as 'flexible' and 'approachable', so that

clients would feel safe with him or her.

Dealing with the client in a holistic manner, would also convey an attitude of caring.

"Treating the patient holistically. Looking at.....I don't remember any single one asking, 'who are you staying with at home? Where is your boyfriend? What standard are you doing?' I mean those questions are going to make the girl see, 'oh this person cares about me'."

<div align="right">(Nurse HCP)</div>

Health care providers should try to explore all factors that may impact on the health of the adolescent client and her unborn baby. The respondent felt that this approach, apart from being the most sensible, would make the adolescent client feel that the health care provider was interested in her and cared for her.

Communication Skills

The manner in which health care providers communicate with adolescent clients is very important in making the service appear friendly or not. A characteristic that an effective health care provider should possess is the ability to listen.

"She must have good listening skills. There is nothing bad by a person who is going to be talking, telling the health worker a problem and the health worker is busy answering the phone, busy chatting to friends."

<div align="right">(Nurse HCP)</div>

"They need to be a listener and not just a hearer."

<div align="right">(Nurse HCP)</div>

"Must be able to listen, communication skills, which listening is part of communication. And a sharp eye to be able to see beyond what she says, you know, looking at the gestures and all that, beyond what she says."

<div align="right">(DoH HCP)</div>

Part of having good listening skills is the ability to read what is being conveyed in body language, namely in unspoken gestures. Being attended to by a good listener will help to foster a feeling of comfort and trust within the adolescent client. The client would feel that she is being taken seriously and that the health care provider is concerned with her and her needs.

When communicating with adolescent clients, it is always important to keep information at the appropriate level for them to absorb.

"And as soon as something doesn't make sense, you switch off in any case. I think we do it as adults. More so for the young person. And maybe because of the tone of voice and the way that we communicate they see it simply as judgment you know and not as something that might really be very valid. You know that we say they are at risk, but maybe the way it's done."

(DoH HCP)

Health care providers should be aware of unconscious negative attitudes or feelings that they may convey in their interaction with adolescent clients. If the client perceives the interaction as negative, they may stop listening to what is being said to them. So, even if what is being said is important, it is lost to the adolescent because of the manner in which it is being said. Hence, the health care providers should try to communicate in a manner that shows caring and concern for the welfare of the adolescent.

4.3.5 Summary of HCP Perceptions of Adolescent-friendly Maternity Services

Information from HCPs on the present maternity services and how it should be improved is summarized under the heading of service, resources and HCps to elicit what constitutes an adolescent-friendly maternity service.

4.3.5.1 Services

- Existing policies on adolescent health should be closely scrutinized to ascertain whether they work harmoniously together.

- Efforts should be made to develop a specific policy for adolescent-friendly maternity care, that fits in with existing policies on maternity care and adolescent health.

- Orientate HCps to the available / relevant policies, so that they understand their desired outcome and implement them appropriately.

- Individuals who are proponents of adolescent-friendly care, should be selected to coordinate the adolescent-friendly initiative, ensuring that by them having global view systems run well.

- While it was not possible to separate adolescent clients from adult maternity clients, due to resource constraints, efforts should be made to differentiate adolescent clients from the rest of the client population and identify and cater for their unique needs.

- A multi-disciplinary team approach should be used when caring for adolescents, so that they benefit from all inputs, ie. doctors, nurses, social workers and such others.

- Continuity of care should be practised with adolescent clients being attended to by familiar HCps, who give horizontal care within a particular service.

- There should be better communication systems between the discharging health care facilities and community services, so that follow-up is more effective and directed.

- Care should be individualized to meet the needs of each individual client and standardized approaches to client management should be avoided.

- All services should stress health promotion and client empowerment, rather than emphasizing curative care.

- Services should run over a 24 hour period at community health care facilities, to make them easily accessible to clients.

- Epidural services should be available to labouring adolescents clients for more effective pain management.

- Contraceptive services should be made available to all adolescent clients, so that they do not have a repeat pregnancy too close to the recent one.

- Postnatal care needs to be increased with longer hospital stays immediately after delivery and better long term community follow-up of mother and baby.

- Significant other support to adolescent clients should be formalized and strengthened by encouraging these individuals to accompany clients to health care visits and by including them in health education sessions.

- Monitoring of adolescent maternity clients should take place across services, by all HCps, irrespective of which service they access to ascertain whether they are coping with the pregnancy or parenting, which ever is applicable.

4.3.5.2 Resources

- Health care facilities should be designed to afford the maximum amount of privacy to clients, with special attention given to labour wards, so that adolescent clients may be accompanied by a birth companion for support.

- More HCps needed to be employed to give better individualized care to clients.

- Authorities should make efforts to retain experienced HCps, so as to increase the quality of care rendered to adolescent clients.

- Transport between the central referral health care facilities and the outlying community facilities should be improved for more efficient referral and transfer.

- Pre-service educational programmes for HCps should increase curricula focus on adolescent maternity care, to better prepare HCps to deal with these specific clients.

- Post-basic / post-graduate programmes specializing in adolescent health should be developed for HCps towards better understanding of this population and more effective care.

- Programmes need to be developed to retrain HCps to be able to render care to adolescent clients by understanding this special client category better.

- All health education endeavours should be tailored to meet the specific needs of adolescent clients and pitched at the appropriate level.

- Programmes should be developed to train adolescent maternity clients to render peer support to other individuals who find themselves in the same position in the future.

- Efforts should be made to raise community awareness of the vulnerability of adolescent maternity clients, so that communities can mobilize to support these clients.

- Older members of the community should be trained as community health workers, who would offer long-term support and follow-up on adolescent clients after discharge from the health care facility.

4.3.5.3 HCps

- HCps offering care to adolescent clients should possess skill and knowledge in adolescent health as well as obstetric / midwifery care.

- HCps should be constantly aware that adolescent maternity clients' needs are different from their adult counterparts.

- HCps should exhibit an attitude of caring by being approachable to adolescent maternity clients.

- HCps should strive to be compassionate and nurturing towards adolescent clients.

- HCps should be non-judgmental and non-punitive in their approach to adolescent clients.

- HCps should be honest in their interactions with adolescent clients, and maintain confidentiality at all times, so as to build a rapport of trust.

- HCps should try to be supportive towards adolescent maternity clients in all their interactions with them.

- HCps should always deal with adolescent clients in a holistic manner.

- HCps should have good communication skills, which includes listening to and reading the body language of adolescent clients.

- HCps should put clients at ease by initiating the interaction and asking probing questions, to arrive at the problems and needs of that particular client.

- HCps should attempt to give individual clients adequate time during consultations, so that they are able to express their needs.

- HCps should use every opportunity to give health education and counselling to adolescent clients.

- HCps should attempt to involve the adolescent's significant others to care for her whenever possible, thereby increasing support available to the client.

4.4 HEALTH CARE PROVIDERS

As part of the pertinent stakeholder groups, data was collected from health care providers (HCp), who afforded care within maternity services. Efforts were made to follow the data in keeping with theoretical sampling employed by this study. The breakdown of respondents within this stakeholder group is as follows:

- 5 labour ward midwives (Provincial Hospital)

- 3 antenatal clinic midwives (Provincial Hospital)

- 4 postnatal midwives (Provincial Hospital)

- 1 midwifery clinical instructor (Provincial Hospital)

- 7 midwives from all sections of the maternity department (Polyclinic)

- 1 private midwife practitioner

- 1 medical officer (Provincial Hospital)

- 1 medical intern (Provincial Hospital)

- 2 doulas

In total, 25 respondents provided data for the HCp stakeholder group, by means of either individual interviews, group interviews or focus group discussions.

Data was collected and analysed with the following research questions in mind:

1. What were the attitudes of health care providers towards adolescent maternity clients and their needs?

2. What were the present strengths and weakness within the maternity services provided to adolescent clients as perceived by health care providers?

3. What were the suggestions from health care providers on how to improve the present maternity services so that they may cater more effectively to the adolescent client?

4. What did the health care providers consider to be an adolescent-friendly maternity service?

Findings are presented using these research questions for the sake of clarity and consistency.

4.4.1 Attitudes of HCps Towards AMCs and their Needs

Data from the HCps on their attitudes towards AMCs and their needs revealed one

core category, namely 'Special Needs':

4.4.1.1 Special Needs

Further analysis allowed two sub-categories to emerge linked to the core category of

'Special Needs'. These sub-categories are presented in Table 16 below, with their

relevant properties.

Table 16: Sub-categories and Properties of 'Special Needs'

Core category	Sub-category	Property
Special Needs	AMCs are different from their adult counterparts	Immaturity. Poor ability to cope. Greater educational needs.
	Vulnerable population Group	Poor antenatal attendance. Lack of preparation. Lack of support.

4.4.1.1a AMCs are Different to Adult Maternity Clients

Adolescent clients are perceived by HCps to have different needs as compared to their

adult counterparts.

"They do have special needs."

(Antenatal Clinic HCp)

"....with these adolescents you can look at them and then you will put an extra mile to cater for their needs because they are not the same as the elderly one."

(Maternity HCp)

Respondents felt that because adolescent clients were different from adult clients,

HCps needed to take extra care for them.

Immaturity

One of the main factors that differentiates adolescent clients is that they are immature

and lack experience.

"I think basically they are different, in a way that they are younger, more inexperienced, and need a lot more support when it comes to labour than other clients who have had babies before."

(Labour Ward HCp)

"They need more attention basically, they need much more attention."

(Postnatal Ward HCp)

"They need more verbal encouragement. They need more soft words, kind words. They need to be mothered, you know. They need to be loved and taken care of."

(Private Midwife HCp)

HCps feel that this immaturity leads to adolescent clients needing more support than other clients. Support was also expressed as giving them more 'verbal encouragement' and being gentle and caring towards them. A reason for needing extra support is that the adolescent client does not fully appreciate the situation in which she finds herself.

"They don't know what they have got themselves into. So basically they do not understand what is going to happen to them, like somebody who is 25 -30, and been through it."

(Labour Ward HCp)

The respondent above saw adolescent clients as not understanding what was going to happen to them during labour and delivery because they lacked previous experience.

Poor coping

Respondents felt that adolescent clients did not fully grasp the enormity of their situations.

"To me I don't think they always know really what they are in for. They are also more anxious. Especially with the labour part, is more stressful for them because they don't know, they're frightened of it and don't know whether they are going to cope with it and all the other stories they hear."

(Clinical Teaching Dept. HCp)

As a result their anxiety levels were higher, as they were unprepared for all that they were going to encounter. Adolescent clients were perceived as having poorer coping abilities as opposed to adult clients. An area of note is the inability to cope with pain during labour and delivery.

"Definitely, especially in adolescents, as they often won't be able to cope with the pain, as good as adult patients."

<div align="right">(Medical HCp)</div>

Most HCp providers were of the opinion that as the persons becomes older and

matures their ability to cope with the labour and delivery situation increases.

HCps saw adolescents' poor coping ability as being manifested in the way they

behaved during labour and in their reaction to their babies, post-delivery.

"Crying, shouting."

<div align="right">(Labour Ward HCp)</div>

The HCps felt that the adolescent clients tend to be unprepared for labour and

delivery, and, therefore, tend to be very uncontrolled when experiencing pain.

Adolescent clients may also refuse to see their babies after deliveries.

"Some they don't even show whether they are happy or not happy about the baby, you know. Some they will just reject the baby, 'you want to see your baby?'. 'No I don't want to see my baby.'"

<div align="right">(Labour Ward HCp)</div>

Post-delivery HCps have difficulty assessing how adolescent clients feel towards their

babies, because of what might appear to be an inappropriate affect.

Greater Educational Needs

Respondents felt that as part of having different needs to their adult counterparts,

adolescent clients had special health education needs.

"They need lot more education than the average patient. I think that one of the areas where we slipped up."

<div align="right">(Antenatal Clinic HCp)</div>

"They kind of need you to explain to them step by step what's happening to them, why, and perhaps because you know they are younger they go into it not thinking much about it and not doing their own research on it so a lot of them go into labour and they don't even know what is happening to their bodies."

<div align="right">(Doula HCp)</div>

According to respondents, adolescent clients need more intensive health education

than other clients using the maternity services.

4.4.1.1b Vulnerable Population Group

Poor Antenatal Attendance

According to respondents, adolescent maternity clients often had poor antenatal care,

which was not due to lack of facilities.

"And a lot of them are unbooked and there are local clinics in each area. They don't attend, they don't know about family planning and you ask them and they tell you, 'I thought you had to pay'."

<div align="right">(Postnatal Ward HCp)</div>

Adolescent clients also did not appear to understand how the health care system

worked and how to access it effectively. Respondents cited family and individual

educational levels, with people not fully understanding the importance of seeking care

as a reason for late commencement of antenatal care.

"But the problem in South Africa, what with illiteracy and lots of families are unaware of potential risks for teenage pregnancy. A lot of them do go later on. And also the stigma associated with teenage pregnancy, they are afraid to admit at first that they are pregnant, so they tend to be late bookers."

<div align="right">(Medical HCp)</div>

The second reason was that adolescent clients often attempted to conceal their

pregnancies, and, therefore, sought care much later than desired.

"Well, you know most of the times you will find that there is (sic) lots of unbooked teens coming in. I suppose more so because they are hiding the fact that they are pregnant. The family don't know, so basically they have had no antenatal care, they have not been to antenatal classes and as a result they don't know what to expect."

<div align="right">(Labour Ward HCp)</div>

"They were hiding it from the family."

<div align="right">(Postnatal Ward HCp)</div>

"It's true the antenatal clinic is the best for this, but they hardly go there, they are hiding everything, they are still at school, they come, they are unbooked."

<div align="right">(Labour Ward HCp)</div>

"And they are also trying to hide it. They are too scared to confront their parents, maybe only at a later stage. They are not educated right from the word go."

<div align="right">(Doula HCp)</div>

Many of the adolescents do not present for antenatal care and only come to the health

care facility to deliver. The result is that these clients do not get the necessary

preparation prior to coming in to deliver their babies, resulting in poor coping skills

and high anxiety levels.

Lack of preparation

Lack of preparation resulted in the adolescent client not being prepared for labour and

delivery.

*"Because some of them, they don't even want to talk, they are shy mostly. One she
was 15 I think, she was just keeping quiet like she does not understand what I am
telling her. So you can see that she was not well prepared to do what she was doing at
that time."*

<div align="right">(Labour Ward HCp)</div>

HCps then found such clients to be non-responsive and difficult to manage because

this compromised their ability to read the clients and anticipate their needs.

HCps felt that adolescent clients had to be prepared for the realities of what they were

going to face as a result of this pregnancy. Often adolescent clients were seen to be in

denial about being pregnant.

*"I think it is from those of them that have not fully accepted the fact that they are
pregnant and going to have a child. I think those are the ones that will not fully bond
with the baby immediately."*

<div align="right">(Labour Ward HCp)</div>

HCps saw lack of preparation during pregnancy as a mitigating factor to adolescent

clients not accepting the fact that they were pregnant and subsequently rejecting their

babies.

Lacking support

HCps viewed adolescent clients as lacking adequate support systems.

*"They are still at school, a lot of these pregnancies are unplanned, they are rejected
by the partner. Not so long ago we had this patient when I was on night duty that, she
was an adolescent, she had a baby, and when she was discharged and she went home,
her friends kicked her out, and she had no family. So she came back to ....(name of
hospital removed)."*

<div align="right">(Postnatal Ward HCp)</div>

Often this lack of support is due to people around the adolescent rejecting them once

they fall pregnant or it maybe because they have kept their pregnancy a secret and

people are unaware of the pregnancy, and, therefore, not able to support them.

"And we had a patient as well, a lot of them, what they do is maybe up country they
fall pregnant and then they come here to the city to keep it a secret. So also that is
why they have no support because it has been kept a secret. So that's why you know
that they get no support, because it is a secret."
<div align="right">(Postnatal Ward HCp)</div>

Another reason for the lack of support was that families did not know better, and did

not realize the need for support.

"They don't have that knowledge that they are allowed to come along with them."
<div align="right">(Maternity HCp)</div>
The respondent in the statement above, also felt that family members may not be

aware that they were allowed to accompany the adolescent on clinic visits.

"Because quite often the family are ....just no help at all. They get no help and
support from anyone, they turn around and say I can't look after this child for you."
<div align="right">(Antenatal Clinic HCp)</div>
From the experience of the above respondent, she had noted that family support to

adolescent maternity clients was very often not available, with the adolescent having

no one to turn to when she was in need. Another respondent related an incident that

she remembered of where an adolescent client's lack of support was noticeable.

"....I felt very sad last year when we had a 13 year old. She was quite 13, she came
alone to book. I felt this was really sad and she was still in primary school and she
had no one with her."
<div align="right">(Antenatal Clinic HCp)</div>
This appears to be a common phenomenon with other respondents relating similar

observations.

"Well, basically most of them actually don't, although we do make a provision of
having a support person, most of them don't have a support person. Although we do
encourage it. But generally when there are people to support, it's usually like mothers
or sisters, but not the partner as such."
<div align="right">(Labour Ward HCp)</div>
Even when the health care facility allowed labouring clients to be accompanied by a

support, HCps reported that many of them still presented without a support person.

Another observation was that when support did exist, it was offered by female family members of the labouring adolescent as opposed to her partner, the father of the baby.

Respondents also noticed that in some situations where parents did attend antenatal visits with pregnant adolescent clients, their presence could be negative rather than supportive.

"And some of them when they come, tend to take over, 'I've brought my daughter'. Like it's their pregnancy, they do all the talking."

"I think it's nice for the mother to be there, but as you say not to take over. You've got to encourage her to be confident, because she is going to be a mother."

(Antenatal Clinic HCp)

With the parent taking over the interaction and talking on behalf of the adolescent client, the adolescent was prevented from assuming responsibility and developing confidence over time.

4.4.2 HCps' Perceptions of Strengths within the Present Maternity Services

Analysis of the data provided by the HCps regarding the strengths within the present maternity system with regards to adolescent clients, revealed one core category, namely 'Perceived Friendly Care'.

4.4.2.1 Perceived Friendly Care

Further analysis of the core category 'Perceived Friendly Care', allowed for the emergence of one sub-category, with its related properties, as presented in Table 17 below:

Table 17: Sub-category and Properties of 'Perceived Friendly Care'

Core category	Sub-category	Property
Perceived Friendly Care	Available Services	Early antenatal care. Medical care. Combined service. Contraceptive service. Birth companion.

According to a medical HCp, while there were strengths within the present maternity service, they were not specific to adolescent clients. These were viewed by respondents as part of providing friendly care to AMCs.

"Well the strengths of the maternity care, I think is (sic) general strengths, not as such specifically for adolescent children or adolescent patients."

(Medical HCp)

4.4.2.1a Available Services

Early antenatal care

One of the identified strengths was the emphasis placed on antenatal care and the fact that antenatal care commenced early in the pregnancy.

"I would think that the strength of the maternity care system is the big emphasis on early antenatal care, which is obviously also very important for antenatal patients."

"I think the system is well organized to give adequate antenatal care."

(Medical HCp)

According to the respondent the service was well set-up to provide antenatal care to pregnant clients.

Medical Care

The availability of medical care was perceived to be a strength within the present maternity service for adolescent clients.

"A strength is the medical care because all teenagers they've got special medical problems and we do address that. This is a fact, that the very young ones see a doctor all the time."

(Antenatal Clinic HCp)

Adolescent clients were regarded as high-risk because of all the potential obstetric problems that could occur.

"But they have to be seen by a doctor if they are under 16."

(Antenatal Clinic HCp)

As a result, adolescent clients under the age of sixteen at this particular health care facility were seen by doctors during their pregnancy, affording better surveillance of obstetric problems.

Combined Services

A respondent presented adolescents using the same maternity service as adult clients

as a strength. In the opinion of the respondent, adolescent clients should not be

separated from the rest of the clients.

*"I think it helps them to grow up quickly and this is part of growing up, to deal with
that. Separating them out, you can't separate them out from life and they are going to
deal with the pregnancy for the rest of their days, now and forever. So it separate
them out completely for this pregnancy will not allow them to grow."*

(Antenatal Clinic HCp)

Combining them with other clients gave them a taste of what they will be

experiencing in the real world, and would help them mature faster within the

situation. Whereas, separating them would not allow them the opportunity to deal

with the reality of being pregnant or of becoming an adolescent parent.

Contraceptive Services

Availability of contraceptive services was perceived as a strength within the maternity

services by some respondents.

"And we have got family planning."

*"And they start you on the pill, so as you get discharged, those mothers that are
breastfeeding, they can offer them."*

(Postnatal Ward HCp)

Postnatal clients were discharged home on a contraceptive method, and respondents

saw this as crucial to preventing a repeat pregnancy close on the heels of the recent

pregnancy.

Birth Companions

HCps at one of the facilities cited allowing the presence of birth companions, when

the client was labouring, as a strength within the maternity services.

"Well it's good in our department here, we do allow one to one, we do allow partners here. That is the only thing that we do provide to all clients that would benefit them in a way."

(Labour Ward HCp)

The HCps in this interview group saw this as a benefit to the adolescent client in that

it increased support available to the client while they were in labour.

4.4.3 HCps' Perceptions of Weaknesses within the Present Maternity Service

Perceptions of weaknesses within the present maternity service with regards to

adolescent clients were extracted from the HCp data. Analysis showed that one core

category emerged, namely 'Perceived Unfriendly care'.

4.4.3.1 Perceived Unfriendly Care

Further analysis revealed three sub-categories with their related properties linked to

the core category of 'Perceived Unfriendly Care'. These are presented in Table 18

below:

Table 18: Sub-categories and Properties of 'Perceived Unfriendly Care'

Core category	Sub-category	Property
Perceived Unfriendly Care	Service variables	HCp-client ratio. Paucity of health education. Physical layout. Pain management. Contraceptive services. Postnatal care and follow-up.
	HCp Profile	Inexperienced HCPs. Non-discriminating treatment.
	HCps' feelings	Conflicting feelings. Judgmental attitude. Frustration. Discomfort. Punitive care.

4.4.3.1a Service Variables

HCp-client Ratio

Many respondents alluded to high client numbers as being a weakness, interfering

with their ability to render care. When asked to elaborate on HCp-client ratios and if

they were able to render individualized care, a respondent had the following to say,

"Oh never, more like one to five, one to six."

(Labour Ward HCp)

"At the end of it all we don't have that patient-nurse relationship. There is no time for that, because the ward is so big, because we.....the patient ratio is increased so completely, so you can't sit with the patient and that is time."

(Postnatal Ward HCp)

Respondents felt that they were not able to spend adequate time with each client and

this led to sub-optimal care being given.

"So now the problem is, we don't have enough time for our patients. Even if the patient wants to complain about this and that, we don't have enough time because we are short staffed."

(Antenatal Clinic HCp)

According to this respondent, the health care facility in which she worked in was

short staffed, and this resulted in HCps not being able to spend adequate time with

clients, with the client not being able to approach them with problems or questions.

"The problem is that here, nowadays is that we don't have time to give them health education."

(Antenatal Clinic HCp)

The result was that HCps found themselves in a position of not being able to give

health education to clients or pick up problems that may be developing, as in the case

of women having ineffective bonding with their babies and subsequently abandoning

them.

"But we are so busy, you can't focus on one patient, we could have picked up the problem, we could have dealt with it prior to her abandoning the baby."

(Postnatal Ward HCp)

"Because you don't get enough time to spend and explain things to your patients. You just go in there to deliver, push the baby out and then you are moving."

(Labour Ward HCp)

"It's very difficult, honestly to actually give your patients individual care, it's very difficult."

(Postnatal Ward HCp)

Having more than one client to take care of resulted in the HCp not being able to give

health education and support to the client. Interactions were very rushed, with

attention being given to handling the essentials.

As a result of the high client numbers and inadequate number of staff, HCps were

reported to lack patience when dealing with adolescent clients.

"I think that the midwives there, obviously being very over worked, they snapped at the young girls. They....I think they were insensitive to their situation. I don't even think, they thought to think what these girls might be feeling. They were just getting on with their jobs. I think the girls were frightened."

(Doula HCp)

This impatience and lack of individual care could add to the fear that adolescent

clients already appeared to have.

Paucity of Health Education

Many respondents felt that one of the problems with adolescent clients is that they

either commence antenatal care too late or not at all. This was put down to them not

understanding the possible risks associated with adolescent pregnancy.

"They don't really realize the dangers of teenage pregnancy."

(Medical HCp)

Adolescents, not knowing and understanding the 'dangers' associated with adolescent

pregnancy, were further burdened by the lack of health education within the present

health care system.

"I think there is a great lack of experts that can deliver this message to all facets of society, not just teenage pregnancy, but more importantly we are talking particularly about that. And we should have qualified personal where sometimes there may just be one sister in the whole primary health care center. Just you know, staff nurses or students, who are not that well versed in complications."

(Medical HCp)

The respondent felt that this lack of focus on health education was due to the paucity of properly trained personnel within the current health care system, who were capable of fully appreciating and catering for the needs of this specific population group. Lack of health education resulted in the client not being prepared for the experiences that come with being pregnant.

"And another thing that I have noticed, just a simple thing of the pv examination. They don't know that that will be done. And I don't think anybody tells them in the antenatal care that when you go into labour, that this is a type of examination that will have to be done."

(Medical HCp)

This lack of preparation might result in the client not being cooperative during procedures such as, the vaginal examination referred to in the statement above.

In situations where antenatal classes were offered, respondents observed that they were not well attended by adolescent clients.

"Adolescents, very few if any come. It's the more mature, better educated girl who comes to the antenatal classes."

(Antenatal Clinic HCp)

The reason for this was that the classes were held at the end of the clinic, and respondents noticed that adolescent clients did not want to wait to attend.

"And it's nearly impossible for us, with the staff that we have to run one in conjunction with the clinic. And if they didn't have to go home, you know especially the time when we give those antenatal classes, while they are here or encourage them to wait until the end of clinic. But they don't, they are quick to leave here."

(Antenatal Clinic HCp)

The respondent felt that a solution would be to run the antenatal classes together with the clinic rather than at the end. However, the shortage of staff did not permit this.

Apart from staff shortages, it would seem that high client numbers also contribute to the lack of health education.

"There's just so many people there at that time. So they are missing out on the education and they are probably the ones who need it most."

(Antenatal Clinic HCp)

From the statement above it would appear that the large client numbers result in adolescent clients not being identified and targeted for specific health education.

Physical Layout of Facilities

In some health care facilities respondents identified the geographical layout of the facility as a weakness to rendering adolescent-friendly maternity care.

"I think as far as the privacy is concerned they need privacy like any other maternity case. Like here we are expected to render services like 'Better Births Initiative'. But here in our labour ward, the way the geographical structure doesn't allow doulas to come in for them as a relief of pain."

(Maternity HCp)

The respondent above worked in a maternity unit that had curtains between labour beds as a means of affording privacy. This was not considered to be very effective, so labouring women could not be accompanied by labour companions, as their presence may compromise the privacy of other labouring clients. The respondent saw the physical layout of the labour ward as diminishing privacy as well as support to the client from sources other than the HCps.

"But because of geographical structure like I said before, they end up sitting there, at times, waiting outside because there are other clients who are being exposed and we can't allow them."

(Maternity HCp)

Labour companions could not carry out their function and ended up sitting outside the labour ward, waiting for the baby to be born.

Pain Management

One of the respondents felt that maternity clients did not receive adequate pain management while in labour.

"I feel that pain management in, especially the public sector is inadequate. The patients don't get pain management."

(Medical HCp)

In this particular facility epidural anaesthesia was not available to labouring clients.

According to the respondent, lack of proper pain relief resulted in the client not

coping adequately during labour.

"I just feel that, we as doctors often don't think about it, the sisters they sometimes also don't think of it."

(Medical HCp)

The respondent felt that despite other forms of pain relief being available, HCps were

often remiss to utilize them, and that more careful consideration needed to be given to

the issue of adequate pain relief.

Contraceptive Services

At some health care facilities, contraceptive services were not easily available to

clients on discharge. At one of the data collection sites, the family planning clinic had

been relocated from the hospital to the primary health care clinic down the road from

the hospital.

"And moving it out to primary health care, that system has fallen down. So the people are told on discharge, go and get your family planning."

(Antenatal Clinic HCp)

This move made the service less accessible. As a result many clients left the hospital

without commencing a contraceptive method. Clients now either went via the primary

health care clinic on their way home or otherwise accessed contraceptive services at

their local clinics.

"Less accessible, you are going to go home and put it off until you have got time to go to the clinic and sex may come first."

(Antenatal Clinic HCp)

As a result, clients might not access contraceptive services as advised and many were

at risk for repeat pregnancies.

However, even in circumstances where contraception was available, not all clients

went home on a method, due to recent changes in the way contraceptives were

prescribed.

"But then we are also very limited. Because I mean they have changed a lot of things in family planning, you can't take the pill before six weeks and stuff like that. So a lot of these mums are actually leaving with nothing anyway because if they are breastfeeding, they can't take anything."

(Postnatal Ward HCp)

So, while the service was available, many clients did not go home on contraception,

but rather were given advice about what method was suitable for them and when to

commence it at their nearest clinic. It was not clear to respondents if clients did

actually follow through on the advice, as there was no follow-up system in place

between the discharging facility and the local community clinic.

Postnatal Care and Follow-up

One of the major weaknesses identified within the present maternity system was the

short postnatal hospital stay.

"Six hours is like really at a push. So they have no clue, they haven't had any support or bonding with the baby, haven't been taught how to breastfeed properly."

(Labour Ward HCp)

Within the present system, uncomplicated clients remained in the hospital for a total

of 6 hours post-delivery, after which they were discharged with their babies. HCps

saw this as being inadequate, especially in adolescent clients, whom they saw as

already having a paucity of support systems.

"Mothercraft, breastfeeding, they need a lot of that, really we don't give it to them, we don't have the time and they go home within a few hours of delivery."

(Postnatal Ward HCp)

The six hour stay was perceived to be too short, as HCps felt that more time was

needed to teach adolescent clients important skills such as breastfeeding and how to

care for their babies.

HCps also recognized that adolescent clients were distressed with having to take care

of their newborns.

"Well it depends if they deliver in the morning they can go home in the afternoon, 6 hours. And some of these girls are 13 and 15, I mean really. You can actually see the look of, they are actually scared, of fear to attend to the baby. We tend to ignore that, we do. All that we will do is get a social worker, who will come in and see that she has got family support, that's it. That's all we do."
<div align="right">(Postnatal Ward HCp)</div>

However, even though they recognized this 'fear', HCps felt that given the short

postnatal stay there was not much that they could do for the adolescent client besides

putting her in touch with the hospital social worker, who would investigate the

support systems available to the adolescent and her baby.

Respondents saw adolescent clients as needing postnatal follow-up after discharge

from the health care facility because the postnatal stay only lasted six hours and was

perceived as being too short to give the needed health education.

"They do need a follow-up care at home because most of them they don't stay with their grannies like before, they don't stay with their mothers like before. You get the history and you talk to them, you find that they stay with boyfriends."
<div align="right">(Maternity HCp)</div>

Postnatal follow-up was essential since HCps recognized the poor support systems

that were available to clients. According to respondents, they had noticed that many

of the adolescent clients were no longer living with their families where they could

benefit from the tutelage of mothers and grandmothers.

"Yes and nobody is advising them regards the care of the baby."
<div align="right">(Maternity HCp)</div>

Instead, they were living with their boyfriends, and therefore, could not benefit from

the advice and assistance of these female role models when it came to child care and

rearing.

Another identified weakness within the maternity service was the lack of home visits.

"And we must try and reach them, you know the home visits. But now we don't do the home visits, all that they do now they just go to their nearest clinic."

<div align="right">(Antenatal Clinic HCp)</div>

Once adolescent clients are discharged from the hospital, they resume care at their

local clinic.

"Just to visit the postnatal mothers for a week, washing the babies, cleaning and cooking, and looking at their personal and environmental hygiene. Help them, what's so ever problems, feeding, teaching them because we have few hours of stay at the clinic."

<div align="right">(Maternity HCp)</div>

However, the respondent above felt that this was not enough and that adolescent

clients needed more specialized attention in the form of home visits.

4.4.3.1b HCp Profile

Inexperienced HCps

The profile of available HCps was cited as a weakness within the present maternity

services. Some respondents felt that mature HCps were what adolescent clients

needed.

".... but unfortunately the staff situation is often that there are not enough mature or experienced people."

<div align="right">(Antenatal Clinic HCp)</div>

However, due to staffing shortages, experienced, so-called 'mature' HCps were not

always available.

"There is a very young profile, inexperienced profile."

<div align="right">(Antenatal Clinic HCp)</div>

Instead, according to respondents, departments were staffed with HCps whom they

considered to be young and lacking experience.

The respondents who were in favour of more experienced HCps, stressed that they did

not discount younger HCps. However, they felt that older HCps had some advantages,

due to their own life experiences.

"The thing of it is that you have to understand where these girls are coming from and where they need to go to, you begin to understand the background where they are coming from and where they are going back to. And prepare them for that situation. We have probably seen a few of the problems that are related to that situation. And their peer group have not quite got that understanding."

(Antenatal Clinic HCp)

As a result they were better able to understand the situation of the adolescent in

comparison to younger HCps, whom they viewed as 'peers' to the adolescent clients.

Non-discriminating Treatment

Another perceived weakness in maternity care according to one of the respondents

was that adolescent clients were seen as part of the general client population. In the

opinion of the respondent, this should not be the case, as adolescents were different

from the rest of the clients.

"I think they need something separate. But I think that where we failing is that when they're coming in, we're just treating them like every other patient. We are not saying this is actually a 'child' as such that I am dealing with. That she is going to need extra health education and support."

(Clinical Teaching Dept. HCp)

The respondent was of the opinion that HCps should bear in mind that adolescent

clients are still children themselves, despite being pregnant, and that their educational

and support needs would be different to adult clients. As such, caregivers / HCps

should identify and cater for these special needs.

4.4.3.1c HCps Feelings

Conflicting Feelings

Respondents also talked about the conflicting emotions that they experience when

dealing with adolescent clients, as HCps are sometimes parents of adolescent children

themselves.

"But at times we are finding it difficult because we are also having adolescents at home. Then once you see this adolescent, little one, you think the behaviour is the same as the one you left at home. Then you start scolding because you are a mother, yet you are not allowed as a health provider. We are not allowed to treat them like they are our own babies but if she is pregnant you know how the mother feels at home and you are trying to put yourself in her position, yet it is not allowed."

(Maternity HCp)

The respondent above found it difficult to separate the adolescent client from her own

child, who was an adolescent as well. She found herself behaving as a mother would

to the client, and reprimanding the client, as she empathized with the client's mother.

"Then it comes into our nerves and we don't behave well at times."

(Maternity HCp)

The respondent recognized that HCps should not let their feelings interfere with the

care that they rendered and admitted to the reprimanding behaviour as being

unaccepatable.

Judgmental and Impatient Attitudes

Judgmental attitudes by health care providers towards adolescent maternity clients

were identified to be another weakness within the maternity service.

"Often when an adolescent patient comes in there is immediately from doctors and from nursing staff, there is a different attitude towards the patients which is, not always, but often negative. And we tend to be more, how can I state it, more impatient with them, when you actually need to be more patient with them. They don't understand everything, but immediately because of our way of thinking about adolescent pregnancy, in a general sense we tend to be a bit negative about it."

(Medical HCp)

Health care providers were perceived as more negative towards this category of

maternity client, demonstrated by a lack of patience during interaction with the client.

"We know that we should be....we shouldn't judge and shouldn't let our emotions get the better of us. But we are human and you can't but let your emotions.....you must try and control it but there will always be some emotion and you will always have some patients that you get irritated with or angry with."

(Medical HCp)

Respondents appear to be very aware of what their behaviour should be, but at the same time admit to finding it difficult to always be understanding towards adolescent clients.

One of the respondents described feelings that health care providers may have towards adolescent clients, which could negatively affect care.

"Often the patients come in when it is very busy and you've got this in your subconscious, you've got this way of thinking about adolescent pregnancy. And you immediately because you are very busy and you might be bit irritated, you don't have the defense against prejudice and immediately that prejudice kicks in. You can be a bit negative or impatient against them when you should be patient with them."

(Medical HCp)

As seen in the statement above, the health care provider may be busy, and, as a result, not have full control over their reactions. The respondent felt that health care providers need to be aware of possible prejudice that they may have towards adolescent clients, and should try at all times to guard against it surfacing.

Frustration

Another respondent related a typical situation of dealing with adolescent clients in labour who may not be coping with the pain and appear 'uncontrolled'.

"She has no idea what it takes to have a baby. And that... when you ask her she says 'no it wasn't planned, it was a mistake', you know. 'But did you know about contraception?' 'Yes. Help me, take me for a Caesar.' That is what becomes frustrating for the health care worker because people should know, you know, what they are getting into."

(Medical HCp)

According to the respondent, health care providers can become frustrated with adolescent clients because they are unable to understand and deal with the consequences of their actions.

Discomfort

Some respondents were very open about their discomfort when working with

adolescent clients.

"They should come with a birth companion, because these people are problematic in labour ward."

(Maternity HCp)

The respondent above felt that adolescent clients, who made difficult labouring

clients, should always be accompanied by a labour companion, who would assist the

HCp when caring for them. Respondents were asked to elaborate on what constitutes

being a difficult client to them. They responded as follows:

"They don't cooperate."

"They don't cooperate these people and they are cheeky."

"They don't want to be touched."

(Maternity HCp)

From the statements above, it would appear that a difficult client, was one who was

uncooperative during labour, who did not follow the instructions of the HCp and who

was perceived to be impudent. A respondent displayed her discomfort towards

adolescent clients, as a suggestion of having a specialized HCp to care for them.

"No I think that there should be a midwife trained for these people. Because these people are very, very much difficult to have, who are going to look after these people. Different midwives from us who are trained for these people (laughter). Because as it is I don't want an adolescent."

(Maternity HCp)

This respondent clearly demonstrated her prejudice against adolescent maternity

clients by this statement, in that she did not want to render care to them.

Punitive Care

Other HCp respondents framed their feelings towards adolescent clients in terms of

helping them.

"We have always said, not that we being cruel, but if we make it too comfortable for them. Then perhaps they will not be thinking about family planning, which is the first thing they should be thinking about."

(Antenatal Clinic HCp)

The respondent above felt that HCps should not be too welcoming to adolescent

clients in a bid to dissuade them from falling pregnant in the first instance. According

to the respondent, if the adolescent knew that the maternity services was not going to

be a comfortable environment, she would be more likely to seek contraceptive

assistance and not fall pregnant. Another respondent shared this view of not making

the services too friendly for adolescent clients.

"Well, I am not for an idea of an adolescent-friendly labour ward, because that will encourage them to fall pregnant out there. So for me it's not good."

(Labour Ward HCp)

"Its actually a thin line, because in one way, you want to be adolescent-friendly but by the same token you don't want to be encouraging adolescent pregnancy. You know, you don't want to make it too wonderful, that they think lets have babies."

(Clinical Teaching Dept. HCp)

According to some respondents, making the services adolescent-friendly may serve to

encourage adolescents to fall pregnant.

4.4.4 HCp Suggestions for Maternity Service Improvements

HCps provided suggestion on how the present maternity service should be improved,

thus making it adolescent-friendly. Hence one core category emerged, namely,

'Constituents of Friendly Care.

4.4.4.1 Constituents of Friendly Care

Analysis of what HCps considered to constitute friendly care revealed two sub-

categories, together with their relevant properties. These are indicated in Table 19

below:

Table 19: Sub-categories and Properties of 'Constituents of Friendly Care'

Core category	Sub-categories	Property
Constituents of Friendly Care	Services	Raising awareness. Counselling. Pain management. Increased postnatal stay. Adequate support. Doulas for support. Adolescent support group. Health education. Separate services. Planning of services.
	Resources	HCp characteristics. Special training. Overcoming language barrier. Improving staffing. Physical setting.

4.4.4.1a Services

Raising Awareness

While antenatal care was perceived to be available, respondents felt that more had to

be done to encourage clients to attend.

"There might be more drive towards sort of advertising antenatal care to the general public, so that they know they must go early. Because we still get patients that come in and they are unbooked."

(Medical HCp)

The respondent suggested that more be done to make clients aware that antenatal care

was available and of the need to utilize this service. The reason for this suggestion

was that, in the opinion of the respondent, many clients commenced care either too

late or not at all, coming in only when they were ready to deliver.

Respondents suggested that communities should be mobilized to help with raising

awareness.

"The community should be involved if the patient is pregnant or maybe in that area, the community should try and advise all adolescent children."

(Antenatal Clinic HCp)

The respondent in the statement above suggested that community members could be helpful in convincing adolescent clients to commence antenatal care by advising them of its benefits.

Counselling

To make services adolescent-friendly, a respondent suggested that better counselling services be available to adolescent clients.

"I think adolescents have their own mind set so it's got to start with the psychological I suppose. That's counselling, ways in which we can prevent pregnancy first. If they do fall pregnant, get them to a counsellor, take them through, who knows about maternity. Take them through all the problems they might experience, risk, how to cope."

(Medical HCp)

According to this respondent, counselling services should precede the pregnancy itself, with an emphasis on preventing adolescent pregnancy. But in cases where pregnancy could not be prevented the emphasis in the counselling should be on preparing the adolescent for what was to come and how to cope with the situation.

"If they come in, they know what they are expecting in that sense and they are more relaxed, it is not a bad experience, as bad experience for them. The whole experience might be more positive and I .....it's simple. It is a very simple measure, they can just be informed at antenatal care that when you go to labour ward for admission, what will happen to you."

(Medical HCp)

A respondent felt that counselling, with specific focus on health education could go a long way to making the whole childbearing experience a more positive one for the adolescent client.

Adequate Pain Management

Pain management was an area that was perceived to be lacking and where improvements could be made.

"I think that is one place where there can be much more improvement easily. Because simple pain management. We don't have access to epidurals but we do have access to opioids and I think we should use it."

<div align="right">(Medical HCp)</div>

While epidural facilities were not always available, other forms of pain relief were available and the respondent felt that more use needed to be made of other pharmacological options for pain relief, leading to better coping with labour and delivery.

Increased Postnatal stays

Increasing the length of the postnatal stay was another suggestion for improving the present maternity service for adolescent clients.

"I think a longer stay in hospital."

"I would say at least 48 hours, especially the first time pregnancy and I think like somebody to push breastfeeding, postnatal exercises, which is all absent at the moment."

<div align="right">(Labour Ward HCp)</div>

"They shouldn't stay for such a short period, I mean 6 hours is not a long time. There should be like little group sessions where you gather all the young mothers together and you know you talk about different problems that they confront. You can help them out, offer them information on rearing this child and there should be less patients."

<div align="right">(Postnatal Ward HCp)</div>

Respondents felt that if the postnatal stay was increased to 'at least 48 hours', HCps would have a better opportunity to prepare the client for breastfeeding, puerperal physiological changes and child rearing, by using small group teaching.

Adequate support

When adolescent clients appeared to be well supported by their parents, they tended to commence antenatal care at an appropriate time.

"Because you get teenage patients who are very well supported by their families and I must say from my experience in the last 3 months that I have worked here, most of the teenage patients that I managed, I am only speaking for myself here, not other doctors, were patients that were well supported by their family, they booked early."

(Medical HCp)

Another suggestion regarding support was for HCp to try to encourage adolescent

clients to bring a support person with them to their clinic visits.

"And they should have at least parents, or elderly relatives to accompany them, so that even at home they can help them to continue with their management of pregnancy, of problems related to pregnancy, besides being taught here at the clinic."

(Maternity HCp)

Respondents saw this as a way to ensure continuity of care, by including the support

person in health education. This person would then, in turn, help to care for the

adolescent at home.

HCps working in the labour ward where labouring clients were allowed to be

accompanied by birth companions had observed that not all companions were able to

give the necessary support.

"Like people who don't know and come are basically in the room, like not really giving much support, just staring out the window, and like not even holding the person's hand, you know, and offering the support."

(Labour Ward HCp)

The respondent felt that labour companions needed to be trained on how to afford the

necessary support to the client.

".....the support person that's coming should be familiar with the birth process, that would help because they would know what to expect and they have been through it. So they can actually afford, I mean can give that support."

(Labour Ward HCp)

"That's why I think that it's also important that a partner come into antenatal check-ups and classes, just to be told well you can be there to reassure her and be there to hold her hand and you mustn't be shocked if she is in pain, just support here."

(Doula HCp)

Apart from the regular antenatal visits, respondents felt that antenatal classes that

specifically target adolescent clients and their partners should be held.

"Antenatal classes are also playing a great role, ... it will also help them in labour ward, include the partners, they must also come to the antenatal classes with them."

(Labour Ward HCp)

The function of these classes would be to prepare the adolescent for labour and

delivery. Including the partner in the antenatal class would serve to formalize and

increase support available to the adolescent client. Also, the support would be more

effective, since the partner would also have received health education during the

antenatal classes and would understand how to offer effective support.

Since respondents felt that adolescent clients needed more support than adult clients,

and that support people should be trained on how to render effective support, a

respondent then suggested that doulas be used to give adolescent clients much needed

support during labour and delivery.

"...having proper doulas will be good and will even assist the nursing staff in a way. Because relatives that stay in the room don't really help. They basically come and bother you all the time, and being as busy as we are, you can't spend every moment in that room. So they come every two seconds, being there, they should be there to help the person, but they come looking for the midwife all the time."

(Labour Ward HCp)

The respondent also saw the role as assisting the HCps by relieving some of the

pressure placed on them by concerned family members.

Doulas for Support

According to a respondent who was working as a doula, doulas had a role to play in

assisting the adolescent client feel empowered during and by the childbirth

experience.

"They need to feel empowered and respected, they're humans just the same. And they must enjoy the birth because they are going to raise that child, if they choose to keep it and they need to have that positive effect right from the word go."

(Doula HCp)

This was reinforced by another respondent who described how a doula had been of

help during labour and delivery experienced by an adolescent client.

"She fell pregnant when she was 13 or something like that. Ya, very young. But the doula that was at the birth was very supportive. She never ever looked at her as a child. She looked at her as the labouring woman in labour and she treated her like someone very special."

(Private Midwife HCp)

The respondent felt that the doula provided the necessary support to the client without prejudice, and tried to make the birth a special event for the client. According to another respondent, doulas could provide a different kind of support to family members of the adolescent client, whom the respondent saw as emotionally more involved in the situation.

"...you notice as well is that if that teenager's mother is there, they can almost sometimes throw a.....too much of a concern in the picture in a sense of actually making the woman think negative like..."

(Doula HCp)

So the perception was that the family member may further increase the anxiety of the adolescent client, whereas a doula, having a better understanding of what was happening, and not being emotionally invested in the situation, could provide a calming presence.

Another respondent felt that adolescent clients would need more advice and guidance during labour, which the doula could offer, as the client had no previous experience and were not sure of themselves.

"More guidance, ya. And I think a lot more care when it comes to pain and things like that. Be almost like a mother to them, you know. Just reassure them, because I think for them it is probably more scary in a way."

(Doula HCp)

Support and guidance could take the form of advising clients on the best positions to labour in, for maximum comfort.

"Whereas with a teenager, we will actually say, well lets maybe try this, lets see if it helps you. Try squatting, don't you want to try going on all fours. Whereas with an adult we might want to see how well they are doing with following their own body. Maybe just instigate that a little bit more, see if they are comfortable with it. Put the ideas in their heads."

(Doula HCp)

Thus, the function of the doula here would be to inform adolescent clients on what options were available to them for better labouring; unlike adult clients, they are not as sure of their bodies and what would work for them in this situation.

From her observations, a doula concluded that often adolescent clients faced reprimands by HCps.

"Because being pregnant so young, they are thinking what are people thinking about me, you know, I am pregnant this young, you know, oh she got pregnant at 15, there is something wrong with her. Give her that attention, almost like a punishment and make her feel guilty."

(Doula HCP)

According to the respondent these reprimands resulted in the client feeling very guilty about being pregnant.

"They must not feel guilty about being pregnant. They must not feel that they are less worthy of a good labour and a nice birth experience than another one just because they are young now and they shouldn't be having babies now. They must know all that, and they must feel comfortable with themselves. That is what I try to do."

(Doula HCp)

The respondent saw the role of the doula as providing support and reassurance, so that the adolescent could have a guilt free pregnancy, labour and delivery.

The private midwife who worked with doulas also felt that the doula was of great help to her by freeing her from providing support and allowing her to concentrate on the obstetric side of things.

"Anyway, I found the doula very beneficial at her birth. Because for me, I am going to be worried about her pelvis, her vagina, her state of mind. How can she possibly have a baby when for me she should be playing with dolls, kind of concept."

(Private Midwife HCp)

The respondent felt that she could concentrate on the progress of the labouring adolescent, whom she considered to be a high-risk client, as she was still very much a child, while the doula provided the adolescent client with support.

The role of the doula starts in pregnancy and extends into the postnatal period. It was suggested that in order to provide adequate support, contact with the adolescent client would need to commence as early as possible.

"Get it going earlier on. Get us in with the teenagers early on. Let them have a whole positive birth experience, well pregnancy, birthing experience. I think if they walk into labour already being positive, there is already a step forward."

(Doula HCp)

The respondent felt that leaving contact until labour would not help to develop the doula-client relationship to the stage of where the client could get the maximum benefit from the doula.

Doulas were found to be instrumental in the bonding between mother and baby in the postnatal period.

"I was busy doing my thesis of paperwork, mothering my paperwork, I haven't got....I mean it is so thick the paperwork........contact is not broken at all, she is with the mother continuously. Whereas I can't be, I have to go to the desk, do this, you know, whatever."

(Private Midwife HCp)

The respondent felt that the doula was able to give the client constant support. As a midwife her contact with the client was interrupted with paperwork and routine hospital procedures. The role of the doula could extend beyond the hospital stay, with the doula conducting visits to the home of the adolescent.

"They help to establish breastfeeding. You know if you have had a tear or episiotomy, care of that. It is also just a lot of encouragement, because that is also just as difficult, that period."

(Doula HCp)

"I think also for the care afterwards, definitely. Look at breastfeeding and things like that as well. It's also thumbs and fingers being a new parent. Help them with bathing, help them with........make sure that the nappy is kept well dried and things like that."

(Doula HCp)

During the postnatal period the doula could provide support and advice to assist the adolescent with breastfeeding and in caring for her baby and herself.

"You know, be there at their call and be there free as well just to.....if they need to call you ten o' clock at night and say my baby is screaming their.......what can you advise."

So, in essence, the doula was someone who was just a phone call away. The adolescent clients could turn to them when a perceived 'crisis' was experienced with their babies.

"Don't forget when you are at hospitals, you have got the midwives and everybody else helping you. You go home, very different kettle of fish."

This was especially important for the adolescent after discharge from the health care facility, when she was no longer surrounded by the supportive environment of health care professionals.

However, according to the respondents, this may become a costly affair, especially in the case of the doula running her own private business.

"..... but finance is always a big issue. So if it was government subsidized, that's why the voluntary doula would work very well."

The respondent suggested two solutions, firstly, that the government subsidize doulas working in maternity units or, secondly, that doulas offer their services on a volunteer basis. A volunteer doula was described as follows.

"Normally the voluntary doula is an elderly woman that has nothing else to do. And it is not that she has to earn the money, she loves doing it and she does it. All they really ask for is bus fare and whatever."

So according to this description, older community members with training could fulfil this role.

Adolescent Support Group

Respondents also came up with the idea of creating a support group made up of adolescent maternity clients, where they would provide support to one another.

"Especially for the follow-up. Allocate someone for two months, every week there will be a group meeting, so that these patients get to know each other and they know they are not alone and then they create a bond amongst each other."

"You never know maybe they can call each other at home."

(Postnatal Ward HCp)

Respondents saw the HCp playing a role as facilitator for this support group, with clients developing bonds between them that could extend beyond the health care facility. It was felt that such support could go a long way towards diminishing feelings of isolation, that adolescent mothers may have ordinarily.

It was also suggested that the support group idea be extended beyond the adolescent to include her mother.

"Because the community health clinics they don't actually have support groups for mothers that have adolescent kids or daughters that are falling pregnant. Because these mothers can supervise them, can take care of them."

(Postnatal Ward HCp)

Support groups should be held for the mothers of adolescent pregnant or parenting girls, as these are the people who help to care for these adolescents and their babies in the long run, and respondents felt that they needed support and guidance in this role.

Health Education

HCps felt strongly that health education needed to be emphasized so that adolescents would receive adequate preparation.

"Its easy if it starts at the antenatal clinic, at that time she is not on labour, she can even listen well and she can understand what is being said and especially with the breastfeeding. It's very easy down there to understand rather than teaching her when she has got episiotomy pains and all the things in labour ward."

(Labour Ward HCp)

With this in mind, teaching should commence when the adolescent begins attending the antenatal clinic. The rationale for this was that the client would be more receptive at this stage and would therefore receive the full benefit of the health education.

"They need ongoing education."

(Antenatal Clinic HCp)

For health education to be more effective it should be done on an ongoing basis

throughout contact with the maternity services.

It was also suggested that health education for adolescent clients should be given

separately from the general antenatal population.

"Health education to teenage pregnant clients alone, that should be done alone so that they should ventilate their views."

(Antenatal Clinic HCp)

Respondents had observed the following response from adolescent clients when they

were put into a group with adult maternity clients for health education:

"They are very shy, they close down, they don't participate and they go very quiet. You can see them looking around, because often they're too big for them."

"And the older mothers sort of look at them, you know and it makes them feel bad."

(Antenatal Clinic HCp)

It would appear from the description of the respondents above that adolescent clients

felt very self-conscious when placed in a mixed group with adult clients.

A suggested option was that health education be done on a one to one basis.

"The education must be wider, one on one."

"Group talking isn't suitable for.....with the other clients together."

(Antenatal Clinic HCp)

This would create a secure environment within which the adolescent clients would

feel free to talk openly about what they feel or need, as privacy would be ensured. A

respondent felt that HCps should try to give good health education to clients, while

examining them, such as when carrying out an abdominal palpation.

"Secondly, is when we are actually palpating the patients, is to give good health education."

(Clinical Teaching Dept. HCp)

Combining health education with another task would serve to combat the problems of

not having enough time, due to HCp-client ratios.

A respondent also felt that one needed to be frank when educating adolescent clients.

"She had to understand the risks in that sense, all the negativities. But she didn't know what a cervix was, so I had to go through, explain to her the vagina, where the cervix is found. I had to teach her that, give her books to go home with. She questioned, she asked me what was happening. She asked me silly questions, which I never laughed at. I understood because when I'm 14 I would have asked the exact same question."

(Private Midwife HCp)

One should not hold back information because it is felt that the adolescent might not

understand. For them to be prepared, they had to know all the facts, and extensive

teaching was needed. The HCp also had to understand the client's level of knowledge

and developmental stage, and bear these factors in mind when dealing with them. But

all efforts should be made to prepare the adolescent clients for the realities with which

she would have to cope.

"They don't need to be shouted at. They just need to know that this is what they have gotten themselves into. That this baby needs constant attention. So that when they go home and they think this is hard, I am tired and the baby is crying and battling to breastfeed, it is not a shock because they didn't expect it, you know."

(Doula HCP)

Another strategy to prepare the pregnant adolescent clients for labour and delivery

was to take them on a tour of the labour ward prior to delivery, while they were using

antenatal services.

"And also visiting labour ward prior to delivery is also helpful, come and visit, see what is done, how do we do it, to make her to relax. So when she comes to labour ward, she knows the place."

(Labour Ward HCp)

This would serve as an orientation, so the adolescent would know what to expect and

would be more relaxed when she entered labour, as the environment would not be

strange.

Another contributing factor to adolescents not receiving adequate health education was the fact that clients under sixteen years were seen by medical staff as opposed to midwives.

"They don't get much education from them."

(Antenatal Clinic HCp)

"We only have referrals for children younger than 16 to go to doctors. So if they go round that side, it tends to be do your blood pressure test, your wee, in to see doctor and out. They actually don't get too much unless you get a mature sister who will pull them one side and reinforce antenatal classes, maybe give them a bit extra health education."

(Clinical Teaching Dept. HCp)

Some respondents felt that midwives were better at giving health education than the medical staff. It was also suggested that a reason for this may be that the client felt more relaxed with the midwife than the doctor.

"We could talk to them, chat with them and also they get a bit scared with the doctor you know."

(Antenatal Clinic HCp)

The respondent above felt that adolescent clients feel intimidated by doctors as opposed to nurses. Another reason for this was that there was a perceived arrangement between nurses and doctors, that while doctors attended to obstetric aspects, the midwives would attend to health education.

"Well, they expect us to do that. But if they are seeing the doctor then we don't see them."

(Antenatal Clinic HCp)

However, while this arrangement worked fine with other clients, it failed with adolescent clients, who were not being seen by midwives, and were therefore losing out on much needed health education. A suggested solution to this problem was to have the client seen by both the doctor and midwives at interchanging intervals, so the client would get both obstetric care and health education.

"But if we could work on the system perhaps of special visits where they go to the doctor but in between times. I mean there is no real reason for them for every visit to go to a doctor because they are 16. Sure the problems start coming in, if they get a blood pressure at 28 weeks, sure. Or assess them for their size and maturity at 36 weeks and go to a doctor from there on. But the early months I really feel we could be giving them better care with a midwife."

(Antenatal Clinic HCp)

The midwife would then see the adolescent client as he or she would see any other

client. In the event a problem was discovered, the client could then be referred to the

doctor, as with other antenatal clients.

Separate Services

A respondent felt that adolescent clients should not use the same antenatal services as

adult clients.

"The first thing that I would do is to separate the clinic from the adolescents from that of the adults."

"Ya, because they are more free when they are alone."

(Maternity HCp)

The rationale for separating the services was that adolescent clients would feel more

comfortable in a clinic of their own, and would therefore, be more open to the HCps.

It was also suggested that HCps rendering care in this separate service should have

specialist training relevant to the adolescent client.

"The midwives should be the one who is interested in the adolescents, not anybody, who will understand them. To be able to talk to them, to discipline them constructively, not just to scold them."

(Maternity HCp)

By specially selecting HCps who choose to work with adolescent clients, respondents

felt that the care rendered would be improved, as these people would understand

adolescent clients better and deal with them in a more useful way.

A strategy to make care adolescent-friendly, apart from having a separate service with

a specialist HCp, was to ensure continuity of care.

"But to have the same familiar face, not to be treated by an entirely different person, might be helpful."

(Antenatal Clinic HCp)

This would mean that the adolescent would be seen by the same HCp at every antenatal visit, as opposed to be seen by a different person during visits. This continuity of care was thought to be useful in creating a rapport between client and HCp and would help to build a relationship of trust.

Planning of Services

Respondents felt that one of the problems with the current maternity system is that HCps who provide the services within facilities are not consulted when the service is planned or the site is developed.

"And even if there are new structures, they do not consider the people who are working, to see what they want with their clinic. They just build the buildings so you can....they force you to go and work."

(Maternity HCp)

As a result HCps felt that the facilities were not designed for optimal use and often HCps found themselves working in a service that they felt was not well thought out and not fitting its purpose.

"And the other problem, when they are improving these structures like building something else, they don't involve us as working staff. They just build and then at the end, we say, 'how, you didn't provide us this, you didn't provide us this'. They should ask us what we need."

(Maternity HCp)

The above respondent suggested that the authorities who are responsible for funding and developing health care facilities should take inputs from HCps on how to design the facility for most effective and efficient use towards adolescent-friendly maternity care.

4.4.4.1b Resources

Health Care Provider Characteristics

HCp respondents felt that HCps caring for adolescent maternity clients should have

certain characteristics in order to be more effective in their interactions with clients.

".....then you don't need to shout because the child already had enough of it at home. For you just to support, encourage, after having your child this is what you must do, how you need to look after yourself, explaining whether she might have an episiotomy, what's an episiotomy. Explain everything so that they will have an idea."

(Labour Ward HCp)

One of the first traits that HCps should possess is that they should not take a

reprimanding stance with adolescent clients. The above respondent, felt that

adolescent clients had already received enough reprimands from their families and

that the HCp did not have to add to it. Instead the HCp should offer support and

encouragement to the client.

A respondent felt strongly that the maternity services should be used to draw

adolescent clients in, rather than frightening them away.

"They shouldn't be chased away or made to feel too uncomfortable once they are here. But they need plenty of love and support. Many of them haven't got family units and they need to get that from somewhere. Many of them are booking very late because they have been scared to go to their families and if we make them scared here, they are not going to get care at all."

(Antenatal Clinic HCp)

In the opinion of the respondent, many adolescents in this position have dysfunctional

family relationships and need somewhere or someone to turn to. Therefore, if the

service was perceived to be unfriendly, the adolescent client would default on care. So

the HCp should interact in a manner that encourages attendance of and compliance to

care.

According to respondents, other characteristics that HCps should possess in order for

adolescent clients to be comfortable are as follows:

"Compassion."

"Understanding."

"Non-judgmental."

(Postnatal Ward HCp)

"Patient person."

(Labour Ward HCp)

HCps should be seen as accepting of adolescent clients, and adopt a non-judgmental

attitude.

"To me, it would be for us not to be judgmental and I think it would be for us to recognize that they are still children and so they are more anxious, and I think they are probably also, you know, are they accepted."

(Clinical Teaching Dept. HCp)

For many respondents the HCp should be perceived to be approachable.

"Be approachable, so that they are gonna come to you and ask is they have something they need to know more. Because if you are a person who doesn't smile and talk, they always feel very scared to come to you."

"You have just got to be an open person."

(Labour Ward HCp)

"A smile on their face. Patients really like that smile. They like to see the smile on them, they open up much more easily."

(Postnatal Ward HCp)

"I think we should be approachable to them. Sometimes they see our facial expressions, they are afraid to tell us their social problems. So I think that is important."

(Maternity HCp)

Adolescent clients should feel that they are able to approach health care providers

with their needs or problems. Openness was essential, with the HCp displaying this by

the use of body language, such as smiling and by initiating the interaction. Health care

providers should also be patient with adolescent clients and should have a good

understanding of the problems that adolescent clients are likely to face.

"So I think you need to understand their problems first."

(Maternity HCp)

Understanding the problems that adolescent clients face was essential before

appropriate care could be given.

Respondents felt that it was important for HCps to listen to adolescent clients, and ascertain from them what they need.

"The kids, we must listen to what they have got to say. We are so good as nurses, of giving information, loading the people with information and sometimes we don't stop long enough to hear what they have got to say. And let them tell us what they want to know and what they need to know."

(Antenatal Clinic HCp)

The respondent felt that often HCps did not stop to listen to clients and instead made assumptions about their needs, which may not in fact meet their actual needs. So HCps needed to be adept at listening to clients and tailoring care to meet individual client needs.

Some respondents felt that adolescent clients responded better to older HCps who could take on a mothering role.

"I think she should be like a mother figure to this girl. You know, I think that is important, somebody she can relate to and you find once they have gained your trust, they will seek you out and ask you, you know, this and this is our problem, is that alright, you know. But I feel they are better with older midwives."

(Antenatal Clinic HCp)

The respondent felt that an older HCp would create a feeling of security, with the adolescent feeling that she could trust the HCp, and, as a result would open up in the situation. Contrary to this view, some HCps held the view that adolescent clients would open up more to a HCp who was closer to their ages.

"But I suppose it would be easier for them to talk to a person who is more or less their age, if possible."

(Postnatal Ward HCp)

However, other respondents felt that the age of the HCp did not matter, what did matter was the level of the HCp's knowledge.

"It would help, but if you are knowledgeable you shouldn't have a problem being 20 or 30."

(Postnatal Ward HCp)

Special Training

HCps felt that in order to care for adolescent clients effectively, specialist training was

needed.

"Sort of counsellor to be trained."

<div align="right">(Maternity HCp)</div>

Respondents suggested that HCps working with adolescents needed special training

so that they could provide adolescents with necessary counselling.

*"It should be a requirement maybe in our maternity unit. Because now we cannot
avoid nursing these adolescents. Like HIV/AIDS counselling, we are taken here and
taught as counsellors. So that we can be able to counsel them."*

<div align="right">(Maternity HCp)</div>

Respondents wanted such training to be made compulsory for HCps working in

certain units, much like HIV counselling training programmes. They felt that this

training would prepare them to render better counselling services to adolescent

maternity clients.

"Maybe, continuous training for us to change our behaviour."

*"Yes, in-service education. Maybe by somebody from the government or somebody
from outside to gear us with the new trends, something, new information. Because we
are stale here, nothing has been done with our attitudes, old attitudes and we are old
gogos in our mind."*

<div align="right">(Maternity HCp)</div>

A respondent suggested that there be continuous in-service education programmes for

HCps so that they could give more appropriate care and make necessary behavioural

changes in themselves to render better care to adolescent clients.

Overcoming Language Barrier

Some respondents mentioned the language barrier that exists between themselves and

the clients whom they nurse, with the HCp not being conversant in Zulu.

"We definitely need something to break the language barrier."

<div align="right">(Postnatal Ward HCp)</div>

The above respondent felt that it was very important that something needed to be done to decrease this barrier of communication between themselves and their clients. A suggestion was that hospitals should conduct language classes for their staff.

"When a nurse comes into the situation and she doesn't know the language, I suppose the hospital should make it compulsory. We are capable enough of learning the language and we need assistance."

"You go through those Zulu classes at least, just to learn the basics."

"It helps in being able to communicate with somebody that doesn't speak English. They also feel comfortable knowing that you can speak their lingo, you know what I am saying. It makes a difference."

(Postnatal Ward HCp)

These classes should be made compulsory for all staff to attend, to ensure that HCps are able to communicate effectively with their clients. Respondents saw this as being crucial to clients feeling more comfortable with HCps. They also felt that health education could be given more effectively when spoken rather than being given via a pamphlet.

"Will they read it, are they even interested in what's on that piece of paper, its not going to make them learn?"

"And if you sat down with the patient, you would pick that up. So it would be nice if we could reduce the amount of patients that do come into clinic."

(Postnatal Ward HCp)

Better communication between HCps and clients would also help to reduce the number of clients attending clinics, as problems would be detected earlier and dealt with successfully and health education would ensure health promotion.

Improved Staffing

HCp respondents felt that for maternity care to become adolescent-friendly, resources within the maternity system had to be improved.

"More staff."

"Employ many more midwives, so you can give that one to one care that people deserve."

(Labour Ward HCp)

More staff was needed so that one on one, individualized care could be given to

clients. This would also serve to improve support given to the client during labour.

Physical Setting

A respondent described the hospital environment as being 'cold' and unfriendly.

"For a young girl coming into this environment it is very scary, sometimes it is a very horrible, cold environment to be in. I mean just the environment of the labour ward itself is so important."

(Doula HCp)

The respondent felt that efforts should be made to soften the environment towards

being more adolescent-friendly.

'I don't know, nice pictures on the walls, some flowers in the waiting room. You know, a lot of the government hospitals, they don't even have clean sheets....you know things like that."

(Doula HCp)

This could be done by making the maternity department more aesthetically pleasing,

and ensuring that clients' basic needs are met in the most hygienic way.

4.4.5 Summary of HCp Perceptions of Adolescent-friendly Maternity Services

Information was extracted from the data that HCps provided, on their perceptions of

strengths and weaknesses within the maternity service, with regards to adolescent

maternity clients. This information together with the HCps' suggestion on how to

improve the present maternity service, have been used to compile the following list of

what constitutes an adolescent-friendly maternity service, under the headings of

Services, Resources and HCps.

4.4.5.1 Services

- There should be a separate maternity service for adolescent clients, so that they may feel more comfortable and less under the scrutiny of adult clients.

- In cases where it is not possible to have a separate adolescent service, specifically identified and trained HCps should render care to adolescent clients in the maternity service.

- Adolescents need to be encouraged to commence antenatal care as soon as they discover that they are pregnant.

- Community awareness and participation needs to be increased, so that community members play an active role in educating and acting as resource persons to these pregnant and parenting adolescents.

- Health education should be intensive and ongoing, so as to prepare the adolescent client to cope with the pregnancy, labour and delivery and being a parent.

- Health education should be done separately for adolescent clients, away from the rest of the clients, to allow them the opportunity to open up.

- As part of the health education, adolescent clients should be oriented to the health care system and its workings.

- Support needs to be formalized by encouraging significant others of the adolescent to be involved in the care, by providing training to these individuals on how to support the adolescent and by the use of doulas.

- Counselling services should be available to adolescent clients, to help them develop better coping skills.

- Adequate management of pain relief should be practised for adolescent clients in labour, towards making the whole experience more positive.

- Postnatal hospital stays for adolescent clients should be extended beyond the current six (6) hours, to at least forty-eight (48) hours, so that these clients could benefit from extra supervision and health education.

- All adolescent clients should be started on a family planning method upon post-delivery discharge from the health care facility.

- Home visits should be conducted for adolescent mothers in the postnatal period, as a means of follow-up, to determine if they are coping.

- Support groups need to be formed for adolescent maternity clients to increase support available to them and enhance their coping ability.

- Care should be given using a multi-disciplinary team approach, so that adolescent clients can benefit from all members of the team, such as doctors, nurses and social workers.

- HCps should be included in the planning and designing of services, so that they could give their input on how to make the service most effective.

4.4.5.2 Resources

- More HCps needed to be employed, so that clients could receive more one-on-one care.

- Attempts should also be made to ensure continuity of care with the adolescent client seeing the same HCps at each visit.

- Health care facilities should be designed to allow for privacy during labour and delivery, so that adolescent clients can be accompanied by a birth companion for support.

- Training programmes need to be developed to strengthen HCps' ability to care for adolescent clients, by focusing on this unique group, their development and needs.

- In-service training for HCps should be ongoing, so that there is continuous updating of knowledge and skills; thus HCps will be up to date with current developments.

- Language courses need to be made available to HCps by health care facilities so that HCps are better able to communicate with clients of different mother tongues.

- Health care facilities should make their environments more aesthetically pleasing and welcoming to adolescent clients.

- HCps should be trained to act as facilitators of support groups for adolescent maternity clients.

- Doulas should be employed by health care facilities to give added support to adolescent clients from the antenatal period until the postnatal period, including client follow-up in the communities.

4.4.5.3 HCps

- HCps needed to be experienced in dealing with adolescent clients.

- HCps should undergo special training so that they are able to afford better care to this vulnerable population.

- HCps need to remember at all times that the needs of adolescents clients are different to that of adult clients, and all interaction and care should reflect this understanding.

- HCps should be approachable and open, so that adolescent clients would feel comfortable with them.

- HCps should develop communication skills, such as effective listening which demonstrate caring.

- HCps should not let their personal feelings, opinions or experiences affect their interaction with adolescent clients.

- HCps should not stand in judgment of adolescent clients.

- HCps should avoid reprimanding adolescent clients as a way of getting the 'prevention of pregnancy' message across to them.

- HCps should strive to be patient with adolescent clients and understand that they have no previous experience from which to draw.

- HCps should attempt to empathize with the adolescent client.

- HCps should be honest when dealing with adolescent clients, so that they are prepared for the reality of what they are going to face.

4.5 CONCLUSION

The findings presented indicated that all stakeholder groups felt that adolescent maternity clients had needs that were in fact different from their adult counterparts. While there were strengths identified within the present maternity service, it would seem that the weaknesses were greater in number. The physical side of maternity care was not much different to that given to adult clients, except for closer surveillance as adolescents were considered to be at high risk for complications. However, all stakeholder groups emphasized the need for better support and health education to pregnant and parenting adolescents.

Respondents made many suggestions for structures that needed to be put in place or resources that needed to be obtained towards giving adolescent-friendly maternity care. The psycho-social aspects of care were very well described and it would seem clear from these findings that AMCs are concrete about what they need and how they would like to be treated. Respondents from all stakeholder groups made recommendations concerning resources, services, and adolescent-friendly interaction. To assist the process of transferring these findings into the reality of a maternity health care programme, the findings have been arranged, using a basic programme logic model in Chapter Five, towards a grounded theory of adolescent-friendly maternity services for KwaZulu-Natal.

CHAPTER FIVE

DISCUSSION

5.1 INTRODUCTION

The discussion that follows, presents a synthesis of the requirements for and constituents of adolescent-friendly maternity services, and in doing so, identifies to the reader, constructs towards a model of action for adolescent-friendly maternity services. These constructs are the groundings from the findings laid out in Chapter Four of this report. Areas of consensus within and between stakeholder groups have been extracted, using the constant comparison techniques cited by Glaser (1998), allowing for the emergence of four core categories, namely:

- AMCs as having special needs

- Perceived friendly care

- Perceived unfriendly care

- Constituents of friendly care

This chapter carries the process towards the formalization of constructs of adolescent-friendly maternity services further, and deals with levels three and four of the conceptual perspective analysis of Glaser (1998). Level three conceptual perspective analysis deals with the process of arranging the categories into a theory based on their thematic patterns and links. While level four conceptual perspective analysis relates to the use of literature within the substantive area under study, being used as a means to legitimize the theory as a valid contribution to the substantive area, which in this case was adolescent-friendly maternity services. However, in this study rather than legitimizing a theory, extant literature will be used to legitimize the

constructs that have emerged from the data. The constructs were arrived at by a process of delimiting data into categories with their related properties, thus extracting stakeholder perceptions of what constitutes an adolescent-friendly maternity service and how to arrive at them.

5.2 PROGRAMME LOGIC MODEL

For the sake of comprehensive clarity and application, and in an attempt to take analysis and model construction one step further, the emergent constructs are presented using a programme logic model approach. "Logic models are tools for program planning, management and evaluation. They can be used at any point in the evolution of a program and can lead to better programs. Program logic models describe the sequence for bringing about change and relate activities to outcomes" (http://www2.uta.edu/sswmindel/S6324/Class%20Materials/Program%20Evaluation/ Executiv.pdf, Retrieved 6th February 2005, p.33).

Using a logic model will benefit the following discussion of the constructs of adolescent-friendly maternity services by doing the following:

- It will help to build and reinforce the argument for investing in such a service.

- Create clear understanding amongst stakeholders on how and why the service will be effective.

- It will indicate the processes that are necessary for effective service provision.

- It will be fluid, allowing for change over time.

(http://www2.uta.edu/sswmindel/S6324/Class%20Materials/Program%20Evaluation/ Executiv.pdf, Retrieved 6th February 2005).

The last benefit of change, over time, fits in very well with Glaser's (1998) criteria of the theory's modifiability as proof of product. Hence, this model also compliments the methodology employed in this study. Another strong point of the logic model that compliments the study's methodology is that it helps to build consensus surrounding what the service is (http://www.the2professors.com/Logic%20Models.htm, retrieved 6th February 2005), which fits in well with the constant comparative techniques used to delimit, code, analyze and arrange data within Glaser grounded theory.

The basic components of a logic model have a casual link from resources to impacts. There are variants to the model, with no one optimal approach. The following, Figure 3, is a modified version of two extant models for the purpose of organizing the discussion that follows (http://www2.uta.edu/sswmindel/S6324/Class%20Materials/Program%20Evaluation/ Executiv.pdf, Retrieved 6th February 2005; (http://www.the2professors.com/Logic%20Models.htm, retrieved 6th February 2005):

Figure 3: Programme Logic Model
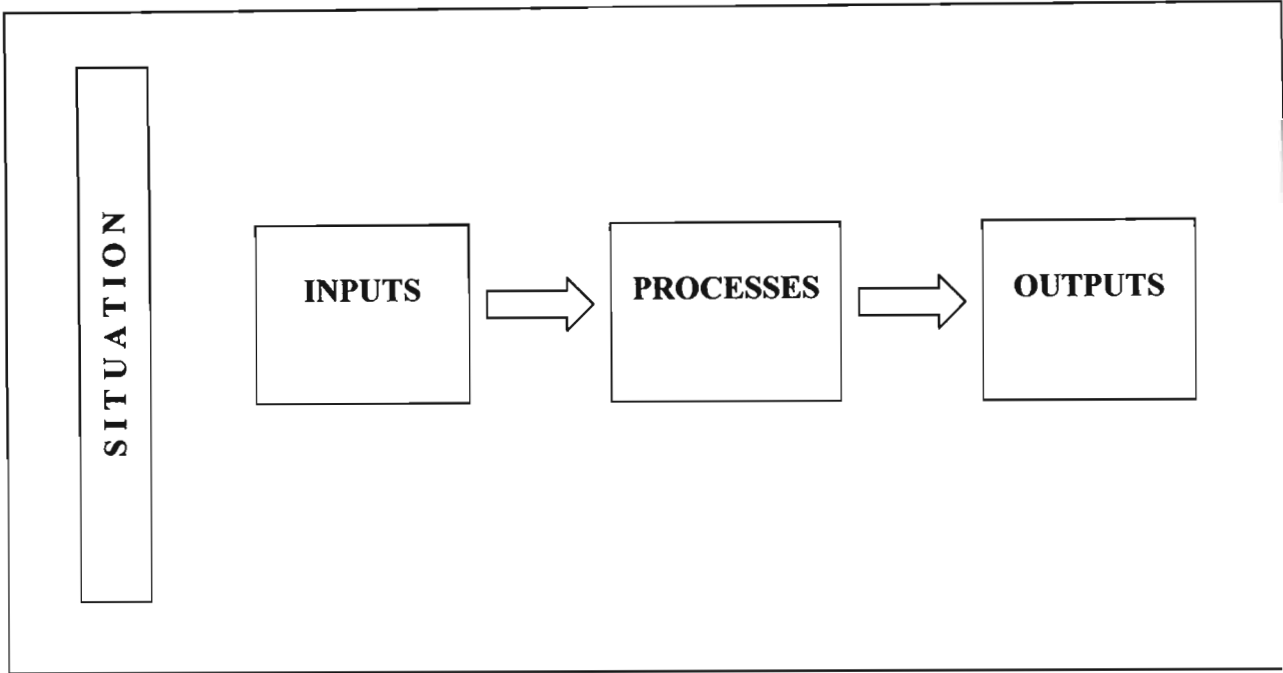
In the following discussion, resources shall be termed, 'inputs', and refer to human,

material, organizational, financial and community resources that need to be put in

place or directed towards the provision of an adolescent-friendly maternity service.

While inputs also include financial resources, it is necessary to note that respondents

in this study did not have direct responsibility for making funds available. With both

HCPs and HCps, while they were involved with planning and provision of services,

they were not directly in a position to control coffers. Respondents in this study made

many recommendations towards achieving an adolescent-friendly maternity service

that have financial implications as will be seen by the discussion of the constructs that

follow. However, they focussed more on what needed to be provided rather than how

it would be provided. Hence, because of their roles within the health care system, the

issue of finances did not clearly emerge.

Next come programme activities, which are the 'processes' that need to be carried out in order to effect a change towards the provision of adolescent-friendly maternity services. The last aspect of the model deals with one's intended result, and is referred to as 'outputs', and relates to the direct results of the programme's processes.

5.3 INPUTS

According to McNamara (2000) inputs "are materials that the organization or program takes in and then processes to produce the results desired by the organization". Inputs can be varied, such as human resources, material resources, finances and time, and have the ability to influence the organization or programme that they are related to (McNamara, 2000). Within this discussion 'inputs' includes all structures and resources that need to be put in place or modified before an adolescent-friendly maternity service can be rendered. From the available data and the responses from all stakeholder respondent groups, Table 20 refers to the essential inputs that are considered to be required in developing an adolescent-friendly maternity service.

Table20: Essential Inputs Towards an Adolescent-friendly Maternity Service

Inputs	Components
Policies	◊ Scrutinize existing policies ◊ Adolescent-friendly maternity care policy ◊ Orientate HCps ◊ Service accessibility

Educational preparation	◊ Curricula focus on adolescent-friendly maternity service in:
	    ◊ pre-service education
	    ◊ post-basic / post-graduate programmes
	    ◊ in-service educational programmes

Administration	◊ Separate emphasis on adolescents within combined services ◊ Adolescent-friendly HCps ◊ Adolescent-friendly administrators & coordinators ◊ Improved communication ◊ Designing of the service ◊ Availability of resources
Health Care providers	◊ Specialized training ◊ Ongoing in-service education ◊ Adolescent –friendly behaviour or characteristics
Formalized Support	◊ Doulas ◊ Community health workers ◊ Support groups
Community participation	◊ Community awareness ◊ Community involvement ◊ Community mobilization ◊ Community support

5.3.1 Policies

Scrutinize existing policies

From the information given by the HCP stakeholder groups, it would appear that

policies do exist within the South African context for adolescent health, such as the

'Policy Guidelines for Youth and Adolescent Health' (Department of Health, 2001)

and 'The Primary Health Care Package for South Africa – a set of norms and

standards' (www.doh.gov.za/docs/policy/norms/part1i.html, Retrieved 28th January

2005). While reference is made to the provision of reproductive services to youth and

adolescent clients, the emphasis of services appears to be the prevention of

pregnancies and sexually transmitted infections

(www.doh.gov.za/docs/policv/norms/part1i.html, retrieved 28th January 2005;

www.doh.gov.za/docs/policy.norms/part1d.html, retrieved 30th January 2005). None

of these extant policies within the South African health context deal specifically with

adolescent maternity care, with the existing policies being of a general nature dealing

with adolescent health as a whole.

*"Well, it's difficult to say because at the moment there are no policies. I don't think
there is any policy as far as maternity is concerned."*

(DoH HCP)

Currently, policies on maternity care encompass care given to the general maternity

population, of which adolescent clients are a part, with no special focus on this

vulnerable and unique population group within the general maternity population,

except with reference to decreasing adolescent births and prevention of sexually

transmitted infections such as HIV, through education, information and counselling

(www.doh.gov.za/docs/policv/mcwh-draft.pdf, retrieved 25th January 2005,

www.doh.gov.za/docs/policy/norms/part1d.html, retrieved 30th January 2005). This is

confusing since the 'Maternal, Child and Women's Health' draft document recognizes

adolescent pregnancy as being the most expensive problem facing South African

youth, with consequences such as interrupted and incomplete education, with resultant

low paying employment and diminished self-esteem

(www.doh.gov.za/docs/policy/mcwh-draft.pdf, retrieved 25th January 2005). Yet no

policy exists on adolescent maternity care, and the focus within pre-existing policies

is on prevention of adolescent pregnancy, rather than how best to deal with adolescent

pregnancy, once it exists. The other problem is that where policies do exist such as the

'Youth and Adolescent Health Policy Guidelines' (Department of Health, 2001) and

the 'Maternal, Child and Women's Health Draft Document'

(www.doh.gov.za/docs/policv/mcwh-draft.pdf, Retrieved 25th January 2005), other

adolescent problems become the focus, such as smoking and, alcohol and drug abuse.

If pregnant, the adolescent client then falls under the policies for adult maternity care.

Respondents in this study were also of the opinion that when policies did exist, they

may in fact contradict one another or not work well in tandem. Such as the example

given by Kaufman et al (2001) where the decentralization of family planning services

resulted in the closing of adolescent specific clinics, thereby decreasing adolescents'

access to these services rather than enhancing it, as was hoped.

"Many times it really is you know, when you look at policies and you know policies contradicting each other, not talking to each other."

(DoH HCP)

Respondents suggested that the reason for this was that health care was often offered

as vertical systems, where each service worked independently of others, with little

communication between services.

"I think you know people developing policies, really don't look at ways, how to integrate so that one policy can speak to the whole range of services for that."

(DoH HCP)

This lack of sharing also led to HCPs and HCps not scrutinizing the existing policies

closely to ascertain whether holistic care was being afforded to adolescent clients

across all services that they are likely to access.

Hence, before any adolescent-friendly maternity service can be offered, the existing

health care policies on adolescent health care and maternity care would need to be

carefully examined to determine the following:

- Strengths

- Weaknesses

- Suitability

- Applicability

- Economic feasibility

- Holism

- Harmony

Unless this is done, any adolescent-friendly initiative cannot be guaranteed success. This is in keeping with the mission of the Strategic Priorities plan laid out by the South African Health Department, which reads, "to improve health status through prevention and promotion of healthy lifestyles and to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability" (www.doh.gov.za/docs/policy/stratpriorities.pdf, retrieved 25th January 2005, p.4).

Develop a policy for adolescent-friendly maternity care

After the existing health care policies have been carefully examined, the next step would be to develop a policy for adolescent-friendly maternity services. Information gleaned from the scrutiny suggested above, would then be used to ensure that the policy is comprehensive and is able to be linked to pre-existing policies. For the developed policy to be successful, HCps who will be responsible for delivering the care to adolescent maternity clients need to be included at the developmental stage.

"And the other problem, when they are improving these structures like building something else, they don't involve us as working staff. They just build and then at the end, we say, 'how, you didn't provide us this, you didn't provide us this'. They should ask us what we need."

(Maternity HCp)

These HCps need to have a sense of ownership of and understanding within this initiative. They will also be able to give sound, practical inputs that may affect the running of the service in its day to day operation.

Another stakeholder group that should be included in this discussion are the adolescent clients themselves. As service consumers, their input is pivotal in ensuring that the policy is targeting their needs and not working at a cross purpose to them, which if it is, will lead to poor service utilization and a waste of resources. The inclusion of clients in the development of health policies forms part of 'The Patients' Rights Charter' which reads, "every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision-making on matters affecting one's health" (www.doh.gov.za/docs/legislation/patientsright/chartere.html, retrieved 28th January 2005, p. 1).

The idea behind an-adolescent-friendly policy of maternity services would be to extend the philosophy beyond the maternity services to all health care services, that the adolescent client was likely to access, such as contraceptive care, immunization and, growth and development. This would ensure that the adolescent client and her infant would receive support and care across the various services, rather than it being limited to the maternity service. This would translate into follow-up systems that are more effective, with more services and HCps being involved and, adolescent clients receiving continuous and ongoing support, long after discharge from the health care facility where delivery (of the baby) took place.

Another issue that needs to be considered when developing a policy is that of access to health care. Maternity care in South Africa is free to women who do not have the benefit of medical aid, a category of which adolescent clients form a part. This made care available to clients, but respondents felt that there were still factors that

negatively affected accessibility to services for adolescent clients. While central

referral health care facilities ran over a twenty-four (24) hour period, some of the

local community facilities did not.

*"For delivery, I think that perhaps the situation isn't as good. Mostly, because we
don't have very good 24 hour systems. "*

(DoH HCP)

So if adolescent clients need to seek maternity care after normal clinic hours, it would

mean that they would have to travel to the referral hospital, which would entail paying

for transport in order to get there, which, for adolescent clients with no source of

income, could be a problem. Kunene (1995) reports a similar finding, where

adolescents would not use the adolescent health clinic because it was located too far

from where they resided. Transgrud (1998) also reports clinic location as a strong

determinant mentioned by youth in deciding whether or not to access reproductive

services. Hence, it is advised that services within communities need to be well

established for easier client access, bearing in mind that only 61% of African youth

were able to access health care within a thirty minute travelling distance from their

homes (1999 HST Update, in Heunis et al, 2000).

Orientate service providers to the policy

For any developed policy on adolescent-friendly maternity care to be taken seriously,

capacity building amongst HCps needs to commence with an orientation to the policy.

*"It's like free health care for women and children, it was introduced like on Monday
we start and nobody knew what was happening. So there was no preparation in
saying to health care workers you know, this is the idea, this is what you can do, this
how you can make it work. "*

(DoH HCP)

Respondents felt that often policies are introduced with only people at the upper

levels of the structure understanding its workings.

*"........because we have policies, people simply don't implement the policies. Or
people, you know, know that there is policies but they have no idea what's in the*

policy or what is the implication of the policy or they have no resources to implement the policy."

<div align="right">(DoH HCP)</div>

This understanding may not filter down to grassroots level, to the HCps who are actually delivering the care. Thus for the policy to take root, HCps who are expected to transform it into action should be oriented and allowed to give inputs. These inputs should be used to enhance the application of the policy into action and service provision.

Orientation should precede the offering of the service in order for the service to commence on a positive note. This would help to ensure that HCps understand the intention behind the service and the part that they are expected to play in ensuring optimal service delivery, resulting in the policy being implemented in the appropriate and most economically feasible manner. Apart from the initial orientation of HCps, ongoing orientation for new staff joining the employ of the services will ensure that the initial philosophy does not fall by the way side. For the remaining HCp population within the service, this reorientation would serve to remind them of the intention behind the service, to keep them on track and motivated towards providing adolescent-friendly maternity care.

Community orientation should also be done as a drive to empower the local communities, by making them aware of the new policy and how it will be concretized. This is important, and serves as a way of advertising the proposed service to the public, who will then know what is going to be available to them and how to access it, and what their rights are within the service.

"Because these young people will go home with their children and if we only change the health care system, nothing will change is they go back to the very same community with the same judgments and non-support. Nothing will really change."

(DoH HCP)

This orientation will also serve to improve the knowledge base of community

members and help to effect a change in their attitudes to adolescent clients and in the

support that they give such individuals within their communities.

The co-orientation model developed by McLeod and Chaffee (1973) is an appropriate

theoretical framework that should be used to guide the development of any

adolescent-friendly maternity service. "Co-orientation models acknowledge the

reciprocal nature of communication common in negotiation and community-based

programs where citizen input is a part of fashioning the delivery of expert

information" (Bowes, 1997, p.8). Figure 4, found below, is a diagrammatic

representation of the co-orientation model.

Figure 4: Co-orientation Model
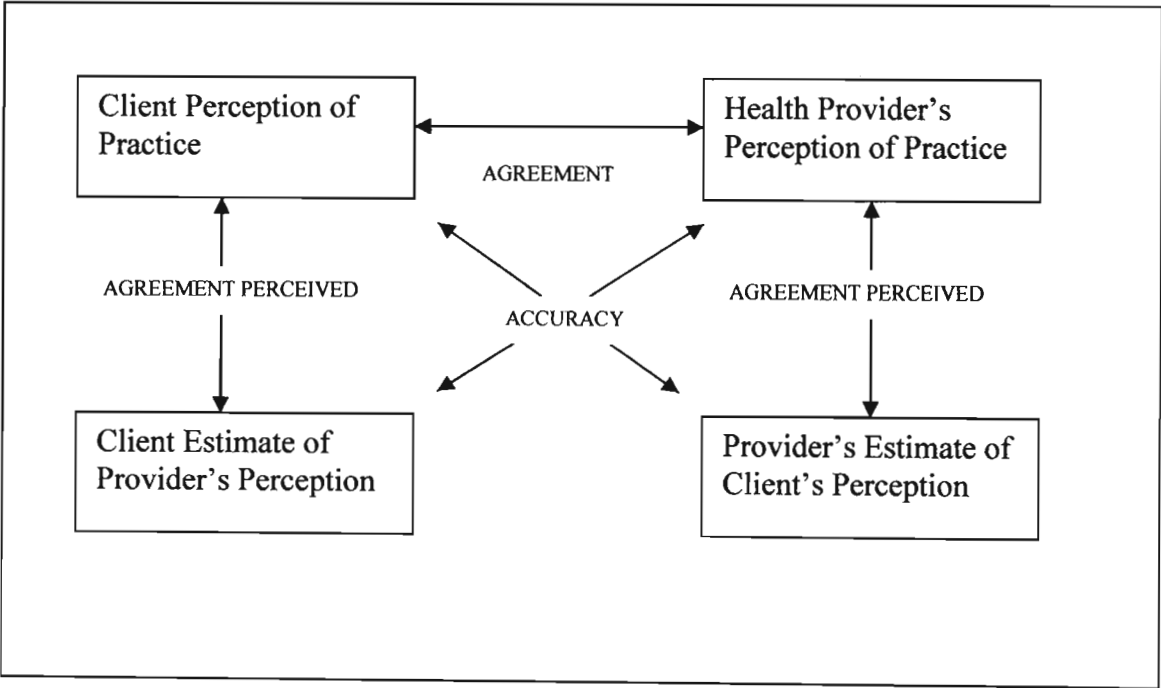
(Bowes, 1997)

For the model to have meaning, three key concepts within the model need to be defined. "Accuracy measures the extent to which each party's estimate coincides with the other's described position or perception. Agreement assesses actual overlap in described position. Agreement perceived suggests the level of discrepancy or congruence with the other" (Bowes, 1997, p.8). The client and the health providers are the stakeholders within the health care system. The arrows used in the diagram above indicate comparisons being made. This model is used to build the frame on which inter-group relationships are identified, where there is a high degree of co-orientation. It also helps to explain relationships between the stakeholders and how these group dynamics affect their activities and satisfaction derivable from encounters with each other.

The co-orientation model is based on stakeholders having 'mental models'. These are described by Brønn and Brønn (http://www.bi.no/users/fg196053/orgcom/bled.htm, retrieved 9th June 2003, p. 3) as "a personal theory of how things work". The thinking is that for a successful process of change to take place, mental models held by the stakeholders need to be congruent. Understanding and discovering mental models is crucial to the process of change towards progress. It is felt that mental models influence all areas of one's behaviour. In an attempt to discover the mental models held by stakeholders in the process the model contains four key components, namely:

- Client's perception of practice
- Health provider's perception of practice
- Client's estimate of provider's perception
- Provider's estimate of client's perception

Bearing these key components in mind, it would make sense that for any adolescent-friendly maternity service to be successful in terms of appropriate service provision and optimal service utilization, all stakeholders need to be invited to participate at all stages of the process, namely, policy development, planning, implementation and evaluation. Hence, the co-orientation model can be used by health care facilities as the underpinning theoretical framework towards an adolescent-friendly maternity service, as it allows for diagnosis of where the actual problem with understanding may exist within a system. Even a good health care system may be under threat of failure when stakeholders are not in agreement or may misunderstand each others' stance in a situation.

5.3.2 Educational Preparation

Increased curricula focus

Many respondents from the HCP and HCp categories felt that the pre-service educational programmes for HCps lacked an adolescent health emphasis. Often when a component on adolescent health did exist, it was brief and did not do justice to illuminate this vulnerable population group. Another problem was that most programmes at this basic or undergraduate level were generalist in nature, whilst what was needed was a HCp with specific training in adolescent health.

"...you know because we are trained as generalists, I think you know that we all come out, although we come up with a yellow bar, a green bar, but in actual fact they train us as generalists."

(DoH HCP)

Hence, the first step in sensitizing HCps towards adolescent clients would be to increase curricula focus during pre-service educational programmes in areas of adolescent health. Special mention was made of adding more adolescent focus to midwifery components of nursing educational programmes and to obstetric and

gynaecology components of medical education programmes, in order to produce

nurses and doctors who are aware of the unique circumstance and special needs of

adolescent clients within maternity care.

Post-basic / post-graduate programmes

Respondents saw HCps working with adolescent clients as needing specialized

training, as currently, most HCps rendering care to adolescent clients were in fact

generalists and not adolescent-specific in their educational orientation.

"It should be included in the general, so that we have a foundation. But I think at post-graduate we must have that, you know. Like you know, I always feel that as nurses we are disadvantaged unlike doctors, because for instance doctors, they all have the general curriculum, there after they specialize, they will be a paediatrician, a neonatologist, an obstetrician, what, and what. We don't have that and as a result I think even those people who have got the potential to do very well in one area do not have that advantage and I definitely think it would be nice to have it as a special component."

(DoH HCP)

It was suggested that HCps should have the option of specializing in the area of

adolescent health and that post-basic or post-graduate programmes need to be

developed to cater for these individuals. This is especially relevant in light of statistics

alluding to the fact that one-fifth of the world's population is in fact made up of

adolescents (Arulkumaran, 2001). Individuals who then receive specialist education in

adolescent health will form the HCp workforce in adolescent health care services, of

which maternity care will be a component.

In-service educational programmes

While it was not possible to wait for HCps to be trained in adolescent health before an

adolescent-friendly service could be offered, current HCps need to be trained in how

to render appropriate care to this special group within the general client population.

Respondents saw in-service education programmes as a means to this end.

"It should be a requirement maybe in our maternity unit. Because now we cannot avoid nursing these adolescents. Like HIV/AIDS counseling, we are taken here and taught as counselors."

(Maternity HCp)

Respondents realized that caring for adolescent clients was unavoidable, as there were not enough HCps who had specialized training. Hence, health care facilities should make in-service education available to HCps coming into contact with adolescent clients. Such programmes should focus on training HCps in the following areas:

- Understanding the growth and development of adolescents, including both physical and psychological aspects.

- Understanding the unique needs of adolescent health care clients.

- Understanding the potential problems that adolescents are likely to face or develop.

- Planning, implementing and evaluating appropriate care to adolescent health care consumers.

- Enhancing counselling skills for adolescent clients.

- Enhancing facilitation skills towards the initiation and maintenance of adolescent support groups.

Such programmes should be mandatory for HCps working with adolescent clients, and ongoing to keep an adolescent-friendly philosophy fresh, and HCp knowledge and skills, current. This condition of service has also been stipulated by the Department of Health under the 'Adolescent and Youth Health' section of 'The Primary Health Care Package for South Africa – a set of norms and standards', where as part of the norms it is laid out that HCps should receive in-service education on youth and adolescents clients and their needs. A standard has also been laid down together with this norm, stipulating that relevant documentation and reading materials be on hand in health care facilities, for HCps to use to update their knowledge on

youth and adolescent health and service provision.

(www.doh.gov.za/docs/policy/norm/part1i.html, Retrieved 28th Janury 2005).

Another aspect of HCp continuing education in adolescent care focused on the HCp's

ability to communicate with the client. Within the South African context there are

eleven (11) officially recognized languages. As a result, HCps may find themselves in

a position of not being able to communicate effectively with the adolescent client to

whom they are rendering care. Respondents saw the need for language instruction as

part of in-service education.

"When a nurse comes into the situation and she doesn't know the language, I suppose the hospital should make it compulsory. We are capable enough of learning the language and we need assistance."

(Postnatal HCp)

Respondents saw themselves as capable of and wanting to learn languages that

allowed them to communicate more effectively with adolescent clients.

5.3.3 Administration

Separate emphasis on adolescent clients within pre-existing combined services.

A clear picture of whether adolescent services should be separate from or combined

with pre-existing services did not emerge, as respondents had differing view points on

this subject. Some respondents felt that adolescent clients tended to 'fall within the

cracks' of the current maternity service and as a result they did not emerge as a

separate population group with separate needs.

"But I think that where we're failing is that when they're coming in, we're just treating them like every other patient. We are not saying this is actually a 'child' as such, that I am dealing with. That she is going to need extra health education and support."

(Clinical Teaching Dept. HCp)

It would appear that unintentionally HCps appear remiss in paying special attention to

adolescent clients who are using maternity services. Another reason for this is that

HCp respondents believed that adolescent clients felt very self-conscious (Jacobson, Richardson, Parry-Langdon & Donovan, 2001) when using the existing maternity services and withdrew in an attempt not to draw attention to themselves.

"....because they are more free when they are alone."
<div align="right">(Maternity HCp)</div>

"....I realize that it's very difficult for young people and when you talk to them, they refer to be on their own because they know they are judged."
<div align="right">(DoH HCP)</div>

"And the older mothers sort of look at them, you know and it makes them feel bad."

"They are very shy, they close down, they don't participate and they go very quiet. You can see them looking around, because often they're too big for them."
<div align="right">(Antenatal Clinic HCp)</div>

Hence the adolescent clients ended up losing the benefit of being identified and targeted with more specific care. So for these reasons, respondents advocated having a separate adolescent maternity service.

Many respondents felt that on 'paper' one of the requirements of an adolescent-friendly service would be that adolescent clients were separated from the general client population and given specific care.

"From my side, all what we are talking about is fluid, saying that we need to have a place where we will be seeing the adolescents, we must not mix them, it hasn't happened but on paper we are putting that this is what we need."
<div align="right">(DoH HCP)</div>

This idea of separating adolescent clients from the general client population is in agreement with a standard laid down by the Department of Health with regards to primary health care service delivery, which says that HCps should be able to render care to youth and adolescents on days and times that are suitable to the clients (youth and adolescents) (www.doh.gov.za/docs/policy/part1i.html, retrieved 28th January 2005).

However, realistically, this was not the case, due to the following constraints:

- Staff shortages prevent the running of tandem, separate services.

- Physical layouts of health care facilities does not allow space for a separate adolescent service within pre-existing structures.

- Services are rendered to the general maternity client population as a whole, with no specific focus on sub-populations within the larger client population.

Hence, respondents felt that while a separate adolescent service was 'nice to have' it was not feasible within the current South African context, where budget constraints would not permit.

"You know I suppose ideally, they should be separate. But this is for a first world country. I think in South Africa it will never be possible, not in our lifetime. I think our total lack of resources, including physical and human resources just simply... you know it will never be possible. But I think in some way we will have to find a way to make existing services, client-friendly and youth-friendly."

(DoH HCP)

Such an endeavour was considered very idealistic within South Africa, given resource paucity, and seen as something that should be considered in the future. Thus the 'National Adolescent-friendly Clinic Initiative' described by Dickson-Tetteh et al (2001) agrees with the outcome of the debate on separate services in this study. So for now, the focus should be on making the pre-existing maternity service friendly to adolescent clients, which according to Finger (2000), would entail doing the following:

- Ensuring client privacy and confidentiality.

- Ensuring adequate consultation time per client.

- Ensuring service affordability.

- Ensuring service accessibility.

- Employing HCps who are sensitive to and respectful of adolescent clients.

Combined maternity services were also viewed by some to be advantageous to adolescent maternity clients, in that it prepared them for the reality of being a pregnant or parenting adolescent.

"Separating them out, you can't separate them out from life and they are going to deal with the pregnancy for the rest of their days, now and forever. So to separate them out completely for this pregnancy will not allow them to grow. Because if they can deal with the people sitting in the waiting room, then they have got to deal with the people in the labour ward, then going out to the baby clinics. They are not going to separate them."

(Antenatal Clinic HCp)

Since it is not possible to separate pregnant or parenting adolescents from the rest of the world in every interaction that they had, respondents felt that there was no need to do so in the maternity services. It was felt that this interaction with the general maternity population would give the adolescent client a 'taste' of what she was going to experience back in her own community and in society and, allow her to prepare to cope with it. It was felt that another advantage of having combined services was that the adolescent would have older role models around her from whom she could learn.

"On the other hand, because if you do that, you say, you come in the morning, you come in the afternoon, you still separating people and you still develop this divide between giving support to these young people, give them role models to learn from."

(DoH HCP)

Hence, combined services were seen as a strength that helped the adolescent to develop coping strategies and adapt faster to her situation.

Adolescent respondents who were interviewed did not suggest the separation of services when asked what improvements they would make to the present maternity services.

"Treat me like I am, like other pregnant women."

(Antenatal AMC

Adolescent clients wanted HCps to treat them as they would any other client using the maternity service, and not make a spectacle of them by drawing special focus on them

in full view of other clients. Instead they wanted equity, with HCps understanding their unique situations and considering their special needs, during one on one interaction (Hanna, 2001).

The pro-con debate on separate services came to the conclusion that while an ideal would be to have a separate maternity service for adolescent clients, resources within the current South African health system did not permit this. The most appropriate strategy would be to make the existing services adolescent-friendly, with the adolescent client being targeted as a sub-population within the general maternity population and simultaneously benefiting from contact with adult clients within the general population.

Adolescent-friendly trained HCps

Since it was not feasible to create a separate maternity service for adolescent clients, respondents suggested that specially trained HCps be used to render services to adolescent clients.

"No I think that there should be a midwife trained for these people. Because these people are very, very much difficult to have, who are going to look after these people?"

(Maternity HCp)

These HCps would have a background in adolescent health, and be able to understand the unique needs that they would have as maternity clients.

"The midwives should be the one who is interested in the adolescents, not anybody, who will understand them. To be able to talk to them, to discipline them constructively, not just to scold them."

(Maternity HCp)

Such service providers should also be imbued with the philosophy of adolescent-friendly services. These qualities are considered essential in an individual working with adolescent clients, as it can be seen from the findings in Chapter Four, that some

of the HCps currently working with adolescent clients appear to have a negative attitude towards them. An example of this is in the statement above, in which the respondent alludes to adolescent clients as being very 'difficult' to work with, therefore, needing a specialized person to render care to them.

There are two ways of looking at the issue of having specially trained HCps. Firstly, that certain people within a service be earmarked for this training and deal with all adolescent clients using the service. This would have a positive slant, in that it would serve also to provide continuity of care simultaneously, with adolescent clients dealing with the same group of HCps throughout the pregnancy, labour and delivery and postnatal period.

"So I mustn't come today and be the one who is providing health education and examination, and tomorrow it is somebody else and tomorrow it is somebody else. They do need to sort of have contact with the same people so that they can build that trust, because unless we have got mutual trust, the provider and the consumer, the adolescent girl, they are not going to open up, we won't reach them."
(DoH HCP)

But one is not sure if given the staff shortages highlighted by HCP and HCp respondents that this would work, as it would mean decreasing HCps available to the general maternity population. Added to this is the fact that one cannot predict on any given day, how many adolescent clients will utilize the maternity service. Therefore, a second and more feasible way to look at the issue of specially trained adolescent-friendly HCps is to provide training to all HCps working in the maternity departments, thereby sensitizing them and creating awareness within them of this unique and vulnerable population group.

"Well, I think there is a lot of capacity building in the first place to happen because I don't think in any case that people understand young people. So there will be a lot of capacity building, so I think a lot of the investments will be in the staff working there. I think to raise awareness of the issue, I think this is where to start."
(DoH HCP)

This would also serve to ensure consistency in treatment from one HCp to another,

and to make contact with the health care system a positive experience for the

adolescent maternity client.

Adolescent-friendly Administrators and Coordinators

Apart from having HCps who were proponents of adolescent-friendly care, it was also

essential that administrators of such an initiative have the same philosophy.

"I think put in place the management understanding the need for that, because I think
without that it would never work."

<div align="right">(DoH HCP)</div>

Management that was sensitive to what the service was trying to accomplish would

support initiatives and assist to make the necessary resources available. Respondents

felt that management would have to have the same outlook as the HCps, otherwise the

service would fail with people working at cross purposes.

In short, a whole system needed to be put in place, with individuals within the system

clearly understanding the role they would be expected to play and the outcome that

the adolescent-friendly maternity services hoped to achieve. The system would

include all levels, from administrators, to community members at grassroots level. To

ensure its success, it was necessary to have an individual at site level to coordinate the

effort and act as liaison between the health care system, its parts and the community.

"There should be definitely a person to coordinate it, so if it's implemented in an
institution for instance, ...there should be a driver of this process to coordinate it in
the hospital itself, in the institution. And this person should be able to also then link
with the community person doing community health."

<div align="right">(DoH HCP)</div>

The advantage this individual would have, was a global view of the adolescent-

friendly maternity service, understanding how parts contributed to the whole and to

the desired outcome. This information would then be used to ensure the smooth

running of the service. The individual who was selected to drive the process would have to be someone who believed in the concept of adolescent-friendly maternity care and who could ensure sustainability of this philosophy. In keeping with this idea, the Department of Health advises that where health care facilities exist for youth and adolescents, regular service review should be done by service coordinators to ensure that the service is running smoothly (www.doc.gov.za/docs/policy/norms/part1i.html, Retrieved 28th January 2005).

Increased service accessibility

Respondents felt that for adolescent clients who were still in school, shorter opening hours at their local facilities would serve to diminish accessibility. This finding agrees with that of Kunene (1995), Dickson-Tetteh et al (2001) and Finger (2000). Adolescent clients may have to interrupt their schooling to attend facilities such as antenatal clinic. Therefore, to encourage better service utilization, it was necessary to increase accessibility by making community services available over a twenty-four hour period. This would mean that the adolescent client could then access the service of her choice without travelling great distances, whenever a need presented.

As seen from the findings, adolescent clients who are sixteen (16) years old and under, are considered to fall into a high-risk category and are seen by doctors for antenatal care, with delivery taking place in a hospital. Those adolescent clients who are above sixteen (16) years are usually seen by midwives in the antenatal clinics and if their pregnancy is found to be uncomplicated, they are allowed to deliver at local clinics in their communities, where such facilities exist.

"And where we do have good 24 hour systems, we don't have very good transport between them and receiving hospital. So if something does go wrong and an adolescent might be more likely to have a Caesarean, then obviously we will be in trouble."

(DoH HCP)

Sometimes pregnancies that start off as being uncomplicated may develop complications when the client goes into labour. As such, respondents remarked on the need to improve transportation facilities between the outlaying health care facilities and the central referral hospital, where obstetric care was available for twenty-four hours. Part of offering an adolescent-friendly service, was ensuring the safe management of labour and delivery of the baby, which respondents felt was better afforded to this high-risk category of client, in a referral hospital as opposed to community clinics.

Improved communication

Respondents mentioned that currently there are no systems in place to ensure communication between the central referral hospital at which the adolescents deliver, and the local community clinics where these adolescents continue with care for themselves and their babies. At present, contact with the adolescent is lost once they are discharged from the central hospital. It would appear that services are provided using a vertical approach, when ideally what should be in place is a horizontal approach with communication between services, and with one HCp taking up where another one left off, much the same as one would do when affording twenty-four (24) hour in-patient hospital care.

"I think there needs to be a system conducive to developing beyond the maternity ward. And I think to me it would be very important to develop a system before any implementation of any strategy in a maternity facility. Because if there is no follow through, if there is no follow-up, it will never ever work."

(DoH HCP)

Any adolescent-friendly maternity care endeavour needs to extend beyond the

maternity services itself, with all sectors of the health system that the adolescent may

access, working together, towards the same end. This is especially relevant with

regards to postnatal follow-up, since their immaturity does not qualify them as

optimal parents, as adolescents are also dealing with the developmental and emotional

changes that come with adolescence itself (Trad, 1999; Hanna, 2001).

Better communications mean that a follow-up system has to be put in place, with

HCps identifying at-risk clients (de Jonge, 2001; Hanna, 2001), in this case,

adolescent maternity clients and then alerting HCps in services that they are likely to

use, of their existence and problems.

"Yes, exactly and say you know, these were the issues that this patient came in with, this 15 year old. Please at her 6 week follow up, follow-up on a,b,c. You know and from the 6 weeks postnatal, to then go to the well baby clinic and to say, you know, watch out for this. To go to, you know the community health component and to say, you know when you do IMCI, when you do a community component, watch out, you know I have so many teenagers ... or whatever the case may be with young children."
(DoH HCP)

In this way, all HCps across all services would be working in partnership with one

another, assessing the adolescent clients when she presented either with her baby or

by herself, depending on which service she was using, identifying real and potential

problems and intervening to help to resolve them. This would serve to provide support

to the adolescent well beyond the maternity department and into the community. The

person acting as coordinator for adolescent-friendly maternity care at an institution

would act as liaison between the central and peripheral services, informing and

keeping track of the progress of adolescent clients and their infants.

Designing of the service

HCps wanted to be consulted before any service could be put in place. They felt that

since they were going to be expected to provide the service, they should be allowed to

have inputs into its development.

"And even if there are new structures, they do not consider the people who are
working, to see what they want with their clinic. They just build the buildings so you
can....they force you to go and work."

(Maternity HCp)

They felt that they could provide crucial logistical information towards the smooth

running of the service, based on previous experience at grassroot level. According to

them this was a view that management sometimes lacked, as they were not the ones to

deliver the service in the end. As a result HCps often found that after the building was

completed or the service was put in place, there were problems that could have been

avoided had they been consulted prior to putting things in action.

The co-orientation model mentioned earlier in this chapter is used to bring about

change within a structure, health system or organization. It is of great significance in

that it helps to locate gaps in information systems within a network. One of the

fundamental beliefs is that stakeholder opinions are vital to service revision and

resultant utilization. If stakeholders are not consulted or considered, no effective,

sustainable utilization of service is likely to take place. As such, this model is in

agreement with the suggestion that HCps be included at the planning stage of any

service.

An example of where HCps felt they needed to have been consulted prior to the health

care facility being built concerned the issue of privacy. One of the biggest problems

with the maternity service that is currently afforded in some places is the lack of client

privacy. This was a complaint raised by AMCs and HCps alike.

"Yes, in front of other people and in the rooms there is no privacy, only when you are getting examined. But other than that, you are out in the open, in front of everybody like that. So everybody hears what is going on, it's not private."

(Antenatal AMC)

AMCs felt that they were not assured of confidentiality because privacy was lacking,

resulting in their cases being discussed in full view of other clients.

"I think as far as the privacy is concerned they need privacy like any other maternity case. Like here we are expected to render services like 'Better Births Initiative'. But here in our labour ward, the way the geographical structure doesn't allow doulas to come in for them ...."

(Maternity HCp)

HCps on the other hand felt that this lack of privacy leads to them not being able to

carry out interventions for better client care. A situation which led to them feeling

frustrated within the working environment, as they were unable to put into practice

initiatives that were current and for which they had received training.

According to Waszak (in Finger, 2000), "the most important thing is to ask youth and

providers in a particular community what they want and what will work best for

them". This thinking is in keeping with the stakeholder-oriented approach to research

that one sees in health systems research, where stakeholders can have either direct or

indirect effects on the process of change. Here, the guiding premise is that research

findings will only be of benefit "if they are known and being used by stakeholders"

(Sauerborn, Nitayarumphong & Gerhardus, 1999, p. 829). Within this theoretical

framework, the clients and health care providers must be able to differentiate between

their point of view and the other's within a stakeholder situation. As can be seen from

the information presented in the above paragraph, both HCps and AMCs expressed

concern over the issue of privacy, although, in this situation, neither group was aware

of the perceptions held by the other group. This lack of understanding of one

another's perception led to adolescents feeling that HCps did not consider their needs for privacy, not knowing that the HCps are aware of this need and are frustrated by their inability to provide it. To this end, the co-orientation model can be used to establish the perceptions of the various stakeholder groups regarding what they consider to be an adolescent-friendly maternity service, towards achieving an agreement between perceptions held by the various stakeholder groups.

Coming back to the issue of privacy, HCps felt that the authorities responsible for designing and building health care facilities should seek their input at the designing phase and ensure that all efforts are made to ensure that care could be given in privacy to every client who used the maternity service. HCps felt that this was especially relevant during labour and delivery, where each client needed to labour in privacy, thus allowing for her to have a birth companion with her of her own choosing, for added support.

"But because of geographical structure like I said before, they (referring to the support person) end up sitting there, at times waiting outside because there are other clients who are being exposed and we can't allow them."

(Maternity HCp)

Unfortunately, what was happening in some facilities was that due to the lack of privacy in the labour ward, with beds being close to one another, with the only partition being a curtain, birth companions had to wait outside the labour ward for the birth of the baby, instead of providing support at the side of the labouring adolescent client.

The aesthetic appeal of the environment was also seen to make a difference to the whole experience of childbirth for an adolescent client and where HCps felt that they could make inputs.

"I actually went to a hospital where they changed the curtains and bedspreads to more bright colours and they've actually worked well."

(DoH HCP)

Respondents found that in situations where attention had been paid to the aesthetics in the health care facility, clientele appeared to be more satisfied with the care. Many adolescent clients come into the experience of pregnancy and childbirth being afraid, as this is the first time for them to encounter the maternity system. Due to their young age, most of them have no previous experiences to guide their understanding and responses. Respondents felt that every effort should be made to ensure that adolescent maternity clients have a very positive childbirth experience.

"I have gone to government hospitals and there is no blankets available and you have got to put on a horrible stained gown. Its cold walls and maybe some peeling paint, its not nice. You know, maybe some nice colour on the walls, some pictures on the walls, clean rooms. You know if you can make that environment warm and friendly, it is important."

(Doula HCp)

Creating a friendly environment by the use of pleasant, inviting colours on the walls of the maternity department, together with other strategies such as good lighting, use of plants and pictures, would serve to enhance the feeling of warmth. HCps could be instrumental in helping to make their work environments more appealing for both themselves and their clients.

From findings presented in Chapter Four, it is clear that adolescent respondents have very definite ideas on what constitutes friendly and unfriendly care. Therefore, as mentioned earlier in this chapter, it would make sense that they should make input when policies are formulated and services are designed and put in place, as one of the stakeholders in the process and as service consumers. The Department of Health also stipulates that one of the standards for primary health care service delivery is that HCps should include youth and adolescents when planning or implementing services

for them and get their inputs, towards a more effective service

(www.doh.gov.za/docs/policy/part1i.html, Retrieved 28th January 2005).

Availability of resources

In order to run an effective service, resources need to be readily available. All

respondent groups highlighted the importance of having adequate human resources

for the maternity service to be adolescent-friendly. HCps were eloquent about the

high client numbers to whom they were expected to render care, which resulted in

them not being able to render optimal, holistic care to each individual client.

"It's very difficult, honestly to actually give your patients individual care, it's very difficult."

(Postnatal Ward HCp)

One to one care was often not an option, and HCps saw adolescent clients as needing

closer supervision than adult clients.

"Employ many more midwives, so you can give that one to one care that people deserve."

(Labour Ward HCp)

Thus if more HCps were employed, better individualized care could be given to

clients. This would also help to prevent problems in the long run, as potential

problems could be identified after working closely with the client and dealt with

timeously.

AMCs spoke about having to wait in long queues before being attended to in antenatal

clinics.

"You know when you are pregnant, you get hungry often and you get very tired. And then I say to myself, they making us wait here so long, not understanding we need to eat, we want to go home and sleep, you know. They don't understand that, they just think for themselves."

(Antenatal AMC)

Often they left such clinics late in the afternoon, after waiting to be seen for most of

the day, arriving home tired, with swollen feet and quite hungry. This led to them

feeling uncared for, as they felt that HCps did not empathize with them. While the

AMCs wanted to be attended to at a faster rate, once they were in consultation, they

wanted the HCp to give them adequate time to be able to say and do all that they

wanted. However, they found that HCps tended to dispense with them very fast. HCps

concurred with this and stated that excessive client numbers in relation to staff

shortages resulted in them not being able to give clients adequate time during

consultations.

"Hello, how are you, is baby moving, stick out your tongue, have you got enough iron tablets, okay you can go, next."

(Nurse HCP)

"Well at the clinic they expect you to be like....they never have time. They just want you to like, okay be fast in whatever you do."

(Postnatal AMC)

However, the AMCs did not rationalize the quick consultations in this way and felt

instead that the HCps were not interested in them and did not care about them

(Jacobson et al, 2001). Hence, more HCps needed to be employed to cater for the high

client numbers, ensuring a better HCp-client ratio and more individualized care,

where the adolescent client would feel cared for.

HCps numbers aside, the other concern was the calibre of the HCps themselves.

"Because of the shortage, we cannot recruit anybody for that. Because it's a rural...."

(Nurse HCP)

Employment packages were not attractive enough to ensure that skilled HCps came to

rural positions.

"Though, the money is not the only solution. I mean even the conditions."

(Nurse HCP)

Respondents felt that conditions of employments should also be improved, as salary improvements alone would ensure the retention of an experienced labour force, which was, what was needed for adolescent-friendly care to be rendered.

HCP respondents felt that experienced HCps were needed to render specialized care to adolescent clients. This is evidenced by the following statement of a respondent who cited advanced training in midwifery as a strength, when caring for adolescent clients.

"....we do have advanced midwives, who are able and capable of attending to these adolescents. That is our strength, we do have trained midwives."

(Nurse HCP)

Firstly, these clients were considered to fall into the high-risk category due to their physical immaturity. Hence, an HCp with advanced obstetric or midwifery skills and knowledge was needed. This individual would then be better at diagnosing problems or needs, and timeously respond to them. Secondly, some respondents felt that a person with life experience would be in a better position to see the long term ramifications of social problems for this adolescent and intervene appropriately. However, there were respondents who felt that knowledge outweighed age.

"Somebody experienced."

(Postnatal Ward AMC)

So in this case, appropriate educational preparation was imperative for HCps working with adolescent clients. Taking all these factors into consideration, respondents felt that the Department of Health should make an effort to retain HCps who were skilled and knowledgeable, by offering better incentives, so that client care could be improved by having more experienced HCps.

To this end, one of the strategic priorities that have been earmarked by the

Department of Health for the five year period preceding the year 2004 and for the

period of the years 2004 to 2009, is the recruitment and retention of HCps by the

"introduction of rural and scarce skills allowances for a range of health workers"

(www.doh.gov.za/docs/policy/stratpriorities.pdf, retrieved 25th January 2005, p. 12).

This would ensure better staffing of health care units with skilled HCps, especially in

the rural, historically under-served areas.

Health Care Providers

All stakeholder categories in this study provided responses that point to the need for

HCps to undergo specialized training towards adolescent-friendly maternity services.

*"You know we need to have more value clarification training so that we don't impose
out own values to these adolescents. I mean, some got pregnant not of their choice,
but as woman we just go and bomb and bomb, making the child feel more guilty. And
at the end she cannot cope up with the child after the delivery. So we need to have
retraining, reorientation, reinforcement about the adolescent care to our health
professionals."*

(Nurse HCP)

*"Yes, in-service education. Maybe by somebody from the government or somebody
from outside to gear us with the new trends, something, new information. Because we
are stale here, nothing has been done with our attitudes, old attitudes and we are old
gogos in our mind."*

(Maternity HCp)

Specialized training in adolescent maternity care or adolescent health as a whole

could be offered as part of pre-service HCp education, or as a post-basic programme,

as well as by ongoing in-service education programmes which would serve to

constantly educate HCps and to keep the philosophy of adolescent-friendly care alive

and current. The idea as can be seen by the statements above, was the refreshment of

knowledge, skills, attitudes and values so that HCps could be more understanding of

and accommodating to AMCs. Wood et al

(ftp://ftp.hst.org.za/pubs/research/contracep.pdf, retrieved 7th February 2005) make

similar recommendations for nurses working in contraceptive services who serve adolescent clients to have value clarification workshops that help them better understand adolescent sexuality, contraceptive needs and the nurse-client relationship in this situation.

Respondents had specific inputs regarding how an adolescent-friendly HCp would present himself or herself. Firstly, respondents saw knowledge and skill in areas of adolescent health and maternity care to be important in rendering optimal services to AMCs. As mentioned earlier in this chapter, having skilful HCps was considered an advantage when rendering care to AMCs who were normally considered to fall into the high-risk category (Trad, 1999; Ehlers, 2000; Rivera et al, 2001; Treffers et al, 2001; Mngadi et al, 2002).

All categories of respondents saw HCps as playing an instrumental role in creating a secure atmosphere for the AMC, one in which she would feel respected and not judged.

"Our attitudes I mean, they do play a role in the care of the adolescents."
(Nurse HCP)

Transgrud (1998) concurs with the statement above and reports that the first factor that youth consider when accessing a health service is the attitudes of the service providers. Extant literature also supports this view and points to the fact that often pregnant and parenting adolescents face a breakdown in family relationships and abandonment and, hence, perceive criticism to come from all quarters (Tanga & Uys, 1996; Hanna, 2001).

"They shouldn't be chased away or made to feel too uncomfortable once they are here. But they need plenty of love and support. Many of them haven't got family units and they need to get that from somewhere. Many of them are booking very late because they have been scared to go to their families and if we make them scared here, they are not going to get care at all."

(Antenatal Clinic HCp)

Therefore, respondents in this study, as seen from the statements above, urge caution in the way HCps receive AMCs when they access health care. The idea is to lay aside judgments and criticisms towards making the AMC feel secure and comfortable within the health care setting.

However, the reality as shown in Wood et al

(ftp://ftp.hst.org.za/pubs/research/contracep.pdf, retrieved 7th February 2005) is that often nurses are reported to moralize and judge adolescent reproductive health consumers. They also report nurses admitting to feeling that it is their duty to inform adolescent contraceptive users that they are too young to be engaging in sexual intercourse, hence adolescent clients perceive these nurses as being an obstacle to them receiving contraceptives.

"We need to understand the adolescent very well. We need to leave our, you know, militarian (sic) approach because they retaliate. And one way of them retaliating is to shut up and you know, cut you off. They will sit there and listen to you and not even respond and all that, they just shut up, if you come with that."

(DoH HCP)

Unless this is done, respondents felt that HCps would not be able to reach adolescent clients who would shut themselves off from the interaction that they considered judgmental in an effort of self-preservation.

From data presented by AMCs, it would appear that they are very suspicious of HCps and tend to be afraid of possible rebuke, which results in them not effectively seeking help.

"You can't say anything because like they'll just ill treat you. You know if you are giving birth and he is seeing to you, like they remember your face and they punish you for saying what you were saying or doing what you were doing. That is how they are with you. So you must just keep quite to them."

(Antenatal AMC)

HCps need to be aware that adolescent clients enter the interaction being suspicious of

HCps and expecting the worst reception (de Jonge, 2001; Hanna, 2001). The HCps

can counteract this view by being the ones to initiate any conversation with the

clients, thus removing the burden from the client.

"And she must start the conversation. She must ask you how you feel."

(Antenatal AMC)

This is also important when attempting to take a history to diagnose problems or

needs. Adolescent clients lack experience and, therefore, may not be able to correctly

identify their own needs and problems. So, with this type of client, it is essential that

the HCp be the one to ask questions that may lead to the adolescents' problems (real

or potential) or needs (Jacobson et al, 2001).

AMC respondents saw being treated with respect as being very important in their

interactions with HCps, as this would assist in making them feel satisfied with using

the service and enhance their compliance.

"I must treat that person with respect. I would make them feel comfortable, so they come again."

(Antenatal AMC)

AMC respondents felt that when HCps appeared friendly, they were able to have a

better interaction with them.

"I found it was very nice because the nurses were very supportive and they are very friendly compared to other clinics."

(Postnatal AMC)

Friendliness was displayed by being broadminded and open towards the client. It was

also conveyed in body language such as having eye contact with the client during

consultations and not paying sole attention to either the physical examination or the

client's chart.

"They sit there and you get up there and they ask you if you feel the baby is fine, okay then its fine, see you next week."

(Antenatal AMC)

Wearing a smiling expression was also seen to put the client at ease during the

consultation.

"Ya, because if I start the conversation and she looks at me like (indicates unfriendly expression on the part of the nurse), like that you know, then aye, it makes you scared."

(Antenatal AMC)

Appropriate facial expressions would serve to diminish the fear of reprimand that

AMCs appear to have when interacting with HCps.

Findings from all stakeholder groups indicate that punishment is often dealt out with

care to AMCs.

"They hurt you and when you say you know, 'it's sore'. 'Oh, relax, relax, relax'. And most of the time they tell the patient, like anybody, 'oh when you were having sex it was nice, now you are complaining'."

(Antenatal AMC)

"But at times we are finding it difficult because we are also having adolescents at home. Then once you see this adolescent, little one, you think the behaviour is the same as the one you left at home. Then you start scolding because you are a mother, yet you are not allowed as a health provider. We are not allowed to treat them like they are our own babies but if she is pregnant you know how the mother feels at home and you are trying to put yourself in her position, yet it is not allowed."

(Maternity HCp)

Instead HCps are cautioned to remember at all times that despite the client being

pregnant, she is in fact an adolescent, who is immature.

"They're really still a child and nobody is reminding them of that. And in a kind way, you know not reprimanding them or moralizing about it. But you know explaining to them, exactly about development and pregnancy, you know and the risks they put themselves through."

(DoH HCP)

Hence, respondents advise that HCps refrain from reprimanding AMCs. Instead, what

is suggested is that HCps realize that this is someone who lacks knowledge, and, with

this in mind, try to educate the adolescent in a kind manner,' so that she is amenable to the information. Wood et al (ftp://ftp.hst.org.za/pubs/research/contracep.pdf, retrieved 7th February 2005) stress that nurses need to be aware of how they come across to adolescent clients, despite having the best of intentions, with some of the comments they make. These comments could be perceived as moralizing and result in the adolescent not using the health services. They suggest using value clarification workshops to achieve this, a method that is in keeping with suggestions by HCP and HCp respondents in this study.

Respondents appeared to concur on the need for HCps working with adolescent clients to have good communication skills. Respondents felt that very often HCps had a way of 'talking down' to clients, and making assumptions about their needs and problems.

"They need to be a listener and not just a hearer."

(Nurse HCP)

"Must be able to listen, communication skills, which listening is part of communication. And a sharp eye to be able to see beyond what she says, you know, looking at the gestures and all that, beyond what she says."

(DoH HCP)

Respondents recommend that a good communicator possesses good listening skills that will allow him or her to ascertain from the client what her problems or needs are. In this way the client will feel cared for and respected, and care given would then be relevant to the individual client. Respondents also advised that HCps make attempts to read body language of clients, as often adolescent clients may not make their needs verbally obvious.

Adolescent clients reported feeling relaxed with HCps who appeared approachable and interested in what they had to say, namely, someone whom they felt listened to them (Jacobson et al, 2001).

"They don't shout. They are just nice. You talk to them and you tell them your problem, and they understand."

<div align="right">(Antenatal AMC)</div>

The Department of Health also recommends that HCps endeavour to ask relevant questions that do not lead to the adolescent feeling that she is under scrutiny and instead encourages her in return to ask questions of the HCp and obtain information (www.doh.gov.za/docs/policy/norms/part1i.html, retrieved 28th January 2005).

5.3.4 Formalized Support

All respondent groups made special mention of support being needed by adolescents, with adolescent clients themselves verbalizing the need to be supported through the childbearing experience. From findings, it would appeared that there is a paucity of support available to AMCs.

"When they come in there is no birth partner with them. It is the saddest thing. There seems to be a tendency a lot of Coloureds coming in, no birth partners. So there is a lot of anger. They express a lot of anger, just before second stage."

<div align="right">(Nurse HCP)</div>

"And we had a patient as well, a lot of them, what they do is maybe up country they fall pregnant and then they come here to the city to keep it a secret. So also that is why they have no support because it has been kept a secret. So that's why you know that they get no support, because it is a secret."

<div align="right">(Postnatal Ward HCp)</div>

Types of support cited by respondents included support provided by AMCs' significant others, doula support, monitoring by community health workers and peer support groups. According to Treffers et al (2001), apart from closer surveillance during pregnancy, labour and delivery and in the postnatal period to detect problems, adolescent clients did not appear to need any other physical care than that afforded to

adult maternity clients. However, in the area of psycho-social care, adolescent

maternity clients needed added support.

Doulas

As mentioned earlier in this chapter as well as the previous chapter on findings, most

health care facilities were running on minimal staffing.

"At the end of it all we don't have that patient-nurse relationship. There is no time for that, because the ward is so big, because we…..the patient ratio is increased so completely, so you can't sit with the patient and that is time."
<div align="right">(Postnatal Ward HCp)</div>

This prevented one on one care, as there was a dearth of HCps in relation to the many

clients using the services. As a solution to this problem, HCps suggested the use of

doulas especially during labour and delivery.

"…having proper doulas will be good and will even assist the nursing staff in a way. Because relatives that stay in the room don't really help. They basically come and bother you all the time, and being as busy as we are, you can't spend every moment in that room. So they come every two seconds, being there, they should be there to help the person, but they come looking for the midwife all the time."
<div align="right">(Labour Ward HCp)</div>

Currently the HCps working in labour wards were finding it difficult to spend time

with the labouring clients, as they were often looking after more than one client

simultaneously. When asked if they were able to render one on one client care, a HCp

respondent said the following:

"Oh never, more like one to five, one to six."
<div align="right">(Labour Ward HCp)</div>

HCps felt that adolescent clients would ordinarily find the whole experience of labour

and delivery frightening, and would therefore need more support to get through this

painful experience. Since they were not able to free themselves to render this support,

they suggested that doulas be used to give support and encouragement during labour

and delivery.

Where doulas worked in conjunction with HCps, they were found to be very useful in freeing the HCp, who could then attend to the physical and obstetrical needs of the client.

"I was busy doing my thesis of paperwork, mothering my paperwork, I haven't got….I mean it is so thick the paperwork……..contact is not broken at all, she is with the mother continuously. Whereas I can't be, I have to go to the desk, do this, you know, whatever."

(Private Midwife HCp)

The doula would then be continually with the client, giving support and encouragement. The client would then feel more secure as she would not be left to labour alone. The doula has been trained to provide appropriate support and would be more beneficial to the client, rather than a family member who may have no previous experience or knowledge and who may in fact serve to increase the anxiety of an already anxious labouring client.

Doula is a term derived from a Greek word that means 'slave to the mother'. This individual acts as an advocate for the birth woman, supporting her and helping her adhere to the birth plan that the labouring woman may have designed for herself (http://www.laborcompanions.com/#doula, retrieved 31st January 2005). Thus the doula helps to give the client a voice, in assisting the client to decide what she needed during labour and what would make her feel comfortable, as doulas often help the client cope with pain by using non-pharmacological methods of pain relief such as aromatherapy and massage. The role of the doula would extend into the postnatal period as well. After delivery the doula would help the client to commence breastfeeding and would play a role in fostering bonding between mother and baby. A follow-up service would be rendered by the doula visiting the client at home after discharge, to ascertain if she was coping with her own physical and psychological

needs, as well as with the demands of having a new baby. The Doula Care Postpartum

Service explains the function of doulas in the postpartum period as follows:

"They give emotional and breastfeeding support along with practical newborn care
tips and take care of necessary household tasks such as grocery shopping, meal
preparation, doing the dishes, laundry or tending to your older children. It helps ease
your transition into motherhood."

(www.webspan.net/~callahan/, retrieved 31st January 2005).

The problem with using doulas at present is that within the current maternity system

at governmental institutions, the cost of their attendance during the birth and in the

postnatal period will have to be covered by the adolescent client, who by virtue of

their stage in life do not have a source of income and are often dependent on others

for economic help (Rivera et al, 2001).

*"..... but finance is always a big issue. So if it was government subsidized, that's why
the voluntary doula would work very well."*

(Private Midwife HCp)

Thus, it was suggested that the Department of Health formalize this support

mechanism by employing doulas on a part-time basis in maternity units. These doulas

would be called in when an adolescent client presents at the antenatal clinic, where a

relationship would begin between the doula and the client, carrying right through the

pregnancy, terminating in the postnatal period once the adolescent is found to be

coping with her baby. These doulas would then be paid an hourly rate for the number

of hours that they put in with the adolescent client, including transportation costs for

postnatal follow-up within the community.

Community health workers

HCP and HCp respondents suggested another way of providing formalized support to

adolescent maternity clients through the use of community health workers who were

specially trained to give support and follow-up to adolescent clients from their communities.

"But it will be somebody popping in, you know, saying "how are you doing with your baby"."

(DoH HCP)

"They could go in, the community health workers for instance, they could go in and be retrained how to help them with the breastfeeding."

(Nurse HCP)

de Jonge (2001) reported that teenage mothers, in her study, expressed a distrust in health professionals, as a result of perceived condescending attitudes. The same is reported by Hanna (2001, p. 460), in whose study adolescent mothers appeared to perceive "nurses like parents, as being authoritative and bossy". It would seem that community health workers may be better received by adolescent clients as opposed to HCps. To this end the Department of Health has in mind as part of its 'Strategic Priorities for the National Health System, 2004 – 2009' the strengthening of community health worker programmes as well as a plan to increase the number of community health workers (www.doh.gov.za/docs/policy/stratpriorities.pdf, retrieved 25th January 2005). Programmes would then need to be developed to train these individuals for their role in maternity care, as in the case of community health workers, who had been trained to work with HIV positive individuals and people infected with tuberculosis.

"But use this opportunity, you know to make young people learn from the older people, and learn to...you know Ubuntu (spirit of sharing) is not there anymore."

(DoH HCP)

It was suggested that older community members should be selected to undergo such training. The reason for this was two-fold. Firstly, they were often retired and could give off their time; and, secondly, they had the necessary life experience and life skills, having parented themselves, and were thus in a position to be nurturing towards the adolescent client, and able to advise her appropriately. Vance (1982 in Flynn,

1999) adds more substance to this reasoning by describing the role as that of a mentor, and explains this as, "an older, more experienced person who guides and nurtures a less experienced person" (Flynn, 1999, p. 183).

Since the motivation for becoming a mentor is to assist another according to their needs, the entire basis of the mentor-adolescent relationship is one of caring (Flynn, 1999). Thus community health workers would also help to pave the way for the adolescent within their communities, as coming from the same community they would provide support that was culturally relevant, and, at the same time, help to desensitize other individuals within that community who may harbour negative feelings or attitudes towards adolescent maternity clients. Maternity community health workers would also serve the important function of acting as resource person to pregnant or parenting adolescents. Often adolescents in such situations experience lack of information as one of the problems confronting them, not knowing what to do to resolve a problem or need, what services to seek and how to go about accessing such services (de Jonge, 2001). Community health care workers can be the resource persons whom adolescent clients turn to, giving direction and guidance as needed.

Support groups

The establishment of support groups was seen as a way of increasing support to adolescent clients.

"Especially for the follow-up. Allocate someone for two months, every week there will be a group meeting, so that these patients get to know each other and they know they are not alone and then they create a bond amongst each other."

(Postnatal Ward HCp)

This would be a support group made up solely of adolescent maternity clients, with HCps acting as facilitators of group process. These support groups could be

established during the antenatal period and continue until the postnatal period, where they could provide support and an outlet to parenting adolescents.

Another alternative that was suggested would be to train adolescent clients who had already gone through the experience of falling pregnant, and delivering a baby, and who were now established in their parenting role to provide support to other adolescent clients.

"Okay, postnatal. I wish, you know there is a programme called 'M to M', mothers to mothers to be, that is what it is called and that, especially for HIV but I think it could work for adolescents as well. ......She then is given a mentoring job to take somebody else and I think you could probably do that with adolescents."

(DoH HCP)

These individuals would give one on one peer support, and would be seen as a person whom the adolescent client could identify with and relate to because of the close proximity of their ages, as well as the shared experience. They could be coupled with adolescent maternity clients from their own communities for relevance and easy access. Apart from providing support to adolescents who had already fallen pregnant, respondents felt that these individuals could play a role in the prevention of adolescent pregnancies, by using their experiences to create awareness amongst other adolescents within their communities. Extant literature indicates that where support groups have been initiated for parent adolescents, they have proven to be very beneficial (de Jonge, 2001).

5.3.5 Community Participation

Community awareness

Respondents in the HCP and HCp groups felt that adolescent-friendly maternity care could not exist without community involvement and support, as adolescent clients

came from communities and went back to these very same communities after discharge from the health care facility.

"But I think society needs to be taken with us in this and I think it cannot happen without an outreach component."

(DoH HCP)

As part of inputs for adolescent-friendly maternity services, community awareness of the incidence of adolescent pregnancy, with its consequences needed to be brought about. Raising awareness was also seen as the first step to empowering the community, by allowing the community to take ownership of such endeavours.

"I think to raise awareness of the issue, I think this is where to start."

(DoH HCP)

Community members should be made conscious of the vulnerability of adolescent maternity clients, as well as their babies. The long-term societal implications should also be made known to community members in a bid to get them to take up the challenge of assisting such clients back on their feet, towards a prosperous and stable future. Currently within the South African context, adolescent clients receive a monthly governmental grant towards the upkeep of their children. Such initiatives, while a blessing to these adolescents and their children, can in fact be a drain on society. "Teenage mothers are a concern to the community in a number of ways, the most pervading being cost to society. This cost can be measured in financial terms, as the majority of teenage mothers rely on government supports for their subsistence" (Hanna, 2001, p. 457). The National Youth Policy confirms the poor economic status of adolescent mothers whose schooling is interrupted, with resultant difficulty of finding employment or having meagre paying employment (National Youth Commission, 1997). Hence the need for the community to mobilize, to see that the adolescent is able to go through her pregnancy problem free, cope with the added responsibility of being a parent and resume her education towards getting proper employment with a good salary. Community awareness needs to be directed to all

sectors of the community and include all age groups, so that it can also have the added

benefit of preventing future adolescent pregnancies.

Community involvement, mobilization and support

Respondents felt that once an awareness of adolescent-friendly maternity care and the

vulnerability of such clients is created, community members would then need to be

encouraged to get involved in endeavours to support such adolescents. Initial

involvement could be actions such as encouraging adolescents who are known to be

pregnant and not seeking maternity care to actually commence antenatal care.

*"The community should be involved if the patient is pregnant or maybe in that area,
the community should try and advise all adolescent children."*

(Antenatal Clinic HCp Interview)

Respondents saw community members as having a duty to educate these adolescents

and give them guidance towards doing the correct thing for themselves and their

babies (either born or unborn).

Willing community members could also be trained as community health workers with

a specific focus on maternity care.

*"Just to visit the postnatal mothers for a week, washing the babies, cleaning and
cooking, and looking at their personal and environmental hygiene. Help them, what's
so ever problems, feeding, teaching them because we have few hours of stay at the
clinic."*

(Maternity HCp)

Their function would be to give formal support and to carry out follow-up care to

parenting adolescents and their families. This can be done in the form of home visits

to adolescents within their communities to determine whether they are coping and to

help them develop their parenting abilities (Barnet, Duggan, Devoe & Burrell, 2002).

Adolescents who lack family support would also see these community health workers

as someone to turn to when they have a problem, either with themselves or their

babies, as many of them may experience a breakdown in family relationships due to the pregnancy (Tanga & Uys, 1996). However, before any community outreach component can be introduced, HCps working in adolescent-friendly services have to be competent in the areas of developing community relationships, working with and educating communities, as well as having a thorough knowledge of pre-existing community initiatives and how best to fit one's self or the service one provides into this existing framework, towards improved community relationships (www.doh.gov.za/docs/policy/norms/part1i.html, retrieved 28th January 2005).

5.4 OUTPUTS IN RELATION TO INPUTS

According to McNamara (2000), 'outputs' make reference to the concrete results in which the activities terminate. So using the programme logic model described earlier in this chapter, this would be the end result of the model as used here. However, for easy recall and quicker understanding, the researcher has decided not to wait until the end of the chapter to present all the outputs and has instead divided outputs into those that result from inputs and those that result from processes. Hence, Table 21 that follows, contains the identifiable outputs that the inputs towards an adolescent-friendly maternity service extracted from stakeholder consensus would be expected to have.

Table 21: Outputs that result from Extracted Inputs

Inputs	Outputs
Policies	► Policies that agree with and complement one another. ► An adolescent-friendly maternity service policy that can be used to set up and guide the offering of services to pregnant and parent adolescents. ► Horizontal, holistic care within and across different service sectors within the health care system. ► HCps who understand and are committed to the provision of adolescent-friendly maternity services. ► Community awareness of the available services will be raised.

Educational preparation	▶ Awareness of the adolescent maternity client will be strengthened in pre-service HCp educational programmes. ▶ Foundation in adolescent health will be formed on which future adolescent specific programmes can build. ▶ An HCp workforce that has specialist training in rendering adolescent health care. ▶ More effective health care to adolescent clients, as a result of improved and specific HCp knowledge and skills. ▶ HCp skills and knowledge in adolescent health would be current and contextually relevant. ▶ HCps would feel more confident in and satisfied with rendering health services to adolescent clients.
Administration	▶ Service provision to adolescent maternity clients within existing health care budgets. ▶ Adolescent clients receive benefits from interaction with the general maternity client population. ▶ Prevention of unnecessary stigmatization of adolescent maternity clients. ▶ Consistency in adolescent-friendly approach to care in all HCps across all aspects of the maternity service. ▶ Service administrators and management that understand and unequivocally support an adolescent-friendly maternity service. ▶ Smoother service delivery, as a result of well coordinated action. ▶ Adolescent-friendly maternity services are more accessible in terms of travelling distance and opening times. ▶ Effective referral pathways with efficient transportation for clients who may develop complications. ▶ Better surveillance of and care given to pregnant and parenting adolescent clients across all sectors of the health service. ▶ HCps and clients would be more satisfied with a service in which they were allowed to give input, as the service would better meet their expectations and needs.
Health Care providers	▶ Employing more HCps would translate into more effective individualized care being given, and greater client satisfaction. ▶ Employing appropriately skilled adolescent-friendly HCps would ensure higher quality care being rendered, with clients having more satisfied interaction.
Support	▶ Support would ensure a more positive outcome for both the adolescent and her infant, with improved coping and mental health.
Community outreach	▶ Community awareness and mobilization would result in better support to adolescent clients and better service utilization.

5.5 PROCESSES

Processes refer to the activities that are carried out, using resources or inputs towards the intended result, which in this case are adolescent-friendly maternity services (http://www2.uta.edu/sswmindel/S6324/Class%20Materials/Program%20Evaluation/ Executiv.pdf, retrieved 6th February 2005).. For the purpose of this report, 'processes' is a broad term used to describe the activities in rendering adolescent-friendly maternity services to adolescent clients during antenatal, labour and delivery and postpartum care. This includes tools, technology, events, actions, etc and encompasses physical and psycho-social care given to AMCs. As such, Table 22 that follows, is a summary of the essential processes that have been extracted from the stakeholder data, together with their components. Following this table, is a detailed discussion of each of these processes.

Table 22: Essential Processes Towards an Adolescent-friendly Maternity Service

Processes	Components
Adolescent-friendly services	◊ Early commencement of maternity care ◊ Orientation to the system ◊ Comfort within the system ◊ Approach to adolescent clients ◊ Pain management ◊ Postnatal Care ◊ Contraceptive Services ◊ Community follow-up
Adolescent-friendly interaction	◊ Egalitarianism ◊ Respect ◊ Empathy and Understanding ◊ Support and Reassurance ◊ Creating rapport
Health Education	◊ Appropriate to the client's level ◊ Individual client teaching ◊ Using peer groups ◊ Consistent thread throughout maternity care
Support	◊ Significant others ◊ Doulas ◊Counselling ◊ Support groups

5.5.1 Adolescent-friendly Services

Early Commencement of Maternity Care

As seen from findings in chapter four, adolescent clients are notorious for either commencing maternity care too late in their pregnancy or not at all, coming into the hospital or clinic in time to deliver their baby (Akinbami et al, 2003).

"Well, you know most of the times you will find that there is (sic) lots of unbooked teens coming in. I suppose more so because they are hiding the fact that they are pregnant. The family don't (sic) know, so basically they have had no antenatal care, they have not been to antenatal classes and as a result they don't know what to expect."

(Labour Ward HCp)

"They asked why did I fall pregnant when I am so young, why I am having that....then I was cross. I didn't come for three months. So when I came back, they said, no, they were just shouting at me to tell me that it's wrong."

(Antenatal AMC)

Adolescent clients also provided information of feeling embarrassed, and on perceptions of reprimand from HCps that caused them to delay antenatal care or default on care. Respondents also felt that within the South African context, a strength was the existence of the maternity service itself and the quality of antenatal care available to adolescent clients. However, while the service was available, respondents felt that something needed to be done to encourage adolescent clients to access it as soon as they discover that they are pregnant.

"There might be more drive towards sort of advertising antenatal care to the general public, so that they know they must go early. Because we still get patients that come in and they are unbooked."

(Medical HCp)

The review of literature surrounding the problem of adolescent pregnancy in Chapter Two, serves to highlight the potential and real problems to which pregnant and parenting adolescents are at risk, due to their physical and psychological immaturity (Trad, 1999; Ehlers, 2000; Rivera et al, 2001; Treffers et al, 2001; Mngadi et al, 2002. Hence, this reaffirms the importance of commencing maternity care as soon as possible.

Earlier in this chapter it was suggested that one of the inputs that had to be put in place towards an adolescent-friendly maternity service, was the training and allocation of community health workers. These individuals would be instrumental in helping to identify pregnant adolescents within the various communities and act as resource persons, informing them of the need to access maternity care and how to go about actually doing this. Another way to get the message out to adolescents in the community is by way of school-based education programmes with schools playing a more important role, working in conjunction with the Department of Health, on a number of adolescent health issues, with adolescent pregnancy being one of these issues (www.doh.gov.za/docs/policy/norms/part1i.html, retrieved 28th January 2005). The media may also be instrumental, by using radio, television, newspapers and magazines to advertise maternity health care services, and to highlight the need to commence care early, so that problems can be detected timeously and treated appropriately, towards optimal health of the mother and baby and a safe delivery.

From the information provided by AMCs on their perceptions of the interaction between the HCPs and themselves, it would appear that once AMCs access maternity care, HCps need to try and ensure that these clients continue with care and not default.

"They didn't .....because of my age they felt that I was too young to have a baby so they didn't actually take care of me."

(Postnatal AMC)

Jacobson et al (2001) report adolescents not feeling relaxed with HCps, whom they perceived to be judgmental or patronizing towards them. This knowledge can help the HCp to guard against coming off in a negative or judgmental manner towards the adolescent, who may then default care as a defensive response.

Barnet, Arroyo, Devoe and Duggan (2004) examine the idea of offering antenatal care at schools, as a strategy for preventing pregnant adolescents from dropping out of schools and also to ensure that adolescent receive vital antenatal care. Another strength of such a suggestion, would be that if boyfriends (who are the fathers of these babies) are attending the same schools they could then be included and attend school-based antenatal visits with their pregnant partners.

"Well, basically most of them actually don't, although we do make a provision of having a support person, most of them don't have a support person. Although we do encourage it. But generally when there are people to support, it's usually like mothers or sisters, but not the partner as such."

(Labour Ward HCp)

As can be seen by the statement above, HCps often noted that pregnant adolescents laboured without much support and in situations when it did exist, the father of the baby was seldom the labour companion. The suggestion of Barnet et al (2004) would thus serve to strengthen this source of support, towards fostering a bond between the father and his child as well. Results in the Barnet et al (2004) study indicate that there was a significant drop in absenteeism in pregnant adolescents attending school-based antenatal care as opposed to those who were not. Apart from absenteeism, the school dropout rate was significantly reduced as well. These results are encouraging and act as a motivating factor towards creating a school-based antenatal initiative within the South African context, that will ensure good antenatal care to pregnant adolescents, as well as prevent disruption in or failure to complete one's education.

Orientation and Comfort

'The Patients' Rights Charter' addresses the issue of health information, stating that as part of access to health care, all patients have access to "health information that includes the availability of health services and how best to use such services and such information shall be in the language understood by the patient"

(www.doh.gov.za/docs/legislation/patientsright/chartere.html, retrieved 28th January 2005, p. 1). de Jonge (2001) states that respondents in her study often found that they lacked information and were therefore, not confident or able to access services that they may need. A similar result emerged from adolescent respondents in this study, where adolescent clients complained about not understanding how the clinic system worked.

"There is no one to tell you, like, okay there is (sic) lines there."
<div align="right">(Antenatal AMC)</div>

Respondents made mention of being reprimanded by HCps for joining incorrect queues in the antenatal clinic or getting lost when being sent to access services in another department of the hospital.

"Then they sent me downstairs, so I am asking the nurse like where's you know, the clinic. She's saying, she doesn't know, she doesn't know!"
<div align="right">(Antenatal AMC)</div>

This was an embarrassing and frustrating experience for adolescent respondents who make all attempts not to draw attention to themselves within the service.

AMCs provided evidence of being embarrassed about using maternity services, as indicated in the statement.

"I feel embarrassed in front of everybody, you know. Girls also will ask, 'oh, you're fifteen', you know."
<div align="right">(Antenatal AMC)</div>

With this in mind, respondents suggested that health care facilities allocate an individual, whose job it is to orientate new adolescent clients to the physical layout of the facilities, so that the client would know where to go to seek whatever service they may desire.

"They need to be informed at this clinic. Once they get to the clinic, the clinic needs to inform them. This is the process, this is how it works because that is where it starts."
<div align="right">(Mother of AMC)</div>

It was suggested that the person doing the orientation explains to the adolescent client, why antenatal care is important and the importance of being compliant with care, as well as how the clinic-day runs and what the adolescent needs to do to access the service, such as where to fetch her file from, which queues to join, in what order and for what aspects of the service, the approximate length of stay in the clinic, so that the client can come prepared with food, drinks and something to keep her occupied (such as reading material).

Respondents recommended that when more than one adolescent client presented for the first time at the antenatal clinic, a group orientation should be done, otherwise it should be done on an individual basis.

"They are very shy, they close down, they don't participate and they go very quiet. You can see them looking around, because often they're too big for them."

"And the older mothers sort of look at them, you know and it makes them feel bad."
(Clinic HCp)

Hence, as can be seen from the statement above, HCps believed that it was not wise to combine AMC's with the general maternity population for health education, as they may feel conscious of themselves (Hanna, 2001) and may close up, losing the opportunity to ask questions that they may have. They may also be afraid of losing anonymity in the event that other adult clients are from their communities (Kunene, 1995; Jacobson et al, 2001). Combining them with adult clients may also serve to make the person doing the orientation forget that they are a special group, with special needs and they may be lost within the general group.

"Health education to teenage pregnant clients alone, that should be done alone so that they should ventilate their views."
(Clinic HCp)

Respondents also argued that if AMCs are given health education separately, it would also provide them with the opportunity to discuss issues that may be worrying them.

All stakeholder groups alluded to adolescent maternity clients feeling very self-conscious when accessing maternity services. Hanna (2001, p.460) found a similar situation of where adolescent clients felt "conspicuous because of their youth" and saw older clients as having "patronizing attitudes towards teenage mothers". Results from Jacobson et al (2001) concur with the finding of adolescent clients' feelings of being under scrutiny in the waiting rooms of general practitioners. With this is mind, it may be necessary to attempt to fast-track them through the antenatal clinics when they present for their routine appointments.

This would also help to decrease the long waits that adolescent respondents complained about, when asked to cite weaknesses within the present maternity system. Adolescent clients also complained about feeling that HCps did not empathize with them and therefore, did not appear to be concerned for their welfare.

"They take their own time if you want to go there. They start chatting and when you want to go home, they don't attend us."

(Postnatal AMC)

They waited for a long time to be seen, and often ended standing in queues the whole time, as there was not enough seating available within the clinic. For care to be friendly, adolescent clients need to feel that HCps are in fact aware of their needs and care for them. A way to achieve this apart from fast-tracking them through the clinic system is also to provide them with adequate seating while they wait to be attended, so that they may rest while waiting.

Approach to Adolescent Clients

In order to offer holistic care to adolescent maternity clients, respondents felt that a multi-disciplinary team approach was needed. As seen from the literature review and

findings, adolescent maternity clients were considered to fall into the high-risk

category (Trad, 1999; Ehlers, 2000; Rivera et al, 2001; Treffers et al, 2001; Mngadi et

al, 2002), especially as their ages dropped. Respondents in this study concurred with

extant literature with regards to AMCs being high-risk clients.

*"It is a known fact that these patients in labour, majority of them land up having
caesarean sections because their pelvises are small, they are not very well developed
and they have babies that are pretty huge. Maternal fatigue is the other problem that
they commonly have. So these patients land up having Caesars either for CPD or
maternal exhaustion or things like that."*

(Medical HCP)

As a result, it was essential that they have access to obstetric care and hospital

delivery facilities. Respondents felt that nursing staff were equally needed, as they

were greater in number than medical staff and often had an unofficial understanding

with the medical staff that they would be the ones to give health education to

antenatal clients. Jacobson et al (2001) found that doctors in their study were viewed

as greater authority figures to adolescent clients, than nurses, which had the potential

to negatively affect the client's ability to communicate with the HCp. Respondents in

the present study also made mention of adolescent clients needing specialized

counselling beyond the scope of nursing staff.

*"The second strength that we have is that when they come to us pregnant, we've got a
social worker that speaks to them and they are consulted with a social worker to see
what their social circumstances are. Whether their parents know that they are
pregnant, whether they have informed them? What is the support structure that they
have?"*

(Medical HCP)

According to the respondent in the statement, AMCs were referred to the social

worker for more extensive counselling and problem identification and solving. Extant

literature also points to pregnant adolescents either having poor dietary habits or

decreasing their dietary intake in an attempt to prevent weight gain and delay those

around them discovering their pregnancy (Flynn, 1999; Treffers et al, 2001). Thus, it

would stand to reason that these clients would need special consultation and teaching from a dietician to ensure good nutrition during pregnancy and optimal foetal development. This is to name a few members of the multi-disciplinary team, thus making an argument for a multi-disciplinary team approach to adolescent-friendly maternity care.

Pain Management

HCP and HCp respondents perceived adolescent clients as lacking experience and therefore being unprepared for the experience of labour and delivery. Adolescent clients were also not perceived to cope very well with labour and delivery by most respondents who rendered labour and delivery care.

"Definitely, especially in adolescents, as they often won't be able to cope with the pain, as good as adult patients."

(Medical HCp)

Postnatal adolescent clients also remarked on how painful their labour and deliveries had been. HCP and HCp respondents felt that adolescent clients did not have the necessary mental preparation to deal with such a painful experience and often appeared to be traumatized by the whole experience. This in turn was reported to have a negative effect on their ability to bond with their babies (Ladewig et al, 2002).

As such, it was suggested that special attention be paid to pain management for labouring adolescent maternity clients. Where pain relief was available, HCps should not be remiss to use it.

Respondents mentioned the lack of epidural facilities, which in turn led to poor pain management in labouring adolescent clients and suggested that efforts be made to correct this situation.

"I think that is one place where there can be much more improvement easily. Because simple pain management. We don't have access to epidurals..."

(Medical HCp)

This would help to decrease the pain experienced during labour, allowing the adolescent client the opportunity to cope with the pains of uterine contraction, making the whole experience of childbirth less traumatic for the adolescent. Pain management would result in the adolescent not feeling resentful of her baby, who may be perceived as the source of the pain. Hence bonding would be enhanced. Less pain in the postnatal period would also allow for early ambulation thereby decreasing postnatal complications such as infections and deep vein thrombosis (Ladewig et al, 2002).

Postnatal Care

Currently, within the sites where data was collected, postnatal hospital stays for women with uncomplicated pregnancies, labour and deliveries last for six (6) hours post-delivery. After which time, the client was discharged home and would seek further care at her local community clinic.

"Six hours is like really at a push. So they have no clue, they haven't had any support or bonding with the baby, haven't been taught how to breastfeed properly."

(Labour Ward HCp)

HCP and HCp respondents felt that this was too short a stay for the adolescent to derive any benefit. Adolescent clients themselves spoke about not having much experience and depended on their significant others to help them cope with their babies. It was suggested that the postnatal hospital stay be extended for adolescent clients from six (6) hours to forty-eight (48) hours. This would give HCps working in postnatal wards a chance to observe the adolescent with her baby, to determine if she was experiencing any problems and what help she needed to be given. Respondents mentioned helping the adolescent mother with establishing and maintaining breastfeeding, daily care of her baby and caring for herself during physiological

postnatal changes. Hence, this extended stay would give the HCps an opportunity to give individualized care to adolescent clients, as well as some much needed health education.

Contraceptive Services

While contraceptive services were available to adolescent postnatal clients, it would seem that there have been some changes in the way contraceptives are now prescribed, with clients not commencing a method immediately post-delivery. This had to do with new findings from the Department of Health about the potential harmful effects to the baby via breastmilk. The Department of Heath advises that women who have opted not to breastfeed can be commenced on a progesterone-only contraceptive, immediately post-delivery. While those women who are not breastfeeding and want a combined (oestrogen and progesterone) oral contraceptive, should only commence on a combined method three weeks post-delivery, so that the risk of developing deep vein thrombosis is reduced. Women who opt to breastfeed can only use a progesterone-only contraceptive method. However, due to the theory of potential risk to the baby in the first six weeks of life from exogenous hormones excreted in the breastmilk, postpartum breastfeeding mothers are advised to wait and commence with a progesterone-only contraceptive method at six weeks post-delivery (www.doh.gov.za/docs/factsheets/guidelines/contraception/contraception02.pdf, retrieved 1st February 2005).

Respondents felt that while they understood the thinking behind this change, they did not always agree with it. The adolescent client was then discharged without being on

a method and was then expected to seek contraception at a later date from her local community clinic.

"Less accessible, you are going to go home and put it off until you have got time to go to the clinic and sex may come first."

<div align="right">(Clinic HCp)</div>

HCps felt that compliance with this was very low, and often the client ended not going on any method of contraception, resumed having unprotected sex and was at risk for another unplanned pregnancy, close on the heels of this one. Flynn (1999) appears to share this concern, and remarks that a compounding factor to adolescent pregnancy is the incidence of repeat pregnancy. Statistics in the United States of America reveal a 30 – 35% chance of adolescents having a repeat pregnancy within a year (Coard, 2000). Hence, as part of adolescent-friendly maternity care, it was imperative that contraceptive services also be provided, so as to ensure prevention of repeat adolescent pregnancy.

Community Follow-up

As mentioned many times already in this chapter and the preceding one, adolescent maternity clients were considered to fall into the 'high-risk' category. As seen in the findings, they did not always have a well established support system.

"Because even your friends in the township, are going to neglect you. Your parents are going to scold you. Nurses are scolding you. Then what is it. You tend to be psychologically deranged because you are not prepared. And when you are young, you are not prepared for all this."

<div align="right">(Nurse HCP)</div>

Adolescent mothers are known to experience depression during the postnatal period (Hanna, 2001). Coupled with this is the fact that adolescent maternity clients also perceive that HCps would be judgmental of them. So often they tend to pretend that everything is fine with them and that they are coping with their babies, when in actual

fact they are not (de Jonge, 2001; Hanna, 2001). Hence, de Jonge (2001) urges HCps to be vigilant when assessing the mental status of adolescent mothers. According to Hanna (2001), adolescent mothers are more likely to be abusive towards their babies as they tend to be less tolerant of its crying and more impatient, due to not understanding normal infant development (physical and psychological). This is coupled with normal narcissistic behaviour which is typical of adolescence and results in the adolescent mother's inability to place the needs of her baby before her own, as expected of an adult parent. Flynn (1999) and Treffers et al (2001) draw attention to the fact that adolescents are more likely to deliver low-birth weight babies, who often present with problems of delayed growth and development, and high morbidity and mortality, with resulting need for increased care. Flynn (1999) draws our attention to the fact that the rate of child abuse amongst adolescents under twenty years of age is very much higher.

These factors highlight the need for HCps to have more contact with adolescent mothers after discharge from the health care facility, with which respondents concurred.

"They do need a follow-up care at home because most of them they don't stay with their grannies like before, they don't stay with their mothers like before. You get the history and you talk to them, you find that they stay with boyfriends."

(Maternity HCp)

A way of doing this is to conduct home visits, where the client can be observed and assessed in her natural environment, to determine if she is well and is coping with her newfound responsibilities. Home visitation programmes are "frequently based on a model in which the home-visiting-paraprofessional serves as a mentor, or role model, to the at-risk mother, providing social support and nurturing as well as education regarding child development and parenting" (Flynn, 1999, p. 183). According to

Barnet et al (2002, p. 1216), "research suggests that home visitation is a cost-effective intervention, and can be effective for enhancing parenting skills, decreasing child abuse and neglect, and improving maternal course of life". Within the South African context, economic constrains may make such visitation impossible. To this end, Barnet et al (2002) suggest the use of volunteers in providing this much needed service of home visits to adolescent mothers and their babies. For this to be effective, community awareness needs to be raised and the community mobilized to volunteer their support. However, results from the Barnet et al (2002) study were not encouraging, in that the presence of these volunteers did not appear to greatly reduce parental stress in adolescent mothers.

Since HCps are unwelcome and perceived in a negative light by the adolescent as suggested by de Jonge (2001), who postulates that this is because adolescents fear that the HCp may feel that she is not coping and take her baby away, then community health workers may be the solution to the problem. These are lay individuals who receive training in aspects of adolescent maternity health care. Since they are members of the very community that the adolescent is from, it stands to reason that they would be perceived in a better light, and seen as someone trying to assist rather than someone with power over the adolescent. Whatever the case may be, adolescent-friendly maternity care needs to include home visits and long-term follow-up within the community. To make follow-up more effective, a woman-focused approach should be used, rather than focusing mainly on the infant. In this way, both the mother and child would be assessed and assisted, rather than purely monitoring the infant's growth and development (Hanna, 2001), which is often the case.

5.5.2 Adolescent-friendly Interaction

Client-HCp interaction should be directed towards helping the adolescent client strengthen the developmental tasks inherent in adolescence, "those being a sense of belonging, the acquisition of skills, feelings of self-worth and the development of appropriate relationships" (Hanna, 2001, p. 462). 'The Patients' Rights Charter' also adds onto this by stating that clients have the right to services where there is "a positive disposition displayed by health care providers that demonstrates courtesy, human dignity, patience, empathy and tolerance" (www.doh.gov.za/docs/legislation/patientsright/chartere.html, retrieved 28th January 2005, p. 1).

Egalitarianism

Adolescent clients do not want to be treated differently from adult maternity clients, "but equally they did expect nurses to recognize that they had additional needs that may have been different from those of other mothers" (Hanna, 2001, p. 460). This agrees with the findings of this study where, while adolescent respondents did not request to have a separate maternity service to their adult counterparts, they did in fact ask to be treated like any other client using the maternity service.

"Treat me equally like how you treating everybody else."

(Antenatal AMC)

Many felt that they were discriminated against and judged for falling pregnant at such a young age. They wanted to be taken seriously and not treated in a dismissive manner.

"If you want to make a suggestion, like why don't …..you know, they won't listen to you because you are a small child. You know, 'who you?' 'Go and sit down', or something. They don't listen to you or anything. They just push you one side."

(Antenatal AMC)

Wood et al (ftp://ftp.hst.org.za/pubs/research/contracep.pdf, retrieved 7th February 2005), report findings of nurses perceiving adolescent contraceptive clients as children, which is in agreement with the sentiment expressed by the adolescent respondent in the statement above. Pregnant or parenting adolescents often reported not having a voice, where their opinions and problems were dismissed by those around them, including the health care providers because it was felt that their problems were self-inflicted (Hanna, 2001). While adolescent respondents did acknowledge that they lacked experience in childbearing, they felt that this did not mean that HCps should disregard information that they provided. They wanted to be shown the same treatment that HCps would give to adult clients.

"They need to feel empowered and respected, they're humans just the same. And they must enjoy the birth because they are going to raise that child, if they choose to keep it and they need to have that positive effect right from the word go."

(Doula HCp)

This philosophy was also conveyed by the doulas and midwife working in private practice, who perceived childbirth as a special experience in a woman's life, irrespective of her age. From accounts given by adolescent respondents it would appear that some HCps rendered punitive care, which adolescents perceived as destructive rather than helpful.

"Bring me up. You know not always degrade me, tell me about my age and all that."

(Antenatal AMC)

Adolescents want HCps to support them rather than being critical of them. All interactions should be directed at developing autonomy within the adolescent, focusing on enhancing communication skills and building of healthy relationships (Hanna, 2001).

Respect

Mutual respect was an essential ingredient if maternity care was to be effective.

Adolescent clients often come into the situation on the defensive, anticipating the

worst reception, either from previous personal experience with HCps, the like of

which was reported by Abdool Karim et al (1992) or from hearsay. Adolescent clients

often report feeling that they were respected less than other health care clients, and

that they were often treated as children by the health care team (Jacobson et al, 2001).

Respondents reported the need to be accompanied by an adult in order to be treated

with respect by HCps.

"They won't say anything to you because if they see an elderly person, then they are not going to say anything. They are going to keep quite. If you there alone, they are going to run you down, make you look like a fool because of your age."

(Antenatal AMC)

If attending maternity services alone, they were at risk for ridicule, which took place

because of perceived judgment by HCps. An adolescent client who was respected

would be likely to reciprocate and be respectful in turn, which would lead to a

harmonious relationship between HCp and client. Respect was conveyed by the way

the HCp interacted with the client. Eye contact, and not remaining buried in one's

paperwork was a way towards making the client feel that they were in fact being seen

as a person.

"Like they weren't interested and if I asked something, they won't give a straight answer or things like that."

(Postnatal AMC)

Sometimes health care providers are seen as being too authoritarian and controlling,

which may become problematic during client-HCp interaction (Hanna, 2001;

Jacobson et al, 2001).

Empathy and Understanding

While adolescent clients wanted HCps to treat them like other maternity clients, they

also wanted HCps to remember that they were in fact different from the normal adult

maternity client (Hanna, 2001). They felt that this knowledge should be used to help

them rather than judge them.

"Just that they must be more caring, I mean they must be more understanding
towards young girls because most of them don't know what to expect and you know,
exactly what they are supposed to do. Instead of shouting at them when they want to
get something across, they should just tell them properly."

(Postnatal AMC)

Adolescent clients lack experience and knowledge due to their immaturity. Therefore,

they needed HCps to be able to empathize with them, as they would their own

children, and in doing so, anticipate their needs.

"You must talk like, the person is your child. You mustn't just treat the person
anyhow."

(Antenatal AMC)

It was expected that this knowledge of adolescent clients as lacking experience,

should serve as a reminder to the HCp to be patient when dealing with them.

Support and Reassurance

AMCs expected HCps to acknowledge that they were going through a stressful time

and make efforts to support them and provide reassurance.

"I just feel that we need support from them. If the nurse is supportive, then that's all I
need her to have."

(Postnatal AMC)

"It is also crucial that health professionals support these women with regards to their

specific needs, without displaying a condescending attitude" (de Jonge, 2001, p. 55).

"I mean, we know that okay fine at a young age we are not supposed to be having
babies and everything. And if it happens, okay fine, it's happened. It's a mistake. We
actually, especially if you like having the baby, you are prepared to face the
consequences and you don't expect anybody to be like looking down on you or putting
you down. You expect them to be supportive and more understanding."

(Postnatal AMC)

Rather, concrete strategies for support would entail assessing the client's level of knowledge, anticipating her educational needs and provide her with health education to bridge gaps in knowledge as a result of inexperience.

"I was like in pain and I was very uncooperative and she was like ....even though she was screaming at me. She was only screaming at me like reasonably. Telling me, 'okay fine, don't do this, don't do that'."

(Postnatal AMC)

Another way would be to help the adolescent develop coping strategies to deal with stressors that may present. HCps could play an important role by providing reassurance to the adolescent client that everything was going to be okay and that she was going to come through the situation. This would go a long way to making the adolescent client feel more confident in herself, as pregnant and parenting adolescents are often reported to have low self-esteem (Hanna, 2001).

Creating Rapport

Apart from those mentioned above, respondents cited certain strategies that can be used to create or enhance HCp-client rapport during consultations. While it would be ideal to have a separate adolescent maternity facility, it is not economically feasible within the South African context. So, instead, it was suggested that certain HCps be selected to render care to adolescent clients within a service. These individuals would be trained in adolescent maternity health care and would provide continuity of care to adolescent clients, who would be attended to by familiar HCps.

"If you have a special task team too, that they get to know. You could always have the same person looking after them, ...But to have the same familiar face, not to be treated by an entirely different person, might be helpful."

(Antenatal Clinic HCp)

Care within a particular clinic or service should then not be compartmentalized, which is so often the case, with different HCps attending to different aspects of the same routine visit.

"A weakness of antenatal care is that we have broken it down into little components and everybody has their little component you know. If I am in urines today, I stand and test urines today and in the end, nobody actually has seen the women as a holistic person and I think that is bad for the mother..."

(DoH HCP)

Affording horizontal care within the service will help to strengthen the HCps

relationship with the client and also help the HCp have a better understanding of the

client, since he or she would have a more global view of the client, as opposed to a

fragmented one.

Adolescent respondents felt that they waited a long time before being seen, and once

they got into the consultation room, they felt that the HCp dispensed with them far too

quickly.

"Like the other doctor that I saw last week. He didn't explain to me, what am I (sic) going to see. You know, he didn't explain what's going to happen before I do give birth."

(Antenatal AMC)

HCp respondents on the other hand felt constrained by the high client numbers in

relationship to the number of HCp working in a particular maternity unit. So from

both points of view the consultation was very rushed. Adolescents wanted the

consultation to be unhurried, with adequate time allowed for them to have all their

needs addressed. Adolescent clients were noted to have a higher degree of satisfaction

when HCps "allowed them time to overcome their initial fears and gain confidence to

voice their concerns" (Jacobson et al, 2001, p. 813). Respondents alluded to

'production line' care being given.

"You can walk into whatever antenatal clinic you like, there is very little education going on. It's more become sausage machine kind of stuff."

(DoH HCP)

To overcome this problem HCps need to give individual clients adequate time during

consultations, so that they are able to express their needs. Clients wanted to be able to

make a connection with HCps, who to this end need to focus on the client as opposed

to the paperwork. The rationale behind this suggestion is that often the adolescent would not freely open up on her own, and it would be up to the HCp to do a thorough assessment of the client by asking relevant questions (www.doh.gov.za/docs/policy/norms/part1i.html, retrieved 28th January 2005).

AMCs had the following suggestions for strategies that HCps could carry out to further enhance rapport. Firstly, the HCp needs to be the one to initiate the interaction once the adolescent client enters the consultation room. This can be done by greeting the client warmly and introducing oneself to her.

"To greet me right (sic)."

(Antenatal AMC)

The HCp's body language and facial expression should indicate caring towards and interest in the client.

"She must smile."

(Antenatal AMC)

Having a cheerful demeanour, was perceived to be friendly.

Privacy and confidentiality were also reported as integral to the adolescent feeling safe and able to interact. Studies have shown that adolescent clients will refrain from using services where they perceive that their privacy and confidentiality will be compromised (McNair & Brown, 1996; Akinbami et al, 2003).

"Ya, we must discuss, you and her, not to go out. Maybe I am telling her something and she goes into the passage and she screams for me, 'you know that thing'. And everybody now, the whole passage know that I got that thing. (sic)"

(Antenatal AMC)

HCps need to be sensitive to the clients' right to privacy and confidentiality, and ensure that clients' details are not discussed in view of other people. AMC respondents felt that having an HCp one could trust was important.

"Ya, you know I must talk about everything that I have got, if I have got problems. You know there are some kind of problems these girls have, you need somebody to talk to, you need to say something that is private. You tell the nurse and she must understand you and she must tell you what's it about and how to treat it."

(Antenatal AMC)

The reason for this was that they (AMCs) sometimes had problems that were of a

sensitive nature, which they needed to discuss and get advice on, safe in the

knowledge that it would remain between them and the HCp.

It was suggested that HCps should ask probing questions to arrive at the problems and

needs of adolescent clients.

"And she must start the conversation. She must ask you how you feel."

(Antenatal AMC)

This is vital since adolescent clients may not possess the necessary knowledge that

would lead them to identify certain things as problematic; thus it falls on the HCp to

take control of the consultation and direct the assessment and enquiry. When

problems presented, HCps needed to be ready to engage in dialogue to educate clients

and discuss curative and health promotive strategies, whichever was relevant. What

was pivotal to this rapport building was that HCps need to remember at all times that

the needs of adolescents clients were different to that of adult clients, and all

interaction and care should reflect this understanding.

5.5.3 Health Education

All stakeholders respondents were firm on the issue of adolescent clients needing

more health education than adult maternity clients, for the simple reason that they

were inexperienced, and, therefore, unprepared for the responsibilities of pregnancy

and parenting. In situations where antenatal education classes were offered as part of

care, adolescent clients were reported not to attend, with HCps respondents

speculating that the reason for this was that these classes did not run in tandem with the clinic itself, but rather were offered after the antenatal clinic had finished.

"And it's nearly impossible for us, with the staff that we have to run one in conjunction with the clinic. And if they didn't have to go home, you know especially the time when we give those antenatal classes, while they are here or encourage them to wait until the end of clinic. But they don't, they are quick to leave here."

<div align="right">(Antenatal Clinic HCp)</div>

HCps found that adolescent clients did not wait for the classes and left the clinics as soon as they were finished with their consultations. The solution that was offered would be to hold a class for them while the clinic was running. However, the problem was that HCps found that with the current staff shortages this would not be possible. Hence, more HCps were needed to ensure that AMCs received much needed antenatal classes.

So for now most health education was limited to the routine consultations during which rapport had first to be established between AMCs and their HCps. The next step was to use this rapport as an advantage in offering health education and counselling to adolescent clients (www.doh.gov.za/docs/policy/norms/part1i.html, retrieved 28th January 2005). All stakeholder groups agreed that health education should be ongoing and given throughout their contact with the maternity health care system.

"They need ongoing education."

"Group talking isn't suitable for.....with the other clients together."

<div align="right">(Antenatal Clinic HCp)</div>

If possible, respondents felt that health education should be given on an individual basis. This is to ensure that adolescents feel safe and able to ask questions and take what they need from the health education session. It has already been made clear that adolescent clients feel conspicuous amongst adult clients, and embarrassed, which may prevent them from interacting during health education sessions, if coupled with

adult clients. So if it is not possible to give them individualized health education, then

HCps should put them in a group that consists of their peers, others of a similar age

group, amongst whom they would then feel comfortable. According to data provided,

all teaching sessions should be tailored to meet the specific needs of adolescent clients

and pitched at an appropriate level for them to understand and absorb it, and to

prevent them from getting bored.

"I think that our health information isn't particularly understandable for adolescents and I think it need to be portrayed in a much more fun, sort of funky way for them to catch on. You know, that kind of stuff. I think that the health education that does occur which is very little is too one sided for adolescents, then they get bored, then they don't actually listen to it."

(DoH HCP)

This would ensure that adolescent clients stay interested in what is being taught to

them and derive benefit from the health education session.

Adolescents in this study expressed the desire to have reading material on pregnancy,

delivery and child care, that they could take home with them and study at their leisure.

The Department of Health has laid down a standard for primary health care delivery

to adolescents and youth, that stipulates that health care facilities should provide

clients with health education information in the form of pamphlets. It is also stipulated

that for better understanding, the pamphlets be written in the native language of the

clients (www.doh.gov.za/docs/policy/norms/part1i.html, retrieved 28th January 2005).

This would also serve to improve internalization of information taught during a health

education session. Respondents in the Jacobson et al (2001) study concurred with this

by verbalizing that leaflets would be beneficial to them as a means to providing health

information. On a final note, adolescent clients should be oriented, as part of health

education efforts, to all services and resources within the community that could be of

use to them (Hanna, 2001;

www.doh.gov.za/docs/legislation/patientsright/chartere.html, retrieved 28th January 2005).

5.5.4 Support

Significant Others

Extant literature suggests that while there is no difference in physical care between adolescent clients and their adult counterparts, the crux of adolescent maternity care is in the support that they will need (Treffers et al, 2001). As such, adolescent-friendly maternity care should find ways of formalizing support systems to adolescent maternity clients. According to Hanna (2001), the lives of pregnant or parenting adolescents is often full of stress, as they often face abandonment by their families and boyfriends when the news of their pregnancy is disclosed, as well as experiencing a breakdown in relationships with their friends. Hence, apart from the strategies suggested by respondents of allocating one individual in the antenatal clinic to orientate these clients and to serve as contact person, should they have any queries, another way would be to try and include people who are significant in the lives of these adolescents. Bear in mind that the crisis of adolescent pregnancy lasts well beyond the pregnancy and delivery, so including 'significant' others will help to develop or strengthen support structures.

"And they should have at least parents, or elderly relatives to accompany them, so that even at home they can help them to continue with their management of pregnancy, of problems related to pregnancy, besides being taught here at the clinic."
<div align="right">(Maternity HCp)</div>

HCps should assist adolescent clients to identify individuals close to them who would be of support to them in this 'crisis situation'.

"... we need not prescribe who this person should be."
<div align="right">(DoH HCP)</div>

According to respondents, the HCp should not prescribe to the AMC regarding whom to choose as her support person.

Once this is done, and the support person has shown a willingness to play this part, the next step is for the HCps to prepare the support person, by explaining what would be expected of them and how best they can help the client.

"Because if she has got a friend, she has got an aunt, any trusted body in her community, somebody she trusts in the family, she must be given, you know, that opportunity to bring that person. That person, when we empower that teenager, we also empower that person to look after her, you know, to provide support."

(DoH HCP)

From this point on, the support person is encouraged to attend every health care visit with the adolescent client. HCps should strive to include the support person in all health education sessions and decisions related to the care of the adolescent client, to enhance the building up of a partnership between the client, support person and HCp. Empowering of the support person through health education sessions will ensure that this person is of benefit to the adolescent, even out of the hospital environment, and it is hoped, well beyond the birth of the baby. Longitudinal studies that have been done on adolescent mothers and their babies, reveal "that those adolescents who have strong supporting networks and complete their education fare better" than those with poorer support structures (Hanna, 2001, p. 457).

Doula

Where it is not possible to have the adolescent maternity client supported by significant others, HCp respondents suggested that doulas could fill this role. Respondents felt that extra support was needed by AMCs, which HCps were not in a position to offer.

"The one thing I would say for intra-partum care, I would make sure that no adolescent ever entered labour by herself. That there was always a birthing companion, either her mother, the boy in her life, some kind of care giver. Because the midwives are just not able to give the back rubbing, sipping of little hot bits of tea, they are not able to give that."

(DoH HCP)

As mentioned under the section on inputs earlier in this chapter, this extra support mechanism would need to be formalized within the maternity services, as it maybe very expensive for adolescent clients to access otherwise. The doula should be put in contact with the adolescent client at her first antenatal visit and continue to be present at every subsequent appointment.

"Get it going earlier on. Get us in with the teenagers early on. Let them have a whole positive birth experience, well pregnancy, birthing experience. I think if they walk into labour already being positive, there is already a step forward."

(Doula HCp Interview)

This will allow for a supportive relationship to develop between the doula and the client, so that they get used to and understand each other better. The doula can also be instrumental in helping family members of the adolescent client learn how to support the adolescent client and overcome possible reluctance.

"They must not feel guilty about being pregnant. They must not feel that they are less worthy of a good labour and a nice birth experience than another one just because they are young now and they shouldn't be having babies now. They must know all that, and they must feel comfortable with themselves. That is what I try to do."

(Doula HCp Interview)

The benefit of the doula is that she is someone who has undergone formal training for this role, and, therefore, will be able to give support that is appropriate to the client's needs and circumstance. The doula will continue to support the adolescent throughout the pregnancy, during the labour and delivery and in the postnatal period. This is another way of ensuring that there is continuity of care and support. Thus the relationship develops along a continuum rather than having too many people coming at different times.

Counselling

Another aspect of support is developing the adolescent to the stage when she can 'stand on her own feet' by learning to problem-solve and by developing coping strategies that will help to carry her through her life. Counselling services should be made available to adolescent maternity clients with this in mind. As such, one of the standards laid down by the Department of Health is the expectation that at services where adolescent and youth health is rendered, there should be at least one staff member who has received training in and is competent to provide counselling to these clients (www.doh.gov.za/docs/policy/norms/part1i.html, retrieved 28th January 2005).

HCp respondents within this study were prepared to undergo specialized training in counselling so that they could render more effective support to AMCs. Nurses, because of their numbers within the health care system and their contact with clients, are in a good position to assess clients and identify those who may appear to be at risk and in need of further intervention, such as counselling (Hanna, 2001). As evidenced by the data, social workers and psychologists, who already have training in the area of counselling, are available. As part of affording holistic care, counselling services should be part of the total adolescent-friendly maternity care package.

Support Groups

From the findings presented, it would appear that there is a shortage of HCps to offer one on one time with clients, and as a result there is diminished support to adolescent clients. It has been suggested that peer support groups be formed, consisting of the adolescent clients, with an HCp acting as facilitator to the group. This HCp would need to be trained to act as facilitator of group process and dynamics, as well as in

how to give effective counselling. Adolescent clients commencing antenatal care can be introduced to the concept of a support group and encouraged to join. The support group will have multiple benefits to the adolescent. Firstly, it will show them that they are not alone with this problem and that there are other people also going through what they are. Secondly, it will allow them to get help from one another by sharing experiences and solutions. Thirdly, it will serve as a social gathering for them, allowing them to meet new people and make friends. Hanna (2001, p. 459) asserts that with support groups, "new friendships were established with other teenage mothers. Much was gleaned from these later relationships, particularly practical advice about parenting".

The support group can extend beyond the birth of the baby and develop into a parenting support group, having the same benefits as mentioned above. Support groups also provide a forum in which adolescent clients can feel valued amongst their peers and have their self-worth increased (Hanna, 2001). As the relationships within the support group develop, the facilitator should slowly begin to step back and allow group members to own the process, thus further empowering the adolescent members towards taking over the running of the group in the end (de Jonge, 2001). These group members can also be used at a later date to act as facilitators to new support groups comprising adolescent maternity clients.

An adolescent pregnancy can place a huge strain on the family unit and be very destructive to family relationships (Kunene, 1995; Makiwane, 1998; Kaufman et al, 2001; Mngadi et al, 2002).

"Because the community health clinics they don't actually have support groups for mothers that have adolescent kids or daughters that are falling pregnant, because these mothers can supervise them, can take care of them."

(Postnatal Ward HCp)

Hence the idea of a support group could also extend beyond the adolescent client,

where support groups are held for family members of pregnant or parenting

adolescents, to help them express and deal with what they are feeling, so that they are

better able to render support to the adolescent, without having unresolved feelings or

issues hampering the process.

5.6 OUTPUTS IN RELATION TO PROCESSES

To reiterate an earlier explanation of 'outputs', it refers to the concrete results in

which programme activities or processes end (McNamara, 2000;

http://www2.uta.edu/sswmindel/S6324/Class%20Materials/Program%20Evaluation/E

xecutiv.pdf, retrieved 6th February 2005). The outputs presented are associated with

benefits that adolescent clients are sure to receive from the processes discussed.

Hence, Table 23 that follows, is a summary of the expected outputs that one would

find in the event that the processes towards adolescent-friendly maternity services are

carried out.

Table 23: Outputs Related to Extracted Processes

Processes	Outputs
Adolescent-friendly services	► Early antenatal commencement will lead to more favourable outcomes for pregnant and parenting adolescents. ► Better understanding on how the services works will result in improved client compliance and satisfaction, and an overall positive experience. ► Special attention within combined services will result in adolescent clients feeling that HCps were interested in them and cared for them. ► The multi-disciplinary team approach would ensure holistic care to pregnant and parenting adolescents, their babies, as well as their significant others. ► Adequate pain management will result in less trauma during labour and delivery, and a more positive postnatal experience. ► Longer postnatal hospital stays would result in improved individualized care and support, with better postnatal outcomes for the adolescent mother and her infant. ► Improved accessibility to contraceptive services would ensure better fertility control and the prevention of repeat adolescent pregnancy. ► Home visitation will increase support to and surveillance of adolescent mothers and their infants, resulting in decreased parental stress.
Adolescent-friendly Interaction	► Adolescent clients will be treated equally to other service consumers. ► Adolescent clients will be respected. ► Adolescent clients will be supported and reassured. ► Adolescent clients will be empathized with and understood. ► HCp-client relationships will be strengthened, towards better client compliance and satisfaction.
Health Education	► Adolescent clients will have improved access to health education information. ► Adolescent clients will ask questions to obtain health education information. ► Adolescent clients will display lifestyle changes based on health promotive information. ► Adolescents will be better prepared to handle the stressors of pregnancy, labour and delivery, the postnatal period and parenting.
Support	► The adolescent client will experience increased support. ► Relationships between the adolescent and significant others in her life will be strengthened. ► The support network that the adolescent builds will extend beyond the delivery of her infant. ► The adolescent will acquire problem-solving skills and develop healthy coping strategies to deal with stressors that may present. ► The adolescent will experience increased self-esteem.

5.7 VISUAL REPRESENTATION OF THE CONSTRUCTS TOWARDS A GROUNDED THEORY OF ADOLESCENT-FRIENDLY MATERNITY SERVICES

The following diagram (Figure 5) is a visual representation of the constructs towards a grounded theory of adolescent-friendly maternity care derived from the data provided by respondents. These constructs have been presented in a three tiered model. An explanation of the model from outer to inner aspects follows.

The first level indicated by the rectangle which is made up of broken lines demarcates the *'structures & resources'* that either needs to exist and or be improved. These are as follows:

- Existing *policies* need to be carefully examined to see if they are congruent and if they cater for adolescent clients. A policy for adolescent-friendly maternity services needs to be developed using inputs from all relevant stakeholder groups.

- HCps need better *educational preparation* in order to render effective care to adolescent clients. Pre-service educational programmes need to increase their curricular focus on adolescent health. The Department of Health and the various health care facilities need to back this initiative by providing ongoing in-service education to their HCps towards adolescent-friendly care.

- *Adequate staffing* is essential in providing optimal individualized care to adolescent clients. HCps in this study complained of not having adequate time to give adolescent clients the necessary care and health education, while AMCs complained of hurried consultation and not receiving

adequate health education. Apart from the number of staff available to render care, the ***calibre of staff*** was also a concern. Hence, more efforts need to be made to strengthen knowledge and skills, and to influence values and attitudes towards adolescent-friendly care. Efforts should include trying to retain efficient, qualified Hcps, who have experience in working with adolescent clients, as well as those who enjoy working with this category of client.

- Any adolescent-friendly initiative needs to be driven by a ***sensitized administration***, which sees and understands the need to cater for these clients separately from the general maternity population. This administration will play a very important role in keeping the momentum of such an initiative going. As part of the administration, a coordinator has to be selected to oversee the programme at a more global level, thereby ensuring smooth running of all components of the adolescent-friendly maternity service.

- Results from this study indicate strongly that AMCs need support, and to this end ***support needs to be formalized*** and become 'part and parcel' of care. In order to do this efforts should be made to firstly encourage the significant others of the AMC to become involved in her care and in supporting her. Secondly, it was suggested that doulas become part of the health care that is offered in provincial hospitals and clinics, so that more constructive support is given by a person who is trained for this role. The third suggestion was that community health workers be trained to render support and act as resource people to pregnant and parenting adolescents within their communities. A final suggestion was to have peer support

groups, where pregnant and parenting adolescents could support and learn from one another.

- The last aspect of this level deals with ***community involvement***. For an adolescent-friendly initiative to last, it should be supported by the community for which it was initiated. To this end, community participation is needed at the developmental and planning phase, so that the service is contextually relevant. Community awareness of the plight of AMCs needs to be raised such that communities mobilize to offer them education and support towards a more positive outcome.

The second level of the model represented by the big circle within the rectangle reflects the ***attitudes*** that the service and service providers should display towards adolescent maternity clients at all times for the service to be 'friendly'. Hence adolescent clients:

- should be treated with ***equality***, namely, in the same manner as the HCp would treat an adult maternity client;

- should be ***supported*** by HCps at all times, as they are going through a stressful experience;

- should be shown ***understanding***, with HCps being aware of their developmental stage and how it impinges on the experience of pregnancy and parenting;

- should be received and treated with ***empathy***, with HCps being aware that this is a new and frightening situation for them;

- should be ***respected*** as human beings at all times and their rights as clients should be protected;

- should receive **_reassurance_** as they have no previous experience from
which to draw on.

The final inner level indicated by the three smaller overlapping circles within the bigger circle represent the different aspects of care that maternity **_services_** are interested in, namely antenatal, labour and delivery and postnatal care. Apart from normal maternity care given to adult clients an adolescent-friendly maternity service should contain all the elements set out in these smaller circles, with some elements obviously overlapping among the three aspects of care, which is the area in the centre of the diagram. Thus adolescent-friendly care should include the following aspects:

- Essential to good **_antenatal care_** is its early commencement for this high-risk group, which can be assisted by community health workers who identify and educate pregnant adolescents about the need for antenatal care. HCps should assist by creating a good rapport with AMCs towards compliance with care. Support to AMCs during antenatal care could be increased by including their significant others in their care and health education teaching sessions. Peer support groups also need to be established to ensure that even AMCs without significant other support can still have a source of support.

- While **_labour and delivery_** care is essentially the same as that given to an adult maternity client, AMCs require more support as they often exhibit poor coping as a result of poor preparation. This support can be given by trained doulas. To help them cope with the pain of uterine contractions and delivery, it was also suggested that AMCs receive good pain management during labour and delivery.

- Due to paucity of resources, ***postnatal care*** has become extremely reduced. Hence, it was suggested that postnatal stays for AMCs be increased so that they can receive more individualized care and gain more confidence in caring for their infants prior to discharge from the health care facility. To ensure the prevention of a repeat pregnancy, access to contraception needs to be improved, with every client commencing a method on discharge from the health care facility. Literature has shown that AMCs are at particular risk for not coping with their infants. Hence a system of home visitation by community health workers needs to be put in place, so that AMCs receive better long-term follow-up. In addition to this, peer support groups need to be established so that parenting adolescents can support and learn from one another.

- Finally, the area where the three small circles overlap indicates a common thread through all the services, namely health education. AMCs lack experience as well as the maturity to handle pregnancy and parenting. HCps play a vital role in effecting a good outcome for the adolescent mother and her baby. Ongoing health education is one way in which to achieve a positive outcome. Every opportunity should be used to educate and prepare the adolescent for the demands of pregnancy and parenting.

Figure 5: Towards a Grounded Theory of Adolescent-friendly Maternity Services

Policies

Structures & Resources

Quality & Quantity of HCps

Attitudes to AMCs

Educational Preparation of HCps

Equality

Services

Empathy

Labour and Delivery Care
Doula Support
Effective pain control

Support

Respect

Health Education

Antenatal Care
Early commencement
Good compliance
Include significant others
Pregnancy support groups

Postnatal Care
Increased postnatal hospital stays
Contraception
Home visitation
Parenting support groups

Formalized support for AMCs

Understanding

Reassurance

Community Involvement

Financial Resources

Sensitized Administration

5.8 RECOMMENDATIONS

5.8.1 Research

- As seen from the findings, respondents had very clear ideas about the constituents of adolescent-friendly maternity care. One of their recommendations was that more staff were needed to provide an effect service. However, a clear view did not emerge of the exact number of staff needed and the acceptable HCp-client ratio for such care. Hence future studies should make efforts to quantify resources that are necessary for adolescent-friendly maternity services, so that the Department of Health can budget for and provide these resources.

- While financial implications of the constructs did not clearly emerge, the discussion makes obvious to the reader the need for finances to be allocated for the provision of adolescent-friendly maternity services. In order for this to be done in the most cost effective and efficient way, further investigation needs to be done to ascertain how this would be possible within the present health care budget. This would entail attempting to cost the entire endeavour and examining what funds were available, as well as how to make more available.

- Since the area of adolescent maternity care is somewhat neglected in South Africa, more researchers need to explore the various constructs of adolescent-friendly maternity care that emerged from this study. Once the constructs have

been individually researched, then only will their thematic connections become stronger, allowing for a further development and the emergence of a theory of adolescent-friendly maternity services.

- With the idea of encouraging future researches, one suggestion is that longitudinal studies should be undertaken of pregnant or parenting adolescents and their offspring to determine the long term value or impact that the components suggested in this study may have, as well as to give a voice to this vulnerable population. Not only will such studies reveal a wealth of information about these individuals and their needs, but has the added benefit of bringing them into focus and providing ongoing support to them as research participants, as in the case of researches into people living with HIV.

- Where strategies suggested in this report towards providing adolescent-friendly maternity care have been utilized, research needs to take place to audit their effectiveness and further recommendations need to be made towards adolescent-friendly maternity services. This will help to constantly modify the information provided in this report, and thereby strengthen the argument for the constructs that have emerged.

- Future research studies need to be done, examining existing health policies to determine how they cater for the adolescent maternity client and how congruent they are with one another, so that a more holistic policy of adolescent-friendly maternity care can emerge to replace pre-existing, possibly inadequate, policies. This will also help health care providers to offer

horizontal holistic health care, rather than compartmentalized care, which is so often the case, as reported by respondents in this study.

5.8.2 Service

- The Department of Health should consult stakeholders and develop a policy for adolescent-friendly maternity care that can be implemented in health care facilities throughout South Africa. Giving a voice to stakeholders should be an ongoing process towards HCp and client satisfaction, leading to better service provision and utilization respectively.

- Capacity building needs to take place involving all levels that impinge on the maternity services, i.e. from management to community members at grassroots level, to prepare them for and sensitize them to the needs of adolescent maternity clients.

- Resources (human and material) need to be improved so that the maternity service can provide more optimal and holistic care to adolescent clients and their infants.

- As promised (www.doh.gov.za/docs/policy/norms/part1i.html, retrieved 28th January 2005), the Department of Health needs to offer training programmes for HCps working with adolescent clients, so that they are better able to understand their clientele and provide a more appropriate service, as well as be happy with the service that they render.

- Pre-service medical and nursing curricula need to increase their adolescent health focus, so that health care providers have a better understanding of the

unique needs of adolescent clients and a better grounding on how to deal with these, which would act as a foundation for future education and training in adolescent health.

- Where policies concerning adolescent health do exist, they should not be treated as 'nice to have', but instead should be inculcated into health care providers, such that all providers are 'speaking the same language' and are not working at cross purposes to one another. This can be done by regularly auditing services and carrying out orientation programmes with the intention of transforming that which is on paper into reality at HCp-client level.

- From the data provided it was clear that HCps held negative views of adolescent clients and AMCs perceived that they were being judged by HCps. This in turn resulted in AMCs not getting the maximum benefit from the maternity service. To this end it is suggested that regular value clarification workshops be held, to iron out negative attitudes towards creating an adolescent-friendly atmosphere.

5.9 CONCLUSION

As can be seen from this chapter and the previous one that the stakeholders of adolescent-friendly maternity care have a very clear idea of how vulnerable adolescent maternity clients are. HCPs and HCps felt that special attention and care was needed. This could be rendered by specially trained HCps. Adolescent clients stressed the need to be treated equally when accessing the services, but at the same time expected HCps to understand

that their needs were different from adult clients and thus should be catered for

differently, with much more emphasis on health education and support.

The earlier review of literature in this report points to the degree of risk to adolescent

clients and their infants, as well as society as a whole if appropriate care is not given.

While strategies to prevent pregnancy are not having the desired effect, it is imperative

for HCPs, HCps, and community members to turn their attention to assisting these

vulnerable individuals and their families towards healthier pregnancy outcomes,

physically, mentally and socially. It would appear that HCps are prepared to make a

commitment towards this end, but feel that the health authorities need to help them

achieve an adolescent-friendly maternity service, by improving resources, knowledge and

skills.

Adolescent-friendly maternity care was also seen as an opportunity to carry out health

promotion strategies, which could extend beyond the health care facility into the

communities. Time needs to be spent, attending to individual clients and their needs, for

quality care to be given.

"...... and you know, I think what people also don't understand, if you render a quality
service in the first place, clients will not come back with a problem that was not
addressed the first visit. So you actually save on man hours in the end if you do quality
work."

<div align="right">(DoH HCP)</div>

Thus a service that is given careful thought and planning, which is well supported, and

regularly audited and improved, with all stakeholders committed to the process is sure to

yield a 'quality' service, with far reaching positive consequences, for adolescents, their

infants, families and communities.

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Appendix 1

Statistics from the KwaZulu-Natal Department of Health

Informatics department

Appendix 1: Statistics from the Kwa-Zulu Natal Department of Health – Informatics department

**Data for PHC Facilities
in KZN**

DataElement	District	Apr-02	May-02	Jun-02	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02	Jan-03	Feb-03	Mar-03	Grand Total
Delivery to woman under 18 years	eThekwini Met	74	56	80	80	69	87	84	81	52	59	92	76	890
	iLembe DM	19	6	13	9	18	8	7	13	10	3	18	15	139
	Ugu DM	8	4	7	5	8	8	2	5	5	6	5	4	67
	uMgungundlovu DM	6	15	6	4	24	7	11	12	9	14	5	12	125
	Umkhanyakude DM	17	10	19	18	13	18	26	16	12	11	7	10	177
	Umzinyathi DM	1			4	0	0	0	0	2		0	0	7
	Uthukela DM	11	15	11	13	10	19	10	12	20	11	21	11	164
	Uthungulu DM	5	7	7	10	13	9	191	9	9	11	13	13	297
	Zululand DM	2	4	5	0	7	5	4	4	2	5	4	3	45
	Amajuba DM	4	6	3	10	6	1	2	1	2	1	6	3	45
	Sisonke DM	1	3	1	10	0	1	2	1	2	1	2	2	26
	KZN	**148**	**126**	**152**	**163**	**168**	**163**	**339**	**154**	**125**	**122**	**173**	**149**	**1 982**
First antenatal visit	eThekwini Met	5 576	4 656	4 527	5 814	4 918	5 220	6 562	5 369	4 436	6 854	6 482	6 223	66 637
	iLembe DM	661	686	553	661	617	611	629	602	515	708	882	802	7 927
	Ugu DM	1 436	1 183	1 266	1 244	1 173	1 100	1 412	1 075	945	1 596	1 210	1 630	15 270
	uMgungundlovu DM	1 131	1 183	1 285	1 268	1 206	991	1 102	1 134	854	1 459	1 166	1 230	14 009
	Umkhanyakude DM	1 668	1 603	1 161	1 314	1 217	1 070	1 840	1 147	1 041	1 626	1 386	1 204	16 277
	Umzinyathi DM	1 001	1 020	1 131	980	882	809	829	799	682	965	892	1 015	11 005
	Uthukela DM	1 392	1 148	1 188	1 343	1 185	1 081	1 222	1 025	972	1 470	1 238	1 204	14 468
	Uthungulu DM	2 051	2 034	1 687	1 914	1 826	1 525	1 899	1 757	1 378	1 758	1 783	1 859	21 471
	Zululand DM	1 552	1 536	1 637	1 853	1 518	1 371	1 518	1 492	1 397	2 110	1 575	1 742	19 301
	Amajuba DM	883	813	738	963	819	747	1 168	878	947	1 115	960	955	10 986
	Sisonke DM	767	720	685	721	825	702	698	573	509	895	757	765	8 617
	KZN	**18 118**	**16 582**	**15 858**	**18 075**	**16 186**	**15 227**	**18 879**	**15 851**	**13 676**	**20 556**	**18 331**	**18 629**	**205 968**
Follow-up antenatal visit	eThekwini Met	18 263	18 756	17 725	17 945	17 137	16 241	18 542	17 057	15 036	17 090	18 144	18 540	210 476
	iLembe DM	1 927	1 724	1 870	1 798	1 848	1 691	1 741	1 792	1 663	1 234	1 925	1 776	20 989
	Ugu DM	3 593	3 447	3 800	4 097	3 950	3 367	3 833	4 131	3 653	3 873	3 724	3 139	44 607
	uMgungundlovu DM	3 696	3 587	3 852	3 541	3 543	2 823	3 531	3 415	2 811	2 940	3 009	3 345	40 093
	Umkhanyakude	4 715	4 556	4 423	4 615	4 688	3 947	4 360	3 569	3 107	4 197	3 952	3 902	50 031

	DM													
	Umzinyathi DM	3 311	3 093	3 048	3 122	3 481	3 411	2 933	2 589	2 475	2 651	2 931	2 686	35 731
	Uthukela DM	3 870	4 245	4 247	4 171	4 256	3 950	3 951	3 544	3 685	3 438	3 869	3 806	47 032
	Uthungulu DM	5 336	5 529	5 035	5 136	5 618	4 986	5 279	4 955	4 637	4 231	4 248	5 157	60 147
	Zululand DM	4 444	3 964	3 842	4 043	4 183	3 888	3 819	4 398	3 297	3 436	3 464	3 720	46 498
	Amajuba DM	3 474	3 490	3 050	3 839	3 270	3 279	3 213	2 147	2 377	2 663	2 815	2 903	36 520
	Sisonke DM	2 207	2 048	1 792	2 226	1 928	1 919	2 049	1 797	1 665	1 893	1 858	1 964	23 346
	KZN	**54 836**	**54 439**	**52 684**	**54 533**	**53 902**	**49 502**	**53 251**	**49 394**	**44 406**	**47 646**	**49 939**	**50 938**	**615 470**
FP Acceptor 18 years and over	eThekwini Met	50 811	52 492	44 883	51 244	51 684	46 449	54 825	49 942	43 093	49 768	48 368	48 125	591 684
	iLembe DM	6 950	7 606	5 898	7 111	6 289	6 448	6 934	6 832	5 387	4 655	5 603	4 602	74 315
	Ugu DM	11 027	10 027	9 432	10 602	10 488	8 676	10 526	10 254	8 778	10 589	9 968	8 290	118 657
	uMgungundlovu DM	16 742	15 875	13 560	15 588	16 054	14 540	16 129	15 523	12 755	16 142	14 050	14 551	181 509
	Umkhanyakude DM	6 715	5 615	5 802	6 639	6 585	4 608	4 319	4 148	4 440	5 075	3 910	4 843	62 699
	Umzinyathi DM	6 170	5 738	5 350	5 945	5 654	5 265	6 237	5 156	5 037	6 394	5 178	4 970	67 094
	Uthukela DM	8 930	9 181	7 945	9 531	8 710	7 847	9 188	7 616	7 321	8 445	8 411	7 957	101 082
	Uthungulu DM	10 862	10 105	10 216	10 857	10 418	9 289	10 595	10 732	9 722	7 853	9 600	9 229	119 478
	Zululand DM	7 363	6 864	6 828	6 531	7 210	6 083	6 467	7 134	6 592	7 300	6 416	6 670	81 458
	Amajuba DM	6 623	5 852	5 236	7 435	5 926	5 762	6 512	5 470	5 587	6 168	5 631	5 761	71 963
	Sisonke DM	6 534	6 019	5 575	6 122	6 918	5 613	5 727	5 882	5 741	6 304	5 893	5 941	72 269
	KZN	**138 727**	**135 374**	**120 725**	**137 605**	**135 936**	**120 580**	**137 459**	**128 689**	**114 453**	**128 693**	**123 028**	**120 939**	**1 542 208**
FP Acceptor under 18 years	eThekwini Met	3 122	3 348	2 709	3 611	3 474	3 415	3 444	5 032	2 791	3 718	4 305	3 599	42 568
	iLembe DM	456	597	337	536	465	513	517	482	360	462	322	504	5 551
	Ugu DM	552	610	512	668	556	533	726	769	667	892	700	1 339	8 524
	uMgungundlovu DM	1 282	1 429	1 314	1 782	1 977	1 670	1 854	1 369	818	1 465	1 409	1 843	18 212
	Umkhanyakude DM	975	1 330	514	466	545	913	596	452	564	455	409	487	7 706
	Umzinyathi DM	605	510	286	286	414	738	406	356	362	520	315	304	5 102
	Uthukela DM	862	960	902	972	1 210	911	1 179	995	906	1 081	604	1 007	11 589
	Uthungulu DM	1 046	920	985	901	961	813	1 168	808	824	670	518	832	10 446
	Zululand DM	707	878	708	903	1 067	707	899	909	867	1 142	832	766	10 385
	Amajuba DM	831	1 112	677	641	679	735	714	790	776	829	839	1 878	10 501
	Sisonke DM	479	577	549	582	526	406	498	430	240	448	340	446	5 521
	KZN	**10 917**	**12 271**	**9 493**	**11 348**	**11 874**	**11 354**	**12 001**	**12 392**	**9 175**	**11 682**	**10 593**	**13 005**	**136 105**
Live birth	eThekwini Met	824	757	685	682	677	796	614	607	564	613	561	580	7 960
	iLembe DM	128	260	143	181	245	196	125	131	115	37	97	169	1 827
	Ugu DM	77	69	71	63	52	80	44	65	72	83	69	67	812
	uMgungundlovu DM	60	85	84	88	53	65	64	64	59	68	83	99	872
	Umkhanyakude	181	169	186	189	208	226	209	159	184	192	163	220	2 286

	DM													
	Umzinyathi DM	4	21	15	14	12	17	11	13	10	8	13	10	148
	Uthukela DM	104	105	105	110	109	102	82	101	96	111	93	127	1 245
	Uthungulu DM	144	172	173	147	142	159	140	131	93	124	114	124	1 663
	Zululand DM	58	94	70	56	53	66	78	78	82	80	80	67	862
	Amajuba DM	48	58	53	42	54	46	47	33	43	50	50	43	567
	Sisonke DM	14	22	13	13	14	18	18	13	18	22	17	13	195
	KZN	**1 642**	**1 812**	**1 598**	**1 585**	**1 619**	**1 771**	**1 432**	**1 395**	**1 336**	**1 388**	**1 340**	**1 519**	**18 437**
Total antenatal visits	eThekwini Met	23 839	23 412	22 252	23 759	22 055	21 461	25 104	22 426	19 472	23 944	24 626	24 763	277 113
	iLembe DM	2 588	2 410	2 423	2 459	2 465	2 302	2 370	2 394	2 178	1 942	2 807	2 578	28 916
	Ugu DM	5 029	4 630	5 066	5 341	5 123	4 467	5 245	5 206	4 598	5 469	4 934	4 769	59 877
	uMgungundlovu DM	4 827	4 770	5 137	4 809	4 749	3 814	4 633	4 549	3 665	4 399	4 175	4 575	54 102
	Umkhanyakude DM	6 383	6 159	5 584	5 929	5 905	5 017	6 200	4 716	4 148	5 823	5 338	5 106	66 308
	Umzinyathi DM	4 312	4 113	4 179	4 102	4 363	4 220	3 762	3 388	3 157	3 616	3 823	3 701	46 736
	Uthukela DM	5 262	5 393	5 435	5 514	5 441	5 031	5 173	4 569	4 657	4 908	5 107	5 010	61 500
	Uthungulu DM	7 387	7 563	6 722	7 050	7 444	6 511	7 178	6 712	6 015	5 989	6 031	7 016	81 618
	Zululand DM	5 996	5 500	5 479	5 896	5 701	5 259	5 337	5 890	4 694	5 546	5 039	5 462	65 799
	Amajuba DM	4 357	4 303	3 788	4 802	4 089	4 026	4 381	3 025	3 324	3 778	3 775	3 858	47 506
	Sisonke DM	2 974	2 768	2 477	2 947	2 753	2 621	2 747	2 370	2 174	2 788	2 615	2 729	31 963
	KZN	**72 954**	**71 021**	**68 542**	**72 608**	**70 088**	**64 729**	**72 130**	**65 245**	**58 082**	**68 202**	**68 270**	**69 567**	**821 438**

Data for Hospitals in KZN

DataElement	District	Apr-02	May-02	Jun-02	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02	Jan-03	Feb-03	Mar-03	Grand Total
Delivery to woman under 18 years	eThekwini Met	135	254	281	263	339	283	297	234	265	260	223	268	3 102
	iLembe DM	62	59	80	101	143	76	63	55	67	13	89	39	847
	Ugu DM	85	98	60	95	76	111	103	65	94	85	69	54	995
	uMgungundlovu DM	94	83	63	54	105	104	114	84	115	119	80	114	1 129
	Umkhanyakude DM	52	66	38	73	86	31	29	74	70	70	52	61	702
	Umzinyathi DM	67	67	79	66	88	63	139	73	58	71	43	61	875
	Uthukela DM	36	184	119	94	98	118	86	88	47	76	51	76	1 073
	Uthungulu DM	100	109	97	149	124	134	130	82	113	84	69	104	1 295
	Zululand DM	68	34	61	51	58	69	94	43	126	78	60	114	856
	Amajuba DM	51	54	61	62	75	77	65	53	59	56	44	78	735
	Sisonke DM	35	81	39	62	86	59	72	56	64	53	35	57	699
	KZN	**785**	**1 089**	**978**	**1 070**	**1 278**	**1 125**	**1 192**	**907**	**1 078**	**965**	**815**	**1 026**	**12 308**

First antenatal visit	eThekwini Met	664	2 852	295	673	733	435	1 207	819	1 134	1 567	981	976	12 336
	iLembe DM	455	363	462	448	425	929	588	630	440	157	338	138	5 373
	Ugu DM	220	146	156	139	127	153	155	107	114	149	133	174	1 773
	uMgungundlovu DM	229	146	576	364	306	575	652	546	513	678	505	499	5 589
	Umkhanyakude DM	171	223	148	174	120	98	170	122	138	85	186	216	1 851
	Umzinyathi DM	257	122	86	151	115	101	169	143	124	141	129	122	1 660
	Uthukela DM	18	23	44				0	0	0	0	0	0	85
	Uthungulu DM	1 021	902	981	988	1 254	943	870	598	573	485	628	1 067	10 310
	Zululand DM	109	158	442	358	309	303	382	265	365	453	354	612	4 110
	Amajuba DM	48	74	51	70	32	12	100	21	26	57	39	39	569
	Sisonke DM	89	50	70	105		76	133	121	123	154	125	266	1 312
	KZN	**3 281**	**5 059**	**3 311**	**3 470**	**3 421**	**3 625**	**4 426**	**3 372**	**3 550**	**3 926**	**3 418**	**4 109**	**44 968**
Follow-up antenatal visit	eThekwini Met	3 209	2 732	1 859	4 323	4 700	2 929	8 180	6 059	6 118	6 930	5 048	5 890	57 977
	iLembe DM	1 302	1 300	1 488	1 261	1 387	1 380	1 850	1 311	1 198	208	778	338	13 801
	Ugu DM	977	846	532	1 025	913	707	923	714	733	784	852	584	9 590
	uMgungundlovu DM	798	984	1 397	1 304	1 523	1 542	1 359	1 168	1 381	1 692	1 652	1 982	16 782
	Umkhanyakude DM	1 134	832	653	659	769	525	722	600	605	698	859	869	8 925
	Umzinyathi DM	481	571	497	510	595	450	523	385	338	340	387	258	5 335
	Uthukela DM		256	44				0	0	0	0	0	0	300
	Uthungulu DM	30	482	911	2 125	2 006	1 726	1 723	1 753	2 038	1 531	1 394	2 878	18 597
	Zululand DM	446	726	1 004	1 266	1 094	1 148	1 396	854	1 084	1 459	1 441	1 364	13 282
	Amajuba DM	131	155	138	186	202	132	401	109	85	132	117	126	1 914
	Sisonke DM	481	344	586	134		525	582	585	427	622	593	820	5 699
	KZN	**8 989**	**9 228**	**9 109**	**12 793**	**13 189**	**11 064**	**17 659**	**13 538**	**14 007**	**14 396**	**13 121**	**15 109**	**152 202**
FP Acceptor 18 years and over	eThekwini Met	3 347	4 843	2 440	3 902	3 130	3 014	5 110	3 996	3 975	4 794	3 147	3 580	45 278
	iLembe DM	1 200	1 066	769	812	1 138	1 045	1 120	1 101	770	181	222	133	9 557
	Ugu DM	1 133	1 086	879	1 085	995	1 124	1 188	994	976	1 286	987	864	12 597
	uMgungundlovu DM	390	323	214	261	303	197	205	199	208	288	182	274	3 044
	Umkhanyakude DM	412	644	676	204	607	875	226	564	604	281	672	617	6 382
	Umzinyathi DM		0	0				0	0	0		0	0	0
	Uthungulu DM	975	807	603	346	731	776	1 008	466	800	934	1 650	1 021	10 117
	Zululand DM	935	459	726	716	839	961	902	574	692	1 044	955	1 013	9 816
	Amajuba DM	851	933	700	793	775	701	1 516	589	676	744	775	712	9 765
	Sisonke DM	0	2	0	0	0	0	0	0	0	0	0	236	238
	KZN	**9 243**	**10 163**	**7 007**	**8 119**	**8 518**	**8 693**	**11 275**	**8 483**	**8 701**	**9 552**	**8 590**	**8 450**	**106 794**
FP Acceptor under 18 years	eThekwini Met	391	330	163	201	193	317	366	346	259	263	227	274	3 330
	iLembe DM	171	50	8	24	83	128	46	61	49	65	14	5	704

	Ugu DM	99	99	69	116	90	121	86	80	87	92	78	51	1 068
	uMgungundlovu DM	38	7	20	7	11	6	7	17	7	27	50	63	260
	Umkhanyakude DM	32	40	66	234	59	46	53	95	134	77	84	26	946
	Umzinyathi DM		0	0				0	0	0		0	0	0
	Uthungulu DM	78	60	18	47	138	180	114	191	100	64	262	175	1 427
	Zululand DM	71	90	115	85	28	78	34	44	55	37	57	72	766
	Amajuba DM	18	23	36	32	20	21	25	84	67	59	42	59	486
	Sisonke DM	0	0	0	0	0	0	0	3	0	0	0	2	5
	KZN	**898**	**699**	**495**	**746**	**622**	**897**	**731**	**921**	**758**	**684**	**814**	**727**	**8 992**
Live birth	eThekwini Met	2 978	3 232	3 062	3 414	3 071	2 910	3 485	3 112	3 307	3 447	2 666	2 970	37 654
	iLembe DM	407	413	445	441	405	522	460	482	486	123	464	417	5 065
	Ugu DM	734	687	699	814	796	1 120	901	749	859	813	778	769	9 719
	uMgungundlovu DM	1 754	1 243	902	653	988	934	1 216	870	1 190	1 182	1 019	1 276	13 227
	Umkhanyakude DM	520	574	254	420	409	134	295	415	486	445	487	574	5 013
	Umzinyathi DM	810	836	795	736	852	1 118	1 544	692	810	775	667	901	10 536
	Uthukela DM	483	855	850	840	875	1 050	852	701	836	814	678	788	9 622
	Uthungulu DM	1 176	1 209	1 561	1 265	1 283	1 323	1 134	365	1 324	907	837	1 364	13 748
	Zululand DM	400	452	523	525	563	466	663	96	924	837	700	807	6 956
	Amajuba DM	555	532	569	579	586	671	813	538	565	577	559	688	7 232
	Sisonke DM	341	510	421	728	724	774	1 211	675	717	557	479	626	7 763
	KZN	**10 158**	**10 543**	**10 081**	**10 415**	**10 552**	**11 022**	**12 574**	**8 695**	**11 504**	**10 477**	**9 334**	**11 180**	**126 535**
Total antenatal visits	eThekwini Met	3 873	5 584	2 154	4 996	5 433	3 364	9 387	6 878	7 252	8 497	6 029	6 866	70 313
	iLembe DM	1 757	1 663	1 950	1 709	1 812	2 309	2 438	1 941	1 638	365	1 116	476	19 174
	Ugu DM	1 197	992	688	1 164	1 040	860	1 078	821	847	933	985	758	11 363
	uMgungundlovu DM	1 027	1 130	1 973	1 668	1 829	2 117	2 011	1 714	1 894	2 370	2 157	2 481	22 371
	Umkhanyakude DM	1 305	1 055	801	833	889	623	892	722	743	783	1 045	1 085	10 776
	Umzinyathi DM	738	693	583	661	710	551	692	528	462	481	516	380	6 995
	Uthukela DM	18	279	88				0	0	0	0	0	0	385
	Uthungulu DM	1 051	1 384	1 892	3 113	3 260	2 669	2 593	2 351	2 611	2 016	2 022	3 945	28 907
	Zululand DM	555	884	1 446	1 624	1 403	1 451	1 778	1 119	1 449	1 912	1 795	1 976	17 392
	Amajuba DM	179	229	189	256	234	144	501	130	111	189	156	165	2 483
	Sisonke DM	570	394	656	239		601	715	706	550	776	718	1 086	7 011
	KZN	**12 270**	**14 287**	**12 420**	**16 263**	**16 610**	**14 689**	**22 085**	**16 910**	**17 557**	**18 322**	**16 539**	**19 218**	**197 170**

* Blank spaces indicate hospitals
did not submit this data

Appendix 2

Pre-planned Topic Guides for

Semi-structured Interviews and Focus Group Interviews

Appendix 2.1

Pre-planned topic guide

Adolescent Maternity Client

- When did you start using the maternity services?

- What services within the maternity department have you used thus far?

- What has your experience been thus far with regards to the maternity care that you have received?

- What would you consider to be an adolescent-friendly maternity service?

- Have the services been adequate and up to your satisfaction?

- What positive experiences have you had when using the maternity services at this hospital?

- What negative experiences have you had when using the maternity at this hospital?

- What in your opinion are the strengths of the present maternity service that is offered at this hospital?

- What in your opinion are the weaknesses of the present maternity service that is offered at this hospital?

- What are the areas that you would like to improve within the present maternity services?

- Suggest ways in which the present services can be improved and made to suit your needs

Appendix 2.2

Pre-planned Topic Guide

<u>Health Care Providers</u>

- For how long have you been working in the maternity department of this hospital?

- Which unit within the maternity department do you currently work in?

- What is your opinion of adolescent maternity clients?

- What are the possible differences in care that these clients may need?

- What would you consider to be an adolescent-friendly maternity service?

- What in your opinion are the strengths of the present maternity service that is offered at this hospital for an adolescent friendly maternity care?

- What in your opinion are the weaknesses of the present maternity service that is offered at this hospital for an adolescent friendly maternity care?

- What are the areas that you would like to improve within the present maternity services for an adolescent friendly maternity care?

- Suggest ways in which the present services can be improved and made to suit the needs of adolescent clients.

Appendix 2.3

Pre-planned topic guide

<u>Health Care Planners</u>

- What is your opinion of adolescent maternity clients?

- What are the possible differences in care that these clients may need?

- What would you consider to be an adolescent-friendly maternity service?

- What in your opinion are the strengths of the present maternity service that is offered at this hospital/area?

- What in your opinion are the weaknesses of the present maternity service that is offered at this hospital/area for an adolescent friendly maternity care?

- What are the areas that you would like to improve within the present maternity services for an adolescent friendly maternity care?

- Suggest ways in which the present services can be improved and made to suit the needs of adolescent clients.

Appendix 3

Written Informed Consent Forms

Appendix 3.1

Adolescent maternity Client Consent Form

Dear Participant,

Within the South African context there are at present no maternity services that cater for the needs of adolescent maternity clients specifically. Current thinking regarding adolescent health care is that adolescent clients are a specific group of clients with specific health care needs that may in fact be different from adult clients. As such I am undertaking a research study to explore the following:

- Whether adolescent clients have different health care needs as compared to adult clients when pregnant.
- What the perceptions of health care providers and health care planners are regarding the adolescent maternity client.
- Whether the present maternity services that adolescent clients utilise are satisfactory and meet the adolescent client's needs.
- What would constitute an adolescent –friendly service.

You are being asked to participate as you are an adolescent who is currently pregnant or has recently been pregnant and as such is using or has made use of the maternity services in this hospital/clinic. The information that you provide will be used to develop constructs of care for adolescent maternity clients that can be used to improve the care received by these clients.

Participation in the study is voluntary and there is no obligation to participate. If you choose to participate and withdraw your participation at a later stage, you will in no way be compromised, and it will not affect the care that you receive at this hospital/clinic. If you agree to participate you will asked to sign a consent form giving your permission. You will be expected to attend either a semi-structured interview or a focus group interview, depending on how many participants at available at the time of the interview. During the interview you will be asked to provide information on the areas of interest mentioned above. The interviews are expected to last between one to one and a half hours in duration and will be held at the hospital where you attended maternity services in a private room, away from the health care providers at the hospital/clinic. You will be given a sum of twenty rands (R20.00) to cover your transportation costs to and from the hospital/clinic.

During the interview you will not need to provide your name to identify yourself, if you choose you may use a false name for the discussion. Any information that you provide will not be linked to you directly. The interview will be tape recorded to assist the researcher writing notes and making memos during the discussion and to prevent information from being lost. The recording will be kept by the researcher and used for purposes of the study only. At the conclusion of the research study a written report will be produced by the researcher within which you will not be personally identified.

If you have any queries regarding your participation you are free to contact the researcher at any time. Contact details are as follows:

Ms. Ravani Chetty
Telephone: 031 – 403 2157
E-mail: ravanichetty@hotmail.com

It would be appreciated if you could please sign the attached consent form in duplicate, so that both you and the researcher may keep a copy.

Thank you for your assistance and participation with this research study.

Yours faithfully,

Ms. Ravani Chetty
Researcher

Written Consent Form –Adolescent Maternity Client

Maternity care in KwaZulu-Natal: towards a grounded theory of adolescent-friendly maternity services

Participant's Copy:

I _____ (full name) have read the information that has been given

to me regarding the proposed research project and understand the part I am being asked to play and am

aware of my rights with regards to my participation. As such I give my consent to participate in this

research project.

Full Name of Participant: _____

Signature of participant: _____

Full name of Witness: _____

Signature of Witness: _____

Written Consent Form –Adolescent Maternity Client

Maternity care in KwaZulu-Natal: towards a grounded theory of adolescent-friendly maternity services

Researcher's Copy:

I _____ (full name) have read the information that has been given

to me regarding the proposed research project and understand the part I am being asked to play and am

aware of my rights with regards to my participation. As such I give my consent to participate in this

research project.

Full Name of Participant: _____

Signature of participant: _____

Full name of Witness: _____

Signature of Witness: _____

Appendix 3.2

Health Care Provider Consent Form

Dear Participant,

Within the South African context there are at present no maternity services that cater for the needs of adolescent maternity clients specifically. Current thinking regarding adolescent health care is that adolescent clients are a specific group of clients with specific health care needs that may in fact be different from adult clients. As such I am undertaking a research study to explore the following:

- Whether adolescent clients have different health care needs as compared to adult clients when pregnant.
- What the perceptions of health care providers and health care planners are regarding the adolescent maternity client.
- Whether the present maternity services that adolescent clients utilise are satisfactory and meet the adolescent client's needs.
- What would constitute an adolescent –friendly maternity service.

You are being asked to participate as you are currently working in the maternity department of this hospital/clinic and as such you are likely to have rendered care to adolescent maternity clients. The information that you provide will be used to develop constructs of adolescent-friendly maternity care that can be used to improve the care received by these clients.

Participation in the study is voluntary and there is no obligation to participate. If you choose to participate and withdraw your participation at a later stage, you will in no way be compromised. If you agree to participate you will asked to sign a consent form giving your permission. You will be expected to attend either semi-structured interviews or focus group interviews depending on how many participants are available at the time, where you will provide information on the areas of interest mentioned above. The interviews are expected to last between one to one and a half hours in duration and will be held at the hospital/clinic where you work, in a private room away from clients and hospital/clinic management.

During the interviews you will not need to provide your name to identify yourself, if you choose you may use a false name for the discussion. Any information that you provide will not be linked to you directly. The interview will be tape recorded to assist the researcher in writing notes and making memos during the discussion and to prevent information from being lost. The recording will be kept by the researcher and used for purposes of the study only. At the conclusion of the research study a written report will be produced by the researcher within which you will not be personally identified.

If you have any queries regarding your participation you are free to contact the researcher at any time. Contact details are as follows:

Ms. Ravani Chetty
Telephone: 031 – 403 2157
E-mail: ravanichetty@hotmail.com

It would be appreciated if you could please sign the attached consent form in duplicate, so that both you and the researcher may keep a copy.

Thank you for your assistance and participation with this research study.

Yours faithfully,

Ms. Ravani Chetty
Researcher

Written Consent Form – Health Care Provider

Maternity care in KwaZulu-Natal: towards a grounded theory of adolescent-friendly maternity services

Participant's Copy:

I _____ (full name) have read the information that has been given to me regarding the proposed research project and understand the part I am being asked to play and am aware of my rights with regards to my participation. As such I give my consent to participate in this research project.

Full Name of Participant: _____

Signature of participant: _____

Full name of Witness: _____

Signature of Witness: _____

Written Consent Form – Health Care Provider

Maternity care in KwaZulu-Natal: towards a grounded theory of adolescent-friendly maternity services

Researcher's Copy:

I _____ (full name) have read the information that has been given to me regarding the proposed research project and understand the part I am being asked to play and am aware of my rights with regards to my participation. As such I give my consent to participate in this research project.

Full Name of Participant: _____

Signature of participant: _____

Full name of Witness: _____

Signature of Witness: _____

Appendix 3.3

Health Care Planner Consent Form

Dear Participant,

Within the South African context there are at present no maternity services that cater for the needs of adolescent maternity clients specifically. Current thinking regarding adolescent health care is that adolescent clients are a specific group of clients with specific health care needs that may in fact be different from adult clients. As such I am undertaking a research study to explore the following:

- Whether adolescent clients have different health care needs as compared to adult clients when pregnant.
- What the perceptions of health care providers and health care planners are regarding the adolescent maternity client.
- Whether the present maternity services that adolescent clients utilise are satisfactory and meet the adolescent client's needs.
- What would constitute an adolescent – friendly service.

You are being asked to participate as you are responsible for or directly involved with the planning of health care services for the adolescent maternity client at either local or regional level. The information that you provide will be used to develop constructs of adolescent-friendly maternity care that can be used to improve the care received by these clients.

Participation in the study is voluntary and there is no obligation to participate. For any reason if you choose to participate and withdraw your participation at a later stage, you will in no way be compromised. If you agree to participate you will asked to sign a consent form giving your permission. You will be expected to participate in semi-structured interviews, where you will provide information on the areas of interest mentioned above. The interviews are expected to last approximately one hour and will be held in the privacy of your office for your convenience.

During the interview you will not need to provide your name to identify yourself, if you choose you may use a false name for the discussion. Any information that you provide will not be linked to you directly. The interview will be tape recorded to assist the researcher in writing notes and making memos during the discussion and to prevent information from being lost. The recording will be kept by the researcher and used for purposes of the study only. At the conclusion of the research study a written report will be produced by the researcher within which you will not be personally identified.

If you have any queries regarding your participation you are free to contact the researcher at time. Contact details are as follows:

Ms. Ravani Chetty
Telephone: 031 – 403 2157
E-mail: ravanichetty@hotmail.com

It would be appreciated if you could please sign the attached consent form in duplicate, so that both you and the researcher may keep a copy.

Thank you for your assistance and participation with this research study.

Yours faithfully,

Ms. Ravani Chetty
Researcher

Written Consent Form – Health Care Planner

Maternity care in KwaZulu-Natal: towards a grounded theory of adolescent-friendly maternity services

Participant's Copy:

I _____ (full name) have read the information that has been given to me regarding the proposed research project and understand the part I am being asked to play and am aware of my rights with regards to my participation. As such I give my consent to participate in this research project.

Full Name of Participant: _____

Signature of participant: _____

Full name of Witness: _____

Signature of Witness: _____

Written Consent Form – Health Care Planner

Maternity care in KwaZulu-Natal: towards a grounded theory of adolescent-friendly maternity services

Researcher's Copy:

I _____ (full name) have read the information that has been given to me regarding the proposed research project and understand the part I am being asked to play and am aware of my rights with regards to my participation. As such I give my consent to participate in this research project.

Full Name of Participant: _____

Signature of participant: _____

Full name of Witness: _____

Signature of Witness: _____

Appendix 4

**Permission from the Ethics Committee of the Faculty of
Community and Development Disciplines, University of
Natal (now, University of KwaZulu-Natal)**

UNIVERSITY OF NATAL
DURBAN, PIETERMARITZBURG & EDGEWOOD CAMPUSES

Faculty of Community & Development Disciplines

13 August 2003

✉ University of Natal Durban 4041 South Africa

Telephone: Faculty Officer   +27 (0)31 260 3271
           Student Records   +27 (0)31 260 2685
           Admissions Officer +27 (0)31 260 1201/2094
Facsimile: +27 (0)31 260 2458
           e-mail: khanyid@nu.ac.za

Ms R Chetty
21-30th Avenue
UMHLATUZANA
4092

Dear Ms Chetty,

RE: RESEARCH PROPOSAL

I am writing to advise that your Research Proposal was approved by the Research Committee of the Faculty of Community and Development Disciplines, at the meeting held on 4 August, 2003.

Enclosed please find the signed Research Ethics Committee form.

Yours sincerely,

Mrs E Tait
Faculty Officer
Community and Development Disciplines

cc Prof O Adejumo

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UNIVERSITY OF NATAL
DURBAN CAMPUS

RESEARCH ETHICS COMMITTEE

Student: _____ Ms. Ravani Chetty _____

Research Title: Maternity care in Kwa-Zulu Natal: towards a grounded theory of adolescent-friendly maternity services

A. The proposal meets the professional code of ethics of the Researcher:

YES ⊠   NO ☐

B. The proposal also meets the following ethical requirements:

		YES	NO
1.	Provision has been made to obtain informed consent of the participants.	✓	
2.	Potential psychological and physical risks have been considered and minimised.	✓	
3.	Provision has been made to avoid undue intrusion with regard to participants and community.	✓	
4.	Rights of participants will be safe-guarded in relation to:		
	4.1 Measures for the protection of anonymity and the maintenance of confidentiality.	✓	
	4.2 Access to research information and findings.	✓	
	4.3 Termination of involvement without compromise.	✓	
	4.4 Misleading promises regarding benefits of the research.	✓	

Signature of Student: _Rb Chit_ Date: _18/07/2003_

Signature of Supervisor: _____ Date: _14/07/2003_

Signature of Head of School: _____ Date: _28/7/2003_

Signature of Chairperson of the Committee: _Helson_ Date: _30 Yr '03_
(Prof. _____)

A:\ETHICS FORM.doc

Appendix 5

Permission from the Department of Health,

KwaZulu-Natal

PROVINCE OF
KWAZULU-NATAL
HEALTH SERVICES

ISIFUNDAZWI
SAKWAZULU-NATALI
EZEMPILO

PROVINSIE
KWAZULU-NATAL
GESONDHEIDSDIENSTE

NATALIA
330 LONGMARKETSTREET
PIETERMARITZBURG

TEL. 033-3952111
FAX 033-3426744

Private Bag : X9051
Isikhwama Seposi Pietermaritzburg
Privaatsak 3200

REFERENCE : 9/2/3/R – Vol.15
ENQUIRIES : Mr G. Tromp
EXTENSION 2761

Ms Ravani Chetty
21-30ᵗʰ Avenue
Umhlatuzana
DURBAN
4092

Dear Ms Chetty

PERMISSION TO CONDUCT RESEARCH STUDY AT ADDINGTON HOSPITAL AND THE MATERNAL AND CHILD HEALTH DEPARTMENT : MARTENITY CARE IN KWAZULU-NATAL : TOWARDS A GROUNDED THEORY OF ADOLESCENT-FRIENDLY MATERNITY SERVICES

Your letter dated 26ᵀᴴ September 2003 refers.

Please be advised that authority will be considered for you to conduct a study towards a grounded theory of adolescent-friendly maternity services at Addington Hospital and the Martenal and Child Health Department, provided that the following is agreed to and submitted to this office.

(a)   Prior approval is obtained from Heads of the relevant Institutions;

(b)   Confidentiality is maintained;

(c)   The Department is acknowledged;

(d)   The Department receives a copy of the report on completion; and

(e)   The staff and patients are not inconvenienced and service delivery not affected.

Yours sincerely,

SUPERINTENDENT-GENERAL
HEAD : DEPARTMENT OF HEALTH
NNkhravan chetty