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# **CHAPTER 1**

## **INTRODUCTION AND ORIENTATION OF THE STUDY**

### **1.1 INTRODUCTION**

Sexual activity in general, and specifically sex without barrier contraceptive measures among adolescents, remains a major concern for nurses as it negates all the efforts made to prevent the occurrence of amongst others, unplanned pregnancies, sexually transmitted infections (STIs), unsafe abortions and childbirth complications (Fantasia, 2011:48). Adolescents are also not emotionally mature enough to have sex and are prone to develop psychological disturbances because of their involvement in sexual relationships (Young, Furman & Jones, 2012:559). The involvement of particularly adolescents in sexual activity is often forced and the problems that they encounter afterwards are considered to be a worldwide concern (De Vries et al., 2014:1087).

Adolescents' involvement in sex is often unplanned, unprotected and because of peer pressure and coercion (Tavara, 2006:396), and therefore increases their vulnerability (Pilgrim, Serwada, Gray, Sekasanvu, Lutalo, Nalugoda, Serwada & Wawer, 2013:2; Wagman, Baumgartner, Waszak Geary, Nakyanjo, Ddaaki, Serwadda, Gray, Nalugoda & Wawer, 2009:2073). Miller, Smith, Coffman, Matthews and Wegner (2015:673) documented that in South Africa, sexual coercion befalls one out of five adolescents, irrespective of gender. Coerced sex happens because of adolescents' eagerness to please friends and to belong to friendship groups (Young & Furman, 2008:306). The researcher is of the opinion that adolescents often hero-worship their friends; they follow their friends' lead and succumb to their ideas without taking heed of adults' advice. Peer pressure and peer coercion are intertwined, as both refer to situations where people are manipulated or forced by others to do something against their own will (Eaton & Stephens, 2016:2). In the case of peer coercion, the pressure from others coincides with threats of exclusion from the group (Shi et al., 2012:173). The researcher chose to investigate both peer pressure and coercion to determine what these concepts mean and how they are understood by adolescents as well as how they impact on them.

Innovative strategies are required to help adolescents to resist peer pressure and coercion and encourage them to not take part in sex to please their friends (Sears et al., 2007:502). Adolescents do not react positively to prescriptive messages in which they are told 'what not to do'. However, despite many national endeavours to reduce the consequences of adolescent sex, such as HIV infections (South African National Strategic Plan on HIV, STIs & TB, 2012:21) and adolescent pregnancies (Panday et al., 2009:14) through the implementation of the National Adolescent Friendly Clinic Initiative (NAFCI) (Ashton et al., 2009:20), many South African adolescents are still having unprotected sex (Reddy et al., 2008:30; Rutherford, 2008:276) and even with multiple partners (Ha et al., 2016:709; Mah & Shelton, 2011:2).

Underhill, Operario and Montgomery (2007:10) hold that measures which focus on the prevention of the consequences of sexual activities by adolescents do not have sufficient impact to support adolescents in making informed decisions about their involvement in sex. Therefore, anticipatory guidance that focuses on guiding adolescents regarding 'what to do' instead of 'what not to do' could help them to resist peer pressure and coercion. In South Africa, 37.5 per cent of adolescents who are sexually active are so because of pressure from their peers (Reddy et al., 2008:30).

In this study, abstinence from sex as the only solution for the prevention of adolescent pregnancies and STIs is not encouraged, but a comprehensive approach is advocated as an alternative. Respect for the right of individuals to decide for themselves to take part in sex is upheld, but it is emphasised that individuals will then also have to take responsibility for their actions (Santelli et al., 2006:79).

Through anticipatory guidance, individuals are provided with information and prepared for age-specific challenges where the emphasis is on 'how to manage' rather than on 'what not to do'. In targeted anticipatory guidance, the intervention is specific to a concern (Magar et al., 2006:450) which, in the case of this study, is the peer pressure and coercion that adolescents experience and that encourage or force them to participate in sex. Through discussions and health education brochures that were prepared based on how the adolescents experienced peer pressure and coercion related to sex, the age group can be guided anticipatorily towards ways of making informed decisions regarding their sexual health (Van de Bongardt et al., 2014:393).



The aim of this study was twofold: *firstly*, to explore how peer pressure and coercion to sexual activity are experienced by male and female adolescents in an urban area in Gauteng, a province in South Africa and, *secondly*, to develop a nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity. Over and above the study process, the researcher was expected to provide educational intervention (as highly recommended by the Research Ethics Committee) after completion of the in-depth interviews to the adolescent participants. During the intervention, information was shared with them about 1) delaying initiation of early sex, 2) prevention of sexually transmitted infections, HIV and 3) building their self-esteem.

A better understanding of the peer pressure and coercion that adolescents experience enabled the researcher to develop an appropriate intervention programme (Herrman, 2008:42) to be implemented on primary healthcare level to guide adolescents towards good health and well-being (Bearinger et al., 2007:1229).

## **1.2 BACKGROUND TO THE PROBLEM STATEMENT**

As background to the problem statement, the involvement of adolescents in sexual activities, peer pressure and coercion towards sexual activities, national programmes for adolescents in South Africa, and the contribution that nurses can make in anticipatory guidance to enable adolescents to make informed decisions about their sexual lives, are described.

### **1.2.1 Adolescents' involvement in sexual relationships**

According to a study in the USA, the incidence of sexual activity before the age of 13 years is small. Adolescent sexual debut increases with age. At the age of 14, about 5 per cent are sexually active, at 15 years 19 per cent are having sex, at 16 years the percentage is 32 per cent. The results also showed that younger adolescents are often forced to have sex (Finer & Philbin, 2013:888).

Based on the USA National Health and Nutrition Examination Surveys 1999-2012 data, 49,2 per cent of adolescents aged 14 to 19 have never had sex, and the median

age for sexual debut was never younger than 17 years (Lui, Hariri, Bradly, Gotlieb, Leichter & Markowitz, 2015:21).

In South Africa, the age of sexual debut differs for females and males. The third South African Youth Risk Behaviour Survey (SAYRBS) conducted in 2011 revealed that more adolescent boys (44,2%) than adolescent girls (28,6%) have had sex at the time of the survey. Involvement in sexual activities increased by school grade and age; the higher the grade, the higher the tendency to engage in sexual activity, being 52,8 per cent for grade 11 and 22,1 per cent for grade 8 (Reddy et al., 2013:26). According to more recent statistics, and accessible limited data, it seems as if there is a small decline in the number of adolescents involved in sex (Reddy et al., 2013:16). In the results of two national youth risk surveys conducted in 2011 and 2013, it is not indicated who the sexual partners of these adolescents were. The latest results of the Youth Risk Behaviour Surveillance System, cited by the American Medical Association, reflected that boys (9%) and girls (3%) engage in sexual activity before they reach 13 years of age (Alexander, Fortenberry, Pollack et al., 2014:167).

A survey done by Reddy et al. (2008:30) indicated that most adolescents face sexual health risks, which affect them physically and mentally at a later stage because of their sexual choices and social circumstances.

### **1.2.2 Peer pressure and coercion related to sexual involvement**

Peer pressure and sexual coercion refer to a myriad of experiences that force individuals to take part in sex against their will (Ha et al., 2016:717). Adolescents use coercion openly or secretly to force others to do what they want them to do which, in fact, relates to the bullying of others (Bierman, 2011:298). The actions that are forced on others are usually contrary to parents' moral values and expectations of their children (Padilla-Walker & Carlo, 2014:189).

Both adolescent boys and girls are equally affected by sexual coercion (Miller et al., 2015:673), although girls are the hardest hit by such ill behaviour as they are physically weaker and cannot defend themselves against boys. Often the victim is young, naïve, vulnerable and unwilling to participate in the sexual activity (Ybarra et al., 2012:2). Adolescents coerce their peers to participate in unwanted sex with the promise that

they will get the approval of specific individuals or the group (Akintola et al., 2011:144). Furthermore, it is unfortunate that adolescents often do not know the person with whom they are coerced to have sex with (Zuma, Setswe, Ketye, Mzolo, Rehle & Mbelle, 2010:48) and thus also do not know the HIV status of the person. The only reason why they take part in coerced sex is out of fear of rejection by their friends (Brendgen et al., 2007:2073; Van de Bongardt et al., 2014:389).

Peer association among adolescents is important as it determines their friendships (Bierman, 2011:97). When it forces adolescents to take part in activities that impact negatively on their self-esteem and the development of healthy relationships, it becomes a negative influence in their lives (Goodwin, Mrug, Borsch & Cillessen, 2012:321). In such situations, peer association becomes peer coercion. It often happens in small groups and at unsupervised social settings where alcohol and drugs are freely available (Young et al., 2012:560). Adolescents need to learn how to identify and avoid such negative influences (Teunissen, Spijkerman, Prinsteen, Geoffrey, Cohen, Engels & Scholte, 2012:1257).

### **1.2.3 Perpetrators of peer sexual coercion**

The perpetrators of sexual coercion usually use verbal threats of physical harm to force their victims to cooperate during unwanted sexual activity (Polis et al., 2009:107). In South Africa, a high prevalence of sexual coercion is experienced (De Vries et al., 2014:1087). Eaton and Stephens (2016:15) highlighted that close male friends and family members (excluding parents) encourage boys to commit verbally coercive behaviours towards girls. Some perpetrators of sexual coercion know their victims as they are in a dating relationship (Williams, Cook-Craig, Bush, Clear, Lewis, Garcia, Coker & Fischer, 2014:1251) but often their partners are not ready for sex, thus the reason for coercion. They may be schoolmates who take advantage of their friend's trust (Tavara, 2006:397) while in other cases, casual partners and one-night stands are involved (Eaton & Stephens, 2016:15).

### **1.2.4 Consequences of peer sexual coercion**

Sexual coercion predisposes adolescents to become involved with multiple sex partners (Soomar, Flisher & Matthews, 2009:104) with direct consequences such as

adolescent pregnancies, multiple STIs (Lansford et al., 2014:1742) and child birth complications (Bearinger et al., 2007:1226). The unsafe sex practices resulting in a range of health problems adversely affect adolescents and expose them to HIV (Pilgrim et al., 2013:2). Van de Bongardt et al.'s (2014:388) findings concurred with the idea in the study done by Pettifor, O'Brien, McPhail, Miller and Rees (2009:82) that adolescents who engage in an early sexual debut were inclined to engage in unprotected sex that predisposes them to dreadful unwanted health consequences. According to Jones, Cornelius, Silverman, Tancedi, Haggerty, De Genna and Miller (2016:57), the USA experienced the highest prevalence of unplanned pregnancies and STIs amongst adolescents and the youth, of which 77 per cent of adolescents aged between 15 and 17 gave birth.

The long-term effects of sexual involvement due to peer pressure and coercion can result in the development of a low self-esteem, feelings of guilt, self-blame and shame with suicidal outcomes (Polis et al., 2009:105). Adolescents' sexual activity has serious negative consequences for academic achievements (Parkes et al., 2010:741) and carries a heavy cost for tax payers and government institutions (Soomar et al., 2009:104; Thomas, 2009:217). Adolescent girls are prone to drop out of school due to unplanned pregnancies (UNESCO Report, 2008:10) resulting in poor prospects of obtaining well paid employment (Kapinus, 2007:1). Being unemployed and in need of healthcare can be problematic for adolescents, because the healthcare sector experiences challenges such as a shortage of nurses to provide the required healthcare and health promotion information (Parker, Steyn, Levitt & Lombard, 2012:6).

A StatsSA survey publicised that, of the 5 124 373 people living with HIV, 5.59 per cent are adolescents and 1 220 000 accounted for new infections amongst the youth (StatsSA, 2015: np). Adolescents in developing countries account for half of all new HIV infections (Tylee, Haller, Graham, Churchill & Sanci, 2007:1). In 2013, the South African Antenatal Care Sentinel and HIV Survey revealed that South Africa has an HIV prevalence rate of 29.7 per cent as compared to 29.5 per cent in 2011. Data also showed that 19.9 per cent of those infected were adolescents aged between 15 and 24 years compared to 23.1 per cent in 2001 (SA National Department of Health [NDoH], 2013:3). It is evident that the expectation to meet the United Nations MDG 6

by reducing HIV in pregnancy was unmet. However, in South Africa there was a slight decline in HIV prevalence among the 15 to 19-year-olds; in 2010 (14%), 2011 (12.7%), 2012 (12.4%) (NSP, 2012-2016:7).

### **1.2.5 National programmes for adolescent health**

The South African NDoH developed the National Strategic Plan on HIV, STIs and TB in 2012-2016 to respond to the demands of the HIV/AIDS pandemic and the impact it has on the whole South African population and thus also on adolescents. It recommends that prevention programmes should target adolescents to address their sexual reproductive health needs and vulnerability to STIs, including HIV infections (NDoH, 2012b:21).

In schools, the National Department of Basic Education (NDBE) implemented a peer education programme in 2010 to address the high rates of HIV/AIDS and STIs among adolescents through the development of life skills (NDBE, 2011:9). Through the combined efforts of the NDBE and non-governmental organisations (NGOs), a comprehensive life skills programme was implemented that focused on risk reduction in adolescents' sexual behaviour (Boonstra, 2012:5). Adolescents are encouraged to avoid substance use and abuse and to make informed decisions to protect themselves against STIs, HIV/AIDS, and unplanned pregnancies (NDBE, 2011: iii).

The National Adolescent Friendly Clinic Initiative (NAFCI) was implemented in 2003 in clinics across South Africa to increase health service utilisation by adolescents. The initiative was aimed at improving the quality of adolescent sexual reproductive healthcare to prevent unplanned pregnancies and STIs. Much was done by the National Department of Health during early 2000. Activities such as conducting training on value clarification and youth friendly services to change the attitudes of nurses to deliver a service that is user-friendly for the youth (Ashton et al., 2009:20). Measures were implemented to improve the standard of care and the nurses were trained to be non-judgemental towards the needs of adolescents (International Planned Parenthood Federation, 2008:4).

### **1.2.6 The contribution of nurses to adolescent healthcare**

For nurses to contribute to turning the tide of new HIV infections, adolescent pregnancies and risky sexual behaviour, they need to support adolescents to reduce multiple concurrent sexual partnerships and delay sexual debut (Mah & Maughan-Brown, 2012:1). They should improve the clinic environments to attract adolescents to the clinics (Geary, Gomez-Olive, Kahn, Tollman & Norris., 2014: 2) and deliver adolescent friendly services (Tylee et al., 2007:2). When adolescents are anticipatorily guided for the challenges that they might face, such as peer pressure and coercion to sexual activity, they are empowered to resist the coercion with a positive outcome regarding the prevalence of pregnancies and STIs among adolescents (Bearinger et al., 2007:369).

### **1.2.7 Anticipatory guidance for adolescents**

Anticipatory guidance is effective if it is not generic but tailor-made to involve a specific target population with specific and appropriate messages (Mulvihill et al., 2005:94). From the existing literature on anticipatory guidance, there is a need to conduct more research to develop adolescent development programmes that focus on specific age groups and health concerns (Sebastian, Ramos, Stumbo, McGrath & Fairbrother, 2014:339). A nursing theory for the anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity could not be found in the literature.

## **1.3 RATIONALE OF THE STUDY**

Adolescents' naivety and the poor choices they make raised the researcher's interest to conduct this study. There was a slight decrease in the national sexual activity prevalence rate among adolescents; it was 36 per cent in 2011 (Reddy et al., 2013:12) compared to 37.5 per cent in 2008 in South Africa (Reddy et al., 2008:30). These results painted a bleak picture about the future of adolescents in the era of an HIV/AIDS pandemic.

Many adolescents take part in sex due to peer pressure and coercion and not out of their own free will. To belong to a peer group is of utmost importance for adolescents

and they would not like to do anything that could jeopardise their acceptance into the group. Much was done by the South African government to improve clinic access for adolescents and it creates opportunities for nurses to interact with the youth and support them to resist peer pressure and coercion to sexual activity.

This study was necessary to determine how adolescents experience peer pressure and coercion to engage in sexual activities. Based on their experiences, a nursing theory was to be developed and used by nurses to support adolescents who are exposed to pressure and coercion by their friends to take part in sex. The theory would complement the current national policies and services regarding reproductive and sexual healthcare for adolescents aimed at reducing new HIV infections and adolescent pregnancy (Harrison et al., 2012:185).

#### **1.4 PROBLEM STATEMENT**

Despite various efforts from government and NGOs to manage adolescent-specific programmes to delay sexual debut among adolescents in South Africa, early adolescent sexual activity still occurs and has dire consequences (Lansford et al., 2014:1749) for the health of those who take part in sex (Thomas, 2009:218). Peer pressure and coercion are the driving forces behind their engagement in sexual activities (Bierman, 2011:297) and need to be addressed in order to prevent poor reproductive outcomes for adolescents (WHO, 2011:6). It remains a challenge to encourage and support adolescents to go against their friendship groups and to resist such pressure and coercion (Hearst, Kajubi, Hudes, Maganda & Green, 2011:1).

Adolescents do not want their parents to forbid them from belonging to friendship groups. Previously, a study by Whitaker and Miller (2000:266) indicated the reluctance of adolescents to tell their parents about sexual activity, peer pressure and coercion. Presently there has been some changes in the sentiments of adolescents in countries such as Burkina Faso, Ghana, Malawi and Uganda (Biddlecom, Awasabo-Asare & Bankole, 2009:73) who now do discuss sexual topics with their parents more so than they do with their sexual partners and friends (Widman, Choukas-Bradley, Helms, Golin & Prinstein, 2014:9). Open sexual communication between parents and adolescents has shown to provide a protective factor in delaying sex, or engaging in

safe sex by adolescents (Widman et al., 2014:13), although most adolescents still find themselves without parental support and guidance. Nurses in South Africa are in a position to support adolescents to find ways to deal with peer pressure and coercion as they work in primary healthcare clinics that support the National Adolescent Friendly Clinic Initiative (NAFCI), which makes it easy for adolescents to utilise clinic services (Dickson et al., 2007:81). With the correct information, these nurses can contribute to a decrease in adolescent pregnancies and STI prevalence.

Adolescents resist prescriptive guidance (Parkin & Kuczynski, 2012:633). They do not want to be told what to do and what not to do (Burns & Porter, 2007:234). They want to be involved in decision making (Braeken et al., 2007:173) and want to feel that they are respected as individuals. In anticipatory guidance, people (in this case adolescents) are led to explore different ways to cope with difficult anticipated situations (peer pressure and coercion) so that they gain the knowledge and develop the skills they need to manage the situations (that may include different manifestations of force) (Schuster, Duan, Regalado & Klein, 2000:1196).

Information regarding the impact of peer pressure and coercion as they relate to the sexual activity of adolescents, exists and was discussed in the section detailing the background to the study. Not much information was, however, available regarding the adolescents' experiences of peer pressure and coercion related to sexual activity. There was also no nursing theory available that could guide nurses in primary healthcare clinics in South Africa to communicate better with adolescents to manage the peer pressure and coercion that they experience and that forces them to take part in sex (Mulvihill et al., 2005:101). Nurses with relevant skills are key to supporting adolescents in the community, as they are considered to be knowledgeable and readily available at primary healthcare settings, enabling them to be a source of information and support.

## **1.5 SIGNIFICANCE OF THE STUDY**

The study is significant as it sought to bring new insights about peer pressure and coercion related to sexual activity in the South African context. It explored the way adolescents viewed, experienced and understood it. In a study conducted through the



University of Witwatersrand, Thomas (2009:218) cited that there was a gap in information to guide nurses to address the adolescents' unique service health needs and service delivery. This was an opportunity to bridge the information gap through the development of a nursing theory for nurses to provide anticipatory guidance to adolescents who faced peer pressure and coercion to take part in sex. In addition, the adolescents were expected to gain knowledge from the education intervention factored in this study during the process of data collection regarding 1) delaying initiation of early sex, 2) prevention of sexually transmitted infections and 3) building their self-esteem. The health education was provided after the interviews were concluded. It could thus not influence the response of the adolescents.

## **1.6 RESEARCH QUESTIONS**

The research questions for this study were as follows:

- What are the experiences of adolescents with regard to peer pressure and coercion to sexual activity?
- How can nurses support adolescents to resist peer pressure and coercion to sexual activity?

## **1.7 AIM AND OBJECTIVES OF THE STUDY**

The aim of this study was to *firstly* explore how peer pressure and coercion to sexual activity are experienced by male and female adolescents in an urban area in Gauteng, a province in South Africa, and *secondly* to develop a nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity.

Over and above the whole process, the researcher was expected to provide an educational intervention (as highly recommended by the Faculty of Health Sciences Research Ethics Committee of the University of Pretoria) after the interviews with the adolescents who participated in the study on 1) delaying initiation of early sex, 2) prevention of sexually transmitted infections, HIV and 3) building their self-esteem.

The research objectives were to:

- Explore and describe peer pressure and coercion sexual activity from the adolescents' perspective.

- Explore and describe how they experienced peer pressure and coercion to sexual activity from the adolescents' perspective.
- Explore and describe how nurses feel adolescents should be supported to resist peer pressure and coercion to sexual activity.
- Develop a nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity.
- Provide an educational intervention to adolescents who participate in the research using age appropriate information on 1) delaying initiation of early sex; 2) prevention of sexually transmitted infections, and 3) building their self-esteem.

## **1.8 CONCEPT CLARIFICATION**

In this study, the following concepts are applicable.

### **1.8.1 Adolescents**

Young et al. (2012:559) defined adolescence as the developmental stage for exploring and experimenting with sex, and Lansford et al. (2014:1749) concurred that it was the stage during which romantic and sexual relationships start. It is a time when the youth are faced by situations that warrant them to make complex choices that shape their health and well-being (Flicker & Guta, 2008:3). The United Nations (UN) defines adolescents as individuals aged between 10 and 19 (Bearinger et al., 2007:1220). In this study, the researcher focused on middle adolescence (14-16 years) and late adolescence (17-19 years), because they are at different developmental stages. The younger group might have considered engaging in sexual activity or might have just started, while the older group might be used to having sex on a regular basis. Input from both groups was essential to inform the much-needed theory for nurses to support adolescents.

### **1.8.2 Sexual coercion**

Sexual coercion is also known as forced sex and defined similarly to rape, which involves non-consensual sexual activity where penetration forcefully occurs irrespective of the victims' gender. However, it slightly differs from rape where physical

violence is used (Miller et al., 2015:674). In this study, sexual coercion relates to acts of force be it subtle or with violence exerted to male or female adolescents to partake in sexual activity.

### **1.8.3 Nursing theory**

A theory is explained as an “integrated set of defined concepts, existence statements, and relational statements that present a view of a phenomenon and were used to describe, explain, predict or control that phenomenon” (Burns & Grove, 2005:133). Nursing theory refers to “interrelated concepts that form building blocks critical for the nursing profession knowledge” (George, 2002:5). It is also defined as “conceptualisation of some aspects of reality that pertains nursing” (Masters, 2015:7). Nursing theory in the context of this study relates to the concepts and statements that emerged from the findings of the study and a comprehensive literature review. It focused on the anticipatory guidance by nurses of adolescents to resist peer pressure and coercion to sexual activity.

### **1.8.4 Anticipatory guidance**

Yamokoshi, Hazen and Kodish (2008:34) explained that anticipatory guidance is an educational idea intended to prepare individuals to be ready to cope with expectations in specific situations. Anticipatory guidance can thus be used to prepare adolescents to cope with peer pressure and coercion to sexual activity. In this study, anticipatory guidance refers to the anticipated preparation that nurses use to prepare adolescents for the pressure and coercion to sexual activity that they might experience from their peers.

### **1.8.5 Sexual activity**

UNESCO (2008:30) defined sexual activity as sexual behaviours where an individual has vaginal or anal sex. Remez (2000:298) highlighted a concern about the exclusion of oral sex from the mentioned definition and defined it as a form of sex. In this study, sexual activity was defined as vaginal, anal and oral sex.

### **1.8.6 Negative peer pressure**

According to the Encyclopaedia of Child Health Forum (2017), negative peer pressure occurs when a child's or teen's friends or other people their age try to convince them to do something that is either harmful to their body or is against the law. In this study, negative peer pressure refers to the negative influence exerted by other adolescents to their peers to persuade them to engage in risky activities like smoking, under-age alcohol drinking and early sexual activity.

### **1.8.7 Risk behaviour**

According to the Online Medical Dictionary (2011), risk behaviour is defined as a lifestyle that places an individual at increased risk of suffering a particular condition, illness or injury. The South African Youth Policy 10<sup>th</sup> draft (2012:17) refers to risk behaviour as behaviour linked to a lifestyle choice which is associated with using alcohol and drugs, which leads to other multiple related risks such as early sexual activity, adolescent pregnancy and dropping out of school due to peer pressure. These risks may have a negative impact on the health and well-being of adolescents. In this study, risk behaviour refers to the tendency of adolescents to engage in unsafe behavioural activities that might predispose their health and well-being to dire consequences.

### **1.8.8 Vulnerability**

Vulnerability is the state or condition of being weak or poorly defended. Adolescents are more at risk than their peers are thus predisposed to exploitation, abuse, neglect, violence and HIV infection. It ranges from resilient to completely helpless (Arora, Shah & Gupta, 2015:195). In this study, vulnerability refers to an instance where adolescents were helpless and at the mercy of their peers taking unfavourable decisions for them because of their emotional weakness and immaturity.

### **1.8.9 Peer pressure**

Peer pressure is described as an act of force from one's peers to take action under duress though acting upon such force it is entirely upon his or her choice (Yüksel-Şahin, 2015:1808). In this study peer pressure referred to being forced to do something or acting against own will by acquaintances, peers or friends.

### **1.8.10 Resisting**

Resisting is defined as making a choice to stop oneself from doing something they admire to do especially where peer pressure is involved (Yüksel-Şahin, 2015: 1808).

## **1.9 THE META-PARADIGM OF NURSING**

In this study, a nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity is developed through grounded theory research in the constructivist paradigm. The meta-paradigm of nursing provided structure to the study.

Anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity, addresses the improvement of health through the intervention of nurses with adolescents as the recipients of care. It takes place where nurses and adolescents interact. The study focused on environments where illness prevention and health promotion were implemented, providing health education and information (Wills 2009:4). In alignment with Watson and Smith's (2002:455) views, the researcher believes that anticipatory guidance of adolescents to enhance their health forms part of individualised nursing interventions to address health challenges and needs of adolescents. In the study conducted to identify risk behaviours of adolescents in Southeastern region of the US; Merritt (2015:S121) identified the need for health professionals to provide relevant anticipatory guidance to curb risk behaviours.

In knowledge generation, nursing scholars focus their research on the concepts of the meta-paradigm of nursing, namely the **patient** or human being (in this study adolescents); health (in this study the improvement of their sexual and reproductive

health); nursing (in this study anticipatory guidance); and environment (in this study the pressure and coercion that adolescents experience from their peers) (Russell & Fawcett, 2006:119; Jarrin, 2012:14; Lee & Fawcett, 2013:97; Schim 2006:75).

In the meta-paradigm of nursing, the concept 'human beings' can also refer to nurses who use their knowledge and skills during all contact sessions to the benefit of patients. In the context of this study, the focus of nursing intervention is the anticipatory guidance of adolescents to resist peer pressure and to improve their health and prevent illness. Through such interventions, early sexual initiation can be prevented and adolescents can be empowered to resist pressure from others (Cohen, Clark, Lawson, Casucci & Flocke, 2011:e13).

The concept 'nursing' forms the core of the meta-paradigm (Lee & Fawcett, 2013:97) and refers to the science and art of the nursing profession (Schim, 2006:76). It describes the delivery of compassionate acts of caring for people in different settings according to a code of conduct and within professional regulations (Thorne, Canam, Dahinten, Hall, Henderson & Kirkham, 2002:1259). In the article by Shah (2015:41), nursing is defined as "the science and practice of promoting adaptation for the reason of affecting health positively". In this study, nursing is related to the anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity. Sexual relationships should not develop because others want them to take part in it. It should happen when they make informed decisions about their sexual lives. Witt, Chiaramonte, Berman, Chesney, Kaplan, Stange, Woolf and Berman (2016:134) also used the old definition of 'health', according to the World Health Organization, which refers health as "a state of complete physical, mental and social well-being; not merely the absence of disease or infirmity", while the latest definition includes new additions such as "equilibrium within environment, capability and possibility of living its own spirituality" (Charlier et al., 2017:36). In this study, the concept 'health' thus refers to the ability of adolescents to resist pressure from others regarding their sexual lives. When adolescents know what the consequences of sexual activities are and they then engage in it, they take responsibility for their health. According to Schim (2006:75), individuals should take responsibility for their own health. In anticipatory guidance, nurses enable adolescents to take responsibility for their own sexual health.

The concept 'environment' can refer to the setting where the nurse-adolescent interaction happens and also to the peer pressure and coercion that adolescents experience. Clinics are readily available for adolescents to use, although not all adolescents visit them for illness prevention and health promotion. They are more likely to make use of clinic services when they are ill and cannot cope with the illness on their own (Shaw et al., 2006:33). The researcher believes that anticipatory guidance of adolescents by nurses in clinics can support them to resist peer pressure and coercion to sexual activity.

### **1.10 CONCEPTUAL FRAMEWORK FOR THIS STUDY**

Notwithstanding the ongoing debates between researchers on whether a conceptual framework should or should not be used in grounded theory research, the researcher decided to use it to indicate the sensitising concepts that were used in the data collection. Analysis processes were grounded in the meta-paradigm of nursing. The researcher endeavoured to develop a nursing theory.

According to Dey (1993), grounded theory researchers should differentiate between an 'empty head' and an 'open mind' (Luckerhoff & Guillemette, 2011:403). No researcher can completely 'divorce' himself or herself from what they know in order to become 'empty headed'. It is, however, possible to enter research with an 'open mind' (Luckerhoff & Guillemette, 2011:403). Sensitising concepts provide researchers with a "place to start and not to end" (Charmaz, 1995:49). The researcher developed the framework based on the meta-paradigm of nursing. The researcher used these concepts to guide the initial interviews during data collection. Thereafter, questions were developed from gathered data. Sensitising concepts can also be used as starting points during data analysis (Bowen, 2006:15). The concepts applicable to this study are reflected in the conceptual framework (Figure 1.1).

Factors in the environment can affect adolescents negatively or positively by being either barriers or facilitators to healthy behaviour. Environmental factors, both physical and socio-emotional, can enable adolescents to resist peer pressure and coercion to sexual activity or encourage them to become sexually active to get the approval from their friends. Nurses at healthcare institutions are also part of the environment of

adolescents. They are easily accessible sources that adolescents can use to improve their health or to get health problems managed. In this theory, intervention refers on the one hand to the pressure from peers that adolescents experience, and on the other hand the anticipatory guidance that nurses can use to support adolescents to resist peer pressure, should they want to. The researcher believes that anticipatory guidance is the best possible intervention to enable adolescents to take control over their sexual health.



## Conceptual Framework using the concepts of the meta-paradigm of nursing

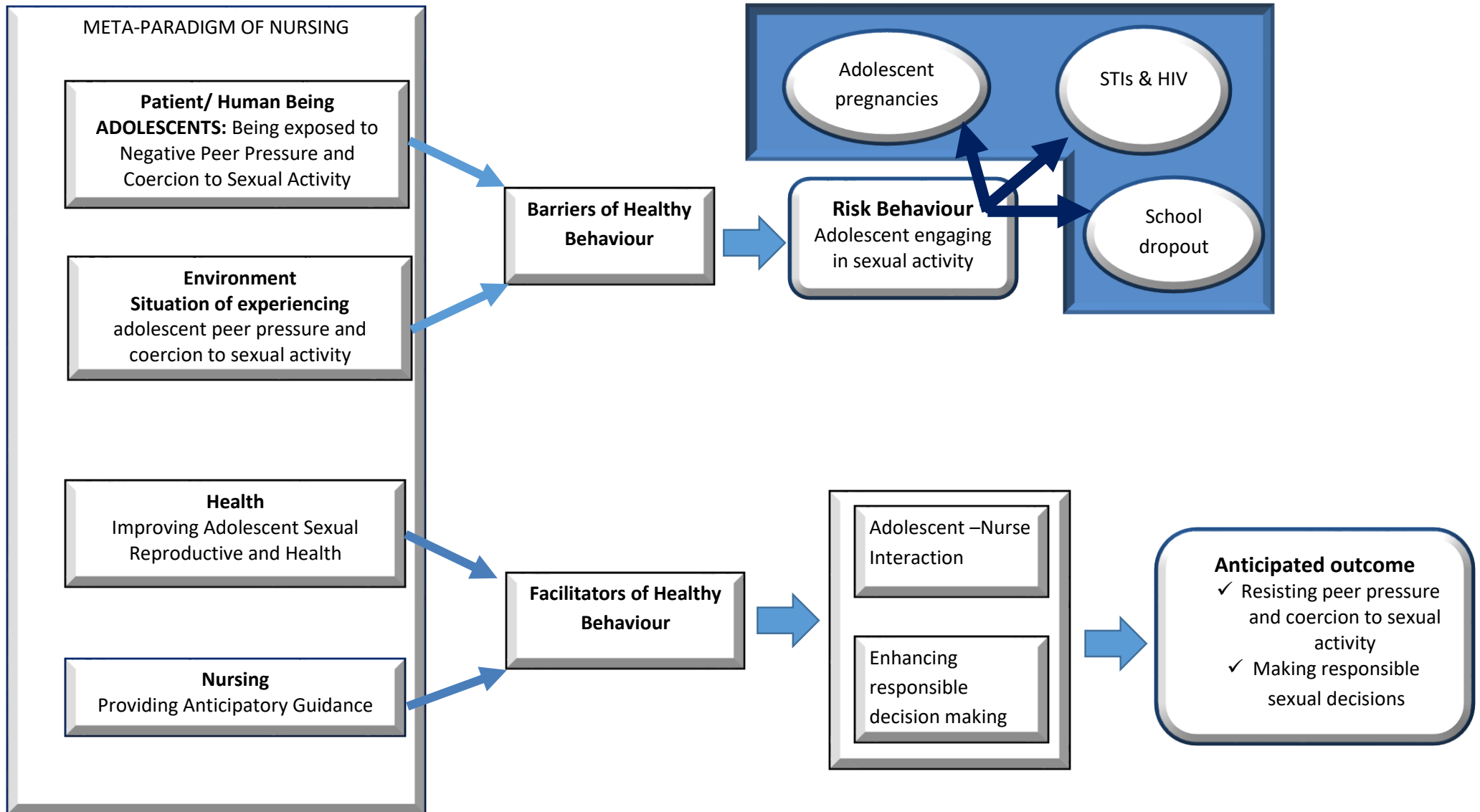


Figure 1:1 Conceptual framework of the study

## **1.11 DELINEATION OF THE STUDY**

This study was conducted in the Tshwane district of the Gauteng Province of South Africa at selected primary healthcare clinics, which were identified in collaboration with the relevant health authority targeting adolescents aged between 14 and 19 years old. Only they could provide information on how they experienced peer pressure and coercion and how it led to sexual activity so that a nursing theory could be developed. The nurse participants were working in the primary healthcare clinics in the district and had specific ideas about their responsibilities towards their adolescent participants. The Health Education Specialist previously worked for the National Department of Health and was responsible for youth and adolescent health programmes.

## **1.12 METHODOLOGY OF THE RESEARCH**

As a detailed description of the research methodology is provided in Chapter 3, only a brief overview is given here.

According to Charmaz (2006:104), grounded theory research is an emerging methodology. The point of departure of grounded theory research is a broad aim looking into the details of what is happening in the specific area of interest (peer pressure and coercion to sexual activities of adolescents). As the study progressed, the questions that were put to the participants changed to explore the phenomenon further and to construct the theory. Existing data determined the questions for collection of additional data. Intensive interviews were conducted with adolescents (male and female; 14 to 19 years of age), nurses and one Health Education Specialist working in the field of youth development and adolescent sexual and reproductive health. Data were analysed as it was collected; the findings of the initial data analysis were used to guide the direction of the study based on emerging categories as building blocks for the theory (Wuest, Merrit-Gray, Berman & Ford-Gilboe, 2010:798). Once the theory emerged from the data obtained, it was appropriate to consider how existing theory related or differed from the emergent theory (Watling & Lingard, 2012:855). It was important to ensure that the theory developed inductively, but once it had developed it could be refined through a comparison with existing theory (McGhee et al., 2007:341). A comprehensive literature review was done to refine the theory. The

most significant works on the topic of peer pressure and coercion to sexual activities that could be incorporated in an anticipatory guidance theory were analysed and critiqued from the vantage point of the theory to formulate the claims that this theory makes in the field of adolescent health.

The concepts and the relationships between the concepts were illustrated in a framework to show the conceptual logic, to show how the new grounded theory is positioned in relation to other theories and to explain the significance of the concepts in the new grounded theory (Charmaz, 2006:169).

### **1.13 ETHICAL CONSIDERATIONS**

Adolescent participants are considered to be a vulnerable group and special measures had to be implemented to protect them from harm during the study (Flicker & Guta, 2008:4). The researcher adhered to the ethical principles of the Belmont Report to ensure that the adolescent and the nurse participants were treated fairly, harm was prevented and their rights were protected (Polit & Beck, 2008:170).

The research was conducted after approval of the proposal by the Research Ethics Committee of the Faculty of Health Sciences of the University of Pretoria (refer to Addendum A1), permission to conduct the study was obtained from the Gauteng Department of Health Research Committee (refer to Addendum A2) and the District Health Services Management (refer to Addendum B1) as well as the City of Tshwane Health Services Management (refer to Addendum B2). The researcher acquired informed consent from the adolescents older than 18 years (refer to Addendum E, and also obtained informed consent from the parents and informed assent of adolescents younger than 18 years (refer to Addendum E (1) & E (2)). The age distribution of the 10 adolescent participants were as follows: five (19 years), three ( 18 years), one ( 17 years) and one (16 years).

The Research Ethics Committee of the Faculty of Health Sciences of the University of Pretoria recommended recognition of the National Health Act 63 of 2003 Section 71(2) of South Africa. It implies that adolescents should not be involved in research without any benefit towards their health. The committee recommended that the researcher

should provide the adolescent participants with health education after each individual interview. The researcher abided to the recommendations and provided them with health education. It was also ensured that the participants were not harmed or exposed to risks in any way. They were neither asked sensitive questions regarding their sexual life nor subjected to invasive physical examinations.

The district and sub-district clinic managers were duly notified about the intended study and the permission granted by the Gauteng Department of Health Research Committee was discussed with them. The researcher obtained their willingness and support to participate in the research before any data were collected. The following principles were strictly adhered to in the study:

#### **1.13.1 Right to self-determination**

According to Polit and Beck (2008:87), informed consent is an important strategy to safeguard the participants in research studies. The participants were given full information and free choice before expecting them to participate. They were given an opportunity to ask questions to ensure they understood what they either assented or consented for. The participants were notified about their right to voluntary participation and their right to withdraw from participation at any stage (Welman, Kruger & Mitchell, 2005:210) if they decided to do so, without fear of victimisation (Offredy & Vickers, 2010:111).

#### **1.13.2 Right to privacy and dignity**

The participants were notified of their freedom to share or withhold information. Data were collected in private areas in the health facility, the researcher's office, an outreach health post or the participants' homes.

#### **1.13.3 Right to confidentiality**

Participants were assured that their personal identification would be kept confidential and it would not be used in reports (Flicker & Guta, 2008:8). No identifying information was made available in the thesis or other research reports, which include manuscripts

published in academic research journals (Offredy & Vickers, 2010:116). All the transcripts of the interviews will be kept safe for 15 years after the completion of the study.

#### **1.13.4 Right to fair treatment**

All participants were subjected to fair and courteous treatment without prejudice. The researcher notified participants that there was no financial gain for taking part in the study. They were also notified that, should they refuse to take part in the study, they would not suffer any negative consequences. The participants were not subjected to unfair treatment at the hands of healthcare providers or the researcher following their decline to partake in the study. The researcher was obligated to maintain the dignity of and respect for all participants irrespective of their involvement in the study (Polit & Beck, 2008:85).

#### **1.13.5 Right to protection from discomfort and harm**

The researcher informed the participants about the benefits and risks involved with the study (Polit & Beck, 2008:172). No harm was inflicted on participants during the study. The researcher actively ensured that participants were not subjected to unnecessary harm and discomfort in any form or nature (LoBiondo, Haber, Cameron & Singh, 2014:118). The participants were reassured that, should emotional turmoil be evoked whilst talking about the influences of peer pressure, the researcher would provide the necessary support and/or refer the participant for further support and, if necessary, therapy (LoBiondo-Wood & Haber, 2006:307). It was arranged that the adolescents who were emotionally upset by the interviews would be debriefed by the clinical psychologists allocated to and operating at the clinics that participated in this study. Although the researcher offered to refer some of the participants to counsellors, they turned the offer down as it was not necessary. Exploitation was avoided at all costs. The researcher remained sensitive to the potential risks throughout the study.

## **1.14 SUMMARY**

Chapter 1 provided an overview of the rationale that motivated the researcher to embark on the study to explore and describe what adolescents experienced regarding peer pressure and coercion to sexual activity and how nurses could support the adolescents regarding resisting peer pressure and coercion. It also outlined the research questions, aims and objectives, assumptions, clarified research concepts, the conceptual framework used in the study as well as provided a brief overview of the research methodology. Overall, this chapter served as introduction of the research activities that were planned and undertaken with the aim of exploring and describing the peer pressure and coercion related to sexual activity from an adolescent perspective, using the constructivist grounded theory methodology.

In Chapter 2, the position of the study in the broader context of the knowledge base of peer pressure and coercion to sexual activity is described.

## **1.15 ORGANISATION OF THE STUDY**

The researcher supports the recommendation of Birks and Mills (2015:132) that the structure for a thesis with a grounded theory methodology should be as follows:

Chapter 1: Introduction and orientation to the study.

Chapter 2: Position of the study in the broader context of the knowledge base of peer pressure and coercion to sexual activity.

Chapter 3: Research methodology.

Chapter 4: Description of findings and emergent theory.

Chapter 5: Discussion of findings and emergent theory.

Chapter 6: Description of a nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity. The study is concluded by a description of the nursing theory on anticipatory guidance of adolescents to peer pressure and coercion to sexual activity.

## **CHAPTER 2**

### **POSITION OF THE STUDY IN THE BROADER CONTEXT OF THE KNOWLEDGE BASE OF PEER PRESSURE AND COERCION OF ADOLESCENTS TO SEXUAL ACTIVITY**

#### **2.1. INTRODUCTION**

In this chapter, the researcher indicates the position of the study in the broader context of the knowledge base (Birks & Mills, 2015:132) of peer pressure and coercion of adolescents to sexual activity. This study stemmed from an identified knowledge gap on anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity. The researcher identified the knowledge gap of adolescents failing to personalize the sexual health risks whilst interacting with adolescents. There was limited or no specific literature on how adolescents could be supported to improve their sexual and reproductive health.

Adolescents are pressured into experimenting with sex and are even forced by their friends to indulge in early sexual activity (Bingenheimer, Asante & Ahiadeke, 2015:1). It is often unplanned and occurs without the use of condoms, resulting in exposure to HIV and STIs (Cherie & Berhane, 2012:159). The sexual risk behaviour of adolescents also leads to unplanned pregnancies (Santelli, Song, Holden, Wunder, Zhong, Wei, Mathur, Lutalo, Nalugoda, Gray, & Serwadda, 2015:497; Slater & Robinson, 2014:189). It also impacts negatively on their general health and well-being (Loke, Mak & Wu, 2016:121). Once adolescents experienced sex, they find it difficult to abstain from further sexual activities (Santelli et al., 2006:73) although they may be aware of the detrimental consequences that their behaviour might have on their well-being (Awaluddin et al., 2015:1). Unplanned pregnancies as a result of sexual activities also have dire financial consequences for adolescents when they are forced to leave school and university to take care of their infants (Darroch Singh, Woog, Bankole & Ashford, 2016:2). A study that was conducted in KwaZulu Natal in South Africa revealed that 37.7 per cent of the male adolescent respondents reported that they were sexually active. They became involved in sex when they were around 12

years old and believed that there was nothing wrong with forcing girls to have sex with them (Harrison et al., 2012:181).

## **2.2 DESCRIPTION OF PEER PRESSURE AND COERCION**

Peer pressure and coercion to sexual activity refer to experiences that force individuals (adolescents) to take part in sex against their will (Erulkar, 2004:182). It can happen openly or secretly and relates to the bullying of others (Bierman, 2011:298). The actions are often contrary to the moral values of the person who is pressured to act according to the peers' discretion (Loke, Mak & Wu, 2016:114).

Coercion and peer pressure is a cause for concern in adolescents' lives. Coercion is when excessive force is used to urge others through physical, violent means or manipulation to do something they do not want to do (Goetz & Shackleford, 2011:125; Ha et al., 2016:707). The adolescents who give in to the coercion may be rewarded with gifts and with time, their ability to decide for themselves becomes clouded and they carry on with the risk behaviour in exchange for gifts (Moore, Biddlecom & Zulu, 2007:9). Coercion and peer pressure are often used interchangeably and there is a fine line between them. In both cases, acts are used to convince people to respond to something against their will. The difference is, however, in the force that is used to influence others. In the case of coercion, unwarranted excessive force is used to instil fear (Kaltiala-Heino, Fröjdd & Marttunen, 2016:12).

Sexual coercion affects both adolescent boys and girls negatively, however the girls are more affected because they value peer relations more than boys. Flack, Salmivalli and Idsoe (2015:484) remarked that girls were found to be emotionally affected by friendship ties, unlike boys who do not stress about peer relations. Moreover, some adolescent friendships are negative because they lead young, naïve, vulnerable adolescents into trouble because at that stage they are not ready for sexual activity and are unwilling to participate in sexual activity (Ybarra et al., 2012:2). Assurance of approval from the peer group is granted upon relenting to coercion into unwanted sexual activity (Akintola et al., 2011:144). According to Zuma et al. (2010:48), many adolescents are unfortunately not familiar with their coerced sexual partners. Fear of rejection forces adolescents to participate in unwanted or early sexual activity



(Brendgen et al., 2007:2073). Adolescent males often use their engagement in early sexual activity to prove their masculinity (Nogueira Avelar e Silva, Wijtzes, Van de Bongardt et al., 2016:10).

### **2.3. DYNAMICS OF PEER PRESSURE AND COERCION**

Peer group dynamics can be classified into four key aspects, namely “(self-perceived) same-sex popularity, (self-perceived) other-sex popularity, perceived peer pressure, and need for popularity” (Abee et al., 2014:8). Adolescents find themselves interacting with their peers in one of these categories. The main actors in the group set the norms for the rest to follow under influence and force. When adolescents question the norms, they get side-lined by the members of the group. According to Veenstra, Dijkstra, Zalk and Steglik (2013:399), influences by peers determine the groups that adolescents choose to belong to. They may choose to associate with people they envy, admire or who have similar interests (Van Workum, Scholte, Cillessen, Lodder & Giletta, 2013:563). Other determinants may be shared socio-demographic attributes, similar peer behaviour, and the status and position that the group has in the larger network of peer relationships (Fearon, Wiggins, Pettifor & Hargreaves, 2015:63).

Adolescent social networks are diverse and dynamic. The way they choose their peers and the rationale for their peer preferences are complicated. For someone to fit in and belong to a specific peer group, similar personal characteristics and behaviour are of utmost importance (Ha et al., 2016:707). For others, the chance of becoming popular in the group determines whether they will join it (Fearon et al., 2015:71).

Relationship dynamics with their peers play a major role in adolescents' social life. For adolescents, peer pressure is a driving force for being or not being in the friendship circle. Adolescents feel alone or lost without friends, because whatever they do is measured against their friends' standards. For adolescents, becoming popular or being respected as well as being feared are critical in peer association. Their desire to please and to impress their peers surpasses the recognition of dangers associated with negative peer pressure that exposes adolescents to risk behaviour. Adolescents get involved in peer pressure activities because they want to belong, become popular

and to have a certain social status among their peers (Abeelee et al., 2014:10;12). Adolescents also become attracted to others who have similar behaviour to them or who present the behaviour that they want to display (Osgood, Ragan, Wallace, Gest, Feinberg & Moody, 2013:500). Sometimes, adolescents are challenged to prove that they are worth being accepted into a group. They may be the ones who are not sexually active or who do not abuse substances. Groups may view them as being outsiders and they can be forced to go through initiation processes that may include risk behaviour (Chan & Chan, 2013:287).

## **2.4 VULNERABILITY OF ADOLESCENTS TO PEER PRESSURE AND COERCION**

Adolescents are found to be vulnerable to peer pressure. A low self-esteem may contribute to adolescents relenting to peer pressure, because such adolescents cannot stand up against others who push them to commit negative acts or illegal activities. Adolescents with poor self-confidence find making responsible choices and setting goals in their life challenging. Poor self-confidence leads adolescents to not believe in themselves, thus depending on their peers and friends to validate their outlook (Cribb & Haase, 2016:108).

Adolescence is a stage when interest in sexual activity begins and peers play a major role influencing adolescents to conform to peer group norms, including engaging in sexual activity. Being involved in peer group activities has consequences, especially if they are driven by negative peer pressure. Smoking, using illicit substances and drinking alcohol are associated with peer pressure (DiClemente, Hansen & Ponton, 2013:3). Adolescents often boast about their adventures and conquests to their peers, hoping that others will admire them. Showing off sensitive pictures in sexually compromising positions is common and indicates their sexual risk status (Ybarra & Mitchell, 2014:758).

Adolescents use social media for interacting with their peers and get exposed to social media, which opens a window for experiencing various uncensored X-rated pornographic material. This mode of sharing negative sensitive material through cell phones is referred to as sexting (Abeelee et al., 2014:8; Ybarra & Mitchell, 2014:758).

Adolescents thus have easy access to material that may stimulate them sexually and without guidance from parents or other adults with whom they have good relationships, they may give in to peer pressure to become sexually active in a risky manner. When they are admired by their peers for the risk behaviour that they practise, risk behaviour patterns are formed and supported, and they may find these difficult to terminate. Should their peers also take part in similar behaviour and they want to maintain the relationships, the behaviour is reinforced (Parkes et al., 2010:1130).

Poverty and the desire of adolescents to escape poverty create situations in which gifts are exchanged for risk behaviour such as having sex with adults (Slater & Robinson, 2014:192). This practice also occurs due to the desire of adolescents to be like their friends who have money to purchase goods. The adult sexual partners wield power to dictate the terms of sexual activity (Kaufman & Stavrou, 2004:377). They can thus demand sex without the use of condoms with detrimental consequences for their young sex partners. Adolescents view these relationships as transactional, as they benefit from it in terms of money and other gifts (Moore, Biddlecom & Zulu, 2007:9).

The desire of poor adolescents to own branded clothes and to dress as their wealthy friends do, contributes to their vulnerability to take part in sexual risk behaviour (Masvawure, 2010:864). When money or branded clothes are offered in exchange for sexual favours, they are tempted to give in to such pressure (Helfert & Warschburger, 2013:2). Both the clothes and the sexual activity are applauded by their peers and it satisfies their need to be accepted by others.

The vulnerability of adolescents is exacerbated when they lack guidance from significant others such as parents and other family members. Sometimes, adolescents are on their own and do not have anybody to guide or mentor them due to being orphaned or having poor relationships with family members. Having an unstable family puts adolescents in a vulnerable position whereby they do not have somebody to guide them in a responsible and appropriate manner. Adolescents without guidance by responsible persons are predisposed to risk behaviour (Santelli et al., 2015:497). At times, parents are not aware of what is happening in their adolescent's life or the adolescents do not communicate their ordeals with their parents (Chan & Chan, 2013:287). Cauffman (2008:130) confirmed that adolescents from unstable families,

where parents are disruptive and not good role models, become vulnerable to risk behaviour. Good relationships between parents and adolescent children, according to Wang, Deveau, Lunn, Dinaj-Koci, Li and Stanton (2016:221), may reduce their vulnerability to risk behaviour.

Upbringing and socialisation play a major role in preparing adolescents to become resistant to peer pressure. Adolescents grow up in families who are expected to provide a secure foundation for them. Upon failing to receive such family support, adolescents depend on their peers and friends to validate their doubts. Therefore, adolescents who are orphans are more vulnerable because they lack parental guidance. In the absence of parental guidance, adolescents listen to their peers (Chan & Chan, 2013:287).

Adolescents who are cared for and supported by their parents are less likely to be affected by peer pressure. Such adolescents are not afraid to share their troubles with their parents, rather than resorting to their friends for consolation. Birkeland, Breivik and Wold (2014:70) attested that having loving and caring parents from emotionally stable families have added benefits for the development of their children. They grow and become emotionally well-grounded adolescents capable of managing their lives. It was revealed that a positive adolescent-parent connection provides adolescents with emotional nurturing and leads to increased self-esteem. It shows that maintaining positive relationships with young and older children is valuable for their emotional growth and stability later in their life when they venture into social relationships (Birkeland et al., 2014:79).

Good relationships between adolescents and their parents can reduce their vulnerability to peer pressure. Adolescents with a good rapport with their parents benefit from sex education from their parents (Etter, Aalsma, Schwartz, Sieferman & Peters, 2016:S63-S85). They also tend to be less vulnerable to peer pressure and risk behaviour (Boislard, Pouli, Keisner & Dishion, 2009:271) and often delay their sexual debut due to the guidance of their parents (Wang et al., 2016:221). It is necessary, however, that the parents have the knowledge and skills to provide such education and guidance (Cherie & Berhane, 2012:161).

## **2.5. GENERAL PICTURE OF ADOLESCENT SEXUAL ACTIVITY IN SUB-SAHARAN AFRICA**

International organisations are concerned about the incidence of HIV and unplanned pregnancies amongst young people. UNAIDS have set out monitoring tools and mechanisms to ensure that all countries report their progress towards the achievement of the Millennium Development Goals (as adopted in 2000) of which adolescent health and well-being is top priority. The point of relevance of the reporting is embedded in discouraging early sexual risk behaviour among adolescents to reap the benefits of an HIV free generation and healthier communities (WHO & UNAIDS Guidance, 2015:31). However, the MDG were criticised for leaving out certain critical aspects which affect the broader population, thus on 25 September 2015 the United Nations General Assembly came up with 17 goals or Sustainable Developmental Goals as opposed to the eight initial MDGs. Goal 3 of the SDGs, which is to ensure healthy lives and promote well-being for all ages, superimposes MDG 4, 5 and 6. The third goal of the SDG covers reproductive, maternal, new-born and child health amongst the other important health aspects and risks. This goal is relevant and highlights the need to address the issues that affect adolescents because of risk behaviour.

The World Health Organization (2011) report on the Health for the World's Adolescents highlighted the global data about the importance of maintaining good health of adolescents to avoid debilitating and death causing diseases. Adolescent risk behaviours were not mentioned outright, but some common health problems were as a consequence of the adolescent risk behaviour. Five key priority health concerns are emphasised and two of them are attributed to sexual risk behaviour. Adolescent females aged 15 to 19 were mentioned in the report due to the negative impact of unplanned pregnancies on their general health (WHO 2011:ix)

The Global Strategy for women's and children's health was launched in September 2010 and the subsequent report released in 2015, also striving to promote the safety and well-being of women and children. The report acknowledges that adolescents receive little or no access to health services (UNICEF, 2015:10).

Morris and Rushwan (2015:S40) indicated that the global burden of sexual ill-health lies within the adolescent sexual and reproductive health and neglecting it poses a great risk to adolescent girls.

A study of 12 Sub-Saharan countries revealed that the exchange of material gifts and substance abuse are the main reasons why adolescents give in to peer pressure with regards to sexual activities (Masvawure, 2010:864). The adolescents listened to their peers and were obliged to please them to be accepted in their groups (Bingenheimer et al., 2015:2). Another Sub-Saharan study indicated that more adolescent girls between 15 and 19 years in West Africa were sexually active than boys of the same age. The age of sexual debut for girls was just under 15 years old (Doyle. Mavedzenge, Plummer & Ross, 2012:797). In contrast, a research report of the latest Caribbean study of early sexual activity indicated that 36.6 per cent of adolescents aged 15 years have had sexual intercourse, but the prevalence for adolescent boys (37.2%) was higher than for girls (16.9%) (Peltzer & Pengpid, 2015:351). It is interesting to note from reports that countries such as Niger, Sierra Leone, Benin and Ethiopia Guinea approve the legal age for consenting sex as young as 13,14 and 15 years for various reasons, depending on whether parents knew about it, in the case of arranged marriages and due to peer union. A low level of education, early marriages and rural circumstances also contribute to participation in early sexual activity (Doyle et al., 2012:799), while living without biological parents, poor parental monitoring and connectedness and complacency towards sex and other risk behaviour were factors identified in the Caribbean study (Peltzer & Pengpid, 2015:352).

Contributing factors related to an early sexual debut among females are intertwined and increase their vulnerability to sexually transmitted infections. The earlier adolescents engage in sex, the more they are exposed to multiple sex partners, repeated sexually transmitted infections, and are they exploited for unsafe and cross-generational sex. They also use alcohol and drugs to numb their emotions (Stöckl Kalra, Jacobi & Watts 2013:28).

The astonishingly high incidence of HIV in adolescents in Sub-Saharan Africa kept scientist working hard towards investigating the adolescent sexual risk behaviours to enable interventions to be evidence based and targeted towards reducing the risks

and consequences of the burden of disease. It was discovered through a study conducted in KwaZulu Natal, South Africa that adolescents who initiate sexual activity early on, risk having repeated sexual encounters with a series of sexual partners over a long period, thus exposing themselves to HIV infections, other sexually transmitted infections and unplanned pregnancies. Moreover, the adolescent girls' sexual reproductive organs are not adequately matured, thus they become prone to various biological and physiological complications during pregnancy and child birth (Wand & Ramjee, 2012:2).

A report from the UNESCO Global Advisory meeting held in December 2007, highlights that those adolescent girls who experienced early sexual activity, faced dropping out of school due to the dire consequences of unsafe risky sexual behaviour as a result of their poor living conditions and social circumstances. The involved adolescent boys became young, incapable fathers because they are not ready for fatherhood. It was reiterated that unless opportunities were not created to enable these adolescents to better their lives, their possibility to be in rewarding careers would be compromised (UNESCO Report, 2008:10).

The link between peer pressure and sexual activity of adolescents was researched in Sub-Saharan Africa and revealed that various factors influence sexual activity among adolescents. Peer norms, peer approval of risk behaviour, associations of peers and relationships among peers contribute to sexual activity among adolescents (Fearon et al., 2015:63). Evidence from a Ugandan study revealed that the incidence of sexual coercion was up to 30 per cent, female adolescents experienced sexual coercion as early as 14 years of age, and the incidences were accompanied by physical force. Such occurrences were the first sexual experience for the relevant adolescent girls (Koenig, Zablotska, Lutalo, Nalugoda, Wagman & Gray, 2004:157).

To demonstrate how far South Africa has progressed with the monitoring of trends for adolescent risk behaviour, the researcher highlighted the extracts of the adolescents' sexual activity in South Africa from the first National Risk Behaviour Survey done in 2002, through the second one done in 2008 and to the third one done in 2011 by the Human Science Research Council (HSRC), South Africa. A study in 2002 in South Africa revealed that 41 per cent of adolescents between 14 and 19 years were sexually

active. Fourteen per cent had their sexual debut at 14 years, 54 per cent of those sexually active had one sex partner, 14 per cent had their sexual experience under the influence of alcohol and 16 per cent endured pregnancy (Reddy et al., 2003:12). In 2008, there was a change in sexual risk behaviour, probably because of a significant percentage of respondents (74%) who indicated that they have had health education on HIV prevention. The comparison of the 2002 and 2008 statistics indicated a decline in sexual activities (Reddy et al., 2009:np).

In 2011, the Third National Youth Risk Behaviour Survey was conducted in South Africa across high schools targeting the 14 to 19-year-old adolescents in Grade 8 to 11. The survey revealed that 39 per cent of adolescents had their sexual debut at 16 years or younger, unlike in 2002 when the sexual debut started at 14 years. Of the 39 per cent of adolescents, 45 per cent were male and 35 per cent were female. It was also revealed that the higher the grade and age, the more the adolescents were sexually active. Fifty-three per cent of the Grade 11 learners as compared to the 22 per cent of the Grade 8 learners and 53 per cent of the 19-year-olds compared to 16 per cent of the Grade 8 learners accounted for those who were sexually active. Mpumalanga adolescents were found to be more sexually active at 43 per cent, while Limpopo adolescents were rated to be the lowest sexually active adolescents at 32 per cent amongst all provinces of South Africa (Reddy et al., 2013:26).

When a race variation is done, black African adolescents initiate sexual activity earlier than white and Indian adolescents; as early as 14 years. Black African adolescents were more sexually active than the adolescents of other racial groups. Seventy-four per cent of the white adolescents had engaged in sexual activity with more than one partner in their life as compared to the black African adolescents at 44 per cent and coloureds at 45 per cent. The adolescents in Gauteng were more inclined to have more than two sexual partners at 59 per cent, as compared to adolescents in Eastern Cape, rated the lowest at 43 per cent. When it comes to substance abuse and sexual activity, drugs and alcohol use contributed to adolescents indulging in sex after consumption of alcohol and drugs. Seventeen per cent of adolescents were found to be under such an influence during risk behaviour (Reddy et al., 2013:27).



Interesting information comes forth when the prevalence of adolescent sex in South Africa is compared to similar statistics in Zimbabwe, following a 2011 survey of youth risk behaviour. In 2014, the Guttmacher Report indicated that in Zimbabwe, 38 per cent of female and 23 per cent of male adolescents had had sex by 18 years of age as compared to 45 per cent of males and 29 per cent of females in South Africa. Their sexual debut happens in late adolescence, unlike in SA where it happens in early adolescence. Female adolescents in Zimbabwe are reported to start sexual activity later than South African girls as it is culturally taboo to have a baby outside wedlock. In Zimbabwe, some adolescent girls prefer to marry older men to escape poverty (Remez, Woog & Mhloyi, 2014:2).

Overall, the trends in adolescent early sexual activities are marred by sexual coercion and accompanied by power relations and a variety of risk behaviours. Adolescent girls are often not able to negotiate for condom use as they get overpowered physically or age-wise (Pettifor, Measham, Rees & Padian, 2004:2002).

## **2.6 INTERVENTIONS IN SUB-SAHARAN AFRICA AND SOUTH AFRICA TO SUPPORT ADOLESCENTS TO IMPROVE SEXUAL AND REPRODUCTIVE HEALTH**

General youth development programmes to empower adolescents to become assertive, focused, socially connected and future-oriented individuals (Walsh-Buhi et al., 2016: 284) represent one way to support adolescents to improve their health and well-being. The focus of the intervention programme can also be more specific, such as those aimed at improving the sexual health of adolescents (Masvawure, 2010:860; Martin, 2005:1).

During the early 2000s, many organisations in Africa were concerned about the increase in incidence of HIV infections and pregnancies among adolescents. In Zambia and the Dominican Republic, the organisation Family Health International developed peer education programmes aimed at empowering adolescents to prevent them from being infected with STIs and getting pregnant. They designed quality assessment tools to evaluate peer education programmes aimed at addressing the challenge of HIV, STIs and pregnancy among adolescents (Youth Peer Kit, 2006:5).

Officials in some countries in Africa (Lule, Rosen, Singh, Knowles & Behrman, 2006:1115) developed adolescent intervention programmes from 2001 to 2003 to provide scientific information about sexual reproductive health in adolescents. Intervention programmes and tools were developed in Mozambique, Senegal, South Africa, Uganda, Tanzania, Zambia and Zimbabwe. Some of the adolescent health manuals and policy guides were sponsored by the United States Agency for International Development, and were designed to add value to the lives of adolescents. In Zimbabwe, programmes were implemented to reduce new HIV infections amongst adolescents (Masvawure, 2010:860).

In South Africa, assistance from experts within the international arena was solicited to address the challenges that were engulfing adolescents. In 2002, the Harvard School of Public Health assisted the South African government to develop a series of peer education manuals called Rutanang Peer Education. These manuals were meant to help organisations to deliver peer education and to implement peer education programmes in their settings. The programmes focused on the development of skills by adolescents to change risk behaviour (Deutsch & Swartz, 2003:5). In addition, the Human Science Research Council assisted the National Department of Health to conduct National Youth Risk Behaviour (NYRB) surveys. Three NYRB surveys were conducted in 2002, 2008 and 2011. The aim was to identify the risk behaviour trends among the adolescents and youth of South Africa and to provide data for provincial departments to act accordingly on their specific problems as identified.

In 2003, the National Department of Basic Education (NDBE) in South Africa implemented Life Orientation as a compulsory subject in all schools from Grade 4 to 12. It is meant to build the capacity of learners (adolescents included) and to provide them with skills to become assertive and self-confident to overcome risk behaviour.

From 1999 to 2006, LoveLife supported the National Department of Health to improve accessibility and increase the utilisation of youth and adolescent health services. In 2006, the abridged version of the National Adolescent Friendly Clinic Initiative (NAFCI/YFS) was implemented across South Africa to address HIV among adolescents through improving the accessibility and quality of health services among

youth and adolescents. All provinces were implementing NAFCl to enable adolescents to access health facilities, trained healthcare providers who treat them with dignity and respect and ensuring that health facilities are conducive for adolescent utilisation (Geary et al., 2014:2). Adolescent requires quality nursing care and support, thus treating them with disrespect as well as not considering them as individual clients but children alienate them from nurses and clinic services (Ramjan, 2004:500).

The WHO developed a tool in 2006 that was valuable in conducting a systematic review of adolescent health and prevention intervention programmes implemented by various countries in Sub-Saharan Africa and Caribbean countries to improve the utilisation of adolescent health services (Denno, Hoopes & Chandra-Mouli, 2015:S24).

In South Africa, the evaluation of the peer education programme was conducted by the Centre for the Support of Peer Education (CSPE) in 2009 and again in 2010 to measure the impact of peer education that would manifest in behavioural change post receiving peer education. The findings were promising, as it revealed that exposure to the correct information and life skills do add value in increasing adolescents' knowledge and health-seeking behaviour (Swartz, Deutsch, Makoe, Michel, Harding, Garzouzie, Rozani, Runciman & Van der Heijden, 2012:252).

The Integrated School Health Policy was amongst the tools meant to target the health and well-being of adolescents. It was also developed in 2012 to provide comprehensive primary healthcare in schools for improving the health and well-being of adolescents. The policy is also meant to curb adolescent pregnancy in response to meeting the goal of reducing child and maternal morbidity and mortality (NDBE, 2012a:28).

In 2012, the National Department of Social Development implemented a groundbreaking initiative to train groups of adolescents to become peer educators and role models of good behaviour for others at school. It also launched a campaign aimed at promoting healthy lifestyles among adolescents in 2015.

In KwaZulu Natal, South African efforts have recently been made to discourage older men to have sexual relationships with adolescent boys and girls (Bhana, 2016:160).

On 24 June 2016, the National Department of Health launched a campaign that targets adolescent girls and young women to empower them to be productive and self-sufficient. The initiative is meant to discourage adolescents from associating with older men who endanger their health and wellbeing through transactional sex (NDOH 2012b:np)

## **2.7 ANTICIPATORY GUIDANCE OF ADOLESCENTS**

Anticipatory guidance is effective if it is not generic but tailor-made to involve a specific target population with specific and appropriate messages (Mulvihill et al., 2005:94). From the existing literature on anticipatory guidance, there is a need to conduct more research to develop programmes that focus on age groups and their specific concerns (Olson et al., 2004:1915). A nursing theory for the anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity could not be found in the literature.

The development of anticipatory guidance dates to the early 1990s with the focus on improving the health of children. The Academy of Paediatrics, in collaboration with a couple of universities in the United States of America, has been leading the development of anticipatory guidance for children and mothers on various childhood health conditions and concerns (Belamarich, Gandica, Stein & Racine 2006:e965). Various health-specific topics were addressed, for example violence, injury prevention, nutrition, obesity, dental care and treatment. Most of the information on anticipatory guidance that exists, targets childhood care (Levine & Coupey, 2006:132).

In 2008, The American Academy of Public Health published *Bright Futures*, a booklet for people working with infants, children and adolescents. It contains valuable information on developmental observation, physical exam, screening and immunisation. The topics outlined for anticipatory guidance of adolescents address physical growth and development, social and academic competence, emotional well-being, risk reduction, violence and injury prevention (Hagan, Shaw & Duncan, 2008:47). Nothing is mentioned about providing adolescents with guidance to cope with peer pressure and coercion to sexual activity.

An extensive search to find literature on anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity yielded insufficient results. Various search engines like Medline, Popline, PubMed and Clinical Key were used, however they were not as successful as Google Scholar. The concepts searched were 'Anticipatory Guidance for Adolescents', 'Peer Pressure', 'Early Sexual Activity' and 'Sexual Coercion'. Through Google Scholar, access was obtained to many journals linked to Worldcatonline.com and interlinked to Elsevier publication sites. The lack of research reports on anticipatory guidance of adolescents to resist peer pressure, and specifically to resist such pressure and coercion to sexual activities, is alarming and encouraged the researcher to do this study.

## **2.8 SUMMARY**

This chapter reviewed the literature associated with peer pressure, coercion and anticipatory guidance in relation to adolescent sexual activity. The literature outlined information covered by other research on adolescent sexual activity and highlighted various types of peer pressure predisposing adolescents to risk behaviour. However, the researcher identified the information gap specific to anticipatory guidance of adolescents on peer pressure and coercion to sexual activity. The next chapter addresses the methodology undertaken to execute the study.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

This chapter outlines the methodology used to execute this study. The chapter focuses on explaining how Grounded Theory Methodology (GTM) was used to develop a nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity. In this chapter, paradigmatic assumptions, research methodology, rigor of the study and the summary thereof is provided. The paradigmatic assumption are comprehensively explained based on the Charmaz' constructivist grounded theory to show how it is applied to this study. A detailed explanation of how data were collected and analysed, including the coding process for developing categories from sensitising concepts for theory development, is given. The methods used to collect data are clarified, sampling methods and ethical considerations explained, and coding processes described. This chapter also highlights how the researcher used GTM processes in the constructivist paradigm to conduct this study.

#### **3.2 PARADIGMATIC ASSUMPTIONS**

Paradigms are used to guide the researcher to identify the appropriate research methodology for the planned study (Ponterotto, 2005:127). Each paradigm has specific assumptions that must be acknowledged in the selection of participants and research methods. They guide the researcher on how to go about testing hypotheses (in quantitative research) or developing theory (in qualitative research).

The research paradigm of a study determines the ontological, epistemological and methodological assumptions that guide the research (Denzin & Lincoln, 2011:3). It sets the scene for the researcher to study a phenomenon in a specific manner (Krauss, 2005:759); is dependent on the research question (Ponterotto, 2005:128); and determines the relationship of the researcher and the studied phenomenon (Heron & Reason, 1997:276). The researcher used a grounded theory approach to develop a

nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity.

The two dominant research paradigms are the positivist and constructivist paradigms. Quantitative research is associated with the positivist paradigm and qualitative research with the constructivist paradigm (Krauss, 2005:760). Positivist paradigm researchers probe for cause-and-effect relationships of dependent and independent variables (Jeon, 2004:250), while constructivist paradigm researchers attempt to understand phenomena through exploration (Krauss, 2005:759).

This study follows a naturalistic inquiry with the influence of Guba and Lincoln's original work developed in 1995 (Guba & Lincoln, 1982:233); it is anchored in qualitative research. The constructivist approach is also known as a naturalistic paradigm (Krauss, 2005:761) because of its tendency to occur in the natural setting. In this study, the researcher collected data in a clinic setting through personally interacting with the research participants. It is also recognised for its ability to afford the researcher a chance to have a close relationship with the participants to co-construct social reality (Plummer & Young, 2010:313).

Researchers who support the constructivist paradigm believe that the truth is found in multiple social realities that are co-constructed through the interaction between the researcher and the participants (Charmaz, 2008:402). The constructivists believe in social reality constructed through multiple consultations, thus referring to it as relativist ontology. Social reality depends on the participants' experience and what they perceive as the truth based on their personal experience of the phenomena. The participants are allowed to interpret what they know and understand according to their own terms (Ponterotto, 2005:130). In constructivist terms, social reality is subjective (Mills, Bonner & Francis, 2006b:2). Interaction between the researcher and the participants in this study enabled the researcher to collect rich data (Charmaz, 2008:402) to construct the theory to anticipatorily guide adolescents to resist peer pressure and coercion to sexual activity.

### **3.2.1 Ontological assumptions**

Ponterotto (2005:129) alluded that the ontological assumption of constructivism implies that social reality cannot be researched through a single source but needs to be co-constructed by the researcher and multiple sources.

Constructivist grounded theory research signifies that even though reality exists, and many truths can be discovered through naturalistic inquiry which is subjective (Johnstone, 2004:261). It affords the researcher and participants the opportunity to interact continuously that they discover the social reality in their meanings (Hallberg, 2006:146). Humans have the capacity to co-create reality through sharing meanings in pursuit of knowledge (Aldiabat & Le Navenec, 2011:1068).

The constructivist researcher is challenged to acknowledge the multiple realities of a phenomenon. In-depth interviewing and a thick description of the presentation of the phenomenon enable researchers to co-construct the meaning of the reality with the participants (Ponterotto, 2005:130). Getting thick descriptions based on participants' assertions provides the data with credibility it requires to consider the findings trustworthy (Shenton, 2004:69). The researcher in this study assumed a relativist ontological position in understanding reality (Mills et al., 2006a:9).

### **3.2.2 Epistemological assumptions**

Aldiabat and Le Navenec (2011:1068) define the constructivist epistemological assumption as anchored in the mutual relationship that the researcher and participants have, to advance the ideals of constructivist approach. The assumption also puts emphasis on exploring what the participants know and what the knower wants to know in order to understand what is meant by phenomena in question (Boychuk-Duchscher & Morgan, 2004:606). The constructivist grounded theory research approach brings the researcher closer to the participants' social world through interaction. The relationship is regarded as transactional and subjective, based on the two-way collaboration between researcher and participants (Ponterotto, 2005:131). During interaction, the researcher and the participants give and take from each other to explore the meaning of the phenomenon (Mills et al., 2006a:9). The researcher tried



to solicit information from the two sets of participants (adolescents and nurses) and one set of theoretically sampled participants, which included a Health Education Specialist, and was involved in this study in order to construct a theory to anticipatory guide adolescents to resist peer pressure and coercion to sexual activity. The researcher and the participants engaged in a dialogue that enabled obtaining an understanding of the studied phenomenon (Burbank & Martins, 2009:27).

### **3.2.3 Axiological assumptions**

The axiological assumption is one of the four philosophical assumptions (Creswell, 2013:21) that enables researchers to value the information that participants share with them and to recognise the possibility that their own personal experiences may influence them (Carnaghan, 2013:np). The axiological assumption, from the naturalistic perspective, encourages researchers to declare the bias they bring when collecting, analysing and reporting data (Bryant & Charmaz, 2009:247). The researcher discussed on an ongoing basis her involvement in the processes with her study leaders to ensure that she co-created the data with the participants and that she did not become the main role player.

### **3.2.4 Methodological assumptions**

According to Charmaz (2006:104), “grounded theory is built on emerging concepts in which data is embedded; thus, the methodology is referred to as emergent”. The collection and analysis of data as well as the construction of the theory in this study did not take place in a social vacuum (Charmaz, 2008:398). The current and past experiences of the researcher and participants influenced the methodological processes and outcomes (Charmaz, 2005:510). Researchers should, therefore, be open about their history and the possible influences that it may have on the construction of meaning (Mills et al., 2006a:11).

Constructivist researchers seek meaning in data that goes beyond the surface. Data are collected and analysed to produce knowledge, based on what participants experience and explain (Madill, Jordan & Shirley, 2000:9). In this study, theoretical

analysis enabled the researcher to retain the data connection as participants clarified the meanings of their experiences (Mills et al., 2006a:11).

In constructivist grounded theory, basic social processes of everyday living require the researcher to enter the participants' subjective worlds in order to develop relationships with them rather than writing about them (Mills et al., 2006c:26). The data present a co-construction between the researcher and the participants (Plummer & Young, 2010:308). An "intimate familiarity" develops between the researcher and the participants (Charmaz, 1995:51) to reveal the ongoing interpretation of meaning as it is produced by individuals engaged in a common endeavour (Suddaby, 2006:633). In this study, the focus was on nurse and adolescent participants' perceptions on peer pressure and coercion to sexual activity.

The researcher interpreted the data that were obtained from the participants and co-constructed with them an emerging theory to anticipatorily guide adolescents to resist peer pressure and coercion to sexual activity (Watling & Lingard, 2012:852). Constant comparative analysis and theoretical sampling are approaches that researchers use to expedite the development of theories in grounded theory (Reed & Runquist, 2007:119). A comparison with existing relevant theories and theoretical frameworks was used to substantiate the concepts and attributes of the emerging theory and to construct the final theory.

### **3.2.5 Theoretical assumptions**

Grounded theory research was originally developed by Strauss and Glaser from an objectivist standpoint that implies that the researcher should manage the research process only and should remain completely objective (Fendt & Sachs, 2008:435; Turner, 1981:225). A methodological split happened when Strauss publically stated that the grounded theory researcher has a much more active role in data collection and analysis (Walker & Myrick, 2006:547). Charmaz (1990:1162) developed her approach to grounded theory research from the original perspective of Strauss and Glaser (developed in 1967), but also supports the methodology of Strauss and Corbin (developed in 1990), namely that the researcher should play an active role in data collection and is therefore not a neutral observer.

Charmaz developed the Constructivist Grounded Theory methodology based on a symbolic interactionist perspective, which according to Blumer (1969:2) rests on three tenets namely: 1) humans act toward things based on the meanings they have for them; 2) that the meaning of things is derived from the social interaction with others; and 3) that the meanings are modified through an interpretive process (Plummer & Young, 2010:309). She thus believes “that data is a co-construction between researchers and participants” (Plummer & Young, 2010:313). The researcher is also a social being and “her previous experiences are also data” (Backman & Kyngäs, 1999:148).

In this study, the researcher developed a theory on anticipatory guidance for adolescents to resist peer pressure and coercion to sexual activity. The aim was not to discover *the* theory, but only a theory (Heath & Cowley, 2004:149) that will aid the understanding of adolescent peer pressure and coercion; how they relate to sexual activity of adolescents and ultimately on how to support the adolescents through anticipatory guidance to resist the pressure that their friends put on them. Through the Constructivist Grounded Theory research methodology and the constructivist research paradigm, the researcher, in interaction with the participants, co-created and co-constructed a theory (Watling & Lingard, 2012:852). The focus in grounded theory research is on studying processes and actions (Charmaz, 2006:21), which in this study refer to the process of peer pressure and coercion and the support of adolescents to resist it.

The researcher refers to grounded theory and constructivist grounded theory in this thesis, as some of the descriptions refer to all grounded theory research and others only to constructivist grounded theory. The goal of grounded theory research is to develop a theory (Bowen, 2006:13) through a continuous intertwined process of data collection and analysis (Coyne & Cowley, 2006:508; Moghaddam, 2006:53) characterised by constant comparison of data, codes and categories (Reed & Runquist, 2007:119) and theoretical sampling (Watling & Lingard, 2006:103) to select more participants to verify the theory as it develops (Charmaz, 2006:101).

The methodology of grounded theory research is compatible with symbolic interactionism to the extent that the two cannot be separated (Milliken & Shreiber,

2012:685). Both symbolic interactionism and grounded theory research are interested in the study of social reality and how human beings construct meanings (Flick, Von Kardorff & Steinke, 2004:91). Through social interaction with others, people learn the meanings (symbolic representations) of objects that are essential to express their thoughts and to communicate with others (Crooks, 2001:14). The meaning of objects is not static, but change through ongoing interaction with others (Milliken & Schreiber, 2012:686). When new information is integrated in the description of the meaning of an object during interaction with others, the meaning changes (Crooks, 2001:16).

Meanings are not only developed during interaction with others, but can also be developed through interaction between the 'I' and the 'Me' of the individual. The person becomes an object to himself and interaction takes place between the 'I' and the 'Me' (Crooks, 2001:15). The 'I' is the interpreting component of the self and the 'Me' refers to the object of self-reflection (Klunklin & Greenwood, 2006:33). Interaction between the 'I' and the 'Me' adds meaning to an object that the individual (referred to as the 'self' in symbolic interactionism) uses to communicate with others (Milliken & Schreiber, 2012:686). The 'Me' represents the generalised other that develops through interaction with others (Jeon, 2004:251). The generalised other can thus represent the way others add meaning to an object. Interactions between humans and their selves are internal, but determine how individuals act towards themselves and others (Aldiabat & Le Navenec, 2011:1065).

Language is used to name the meanings of objects (Klunklin & Greenwood, 2006:33) and forms the data that researchers use to study the meanings. The grounded theory researchers must explore the meanings that their participants assign to the words that they choose to refer to objects (Milliken & Schreiber, 2012:687). An emic research perspective is required as the researcher enters the participants' everyday world to engage them in dialogues until the understanding of the meaning becomes clear (Milliken & Schreiber, 2012:687). In symbolic interactionism, people in interaction with their social groups give meaning to social reality through the interpretation of what they see and discuss (Blumer, 1969:409).

The individual (the self) lives in a world that does not only have objects that they attach meaning to, but in a 'world of human beings' who interpret their gestures and the

meanings that they attach to objects (Benzies & Allen, 2001:543). Humans interpret others' perspectives and can adjust their behaviour taking into consideration the behaviour of others (Aldiabat & Le Navenec, 2011:1065). Therefore, the data that the researcher obtained from the participants (nurses and adolescents) had been shaped through their interaction with others as well as represent the views of others (Milliken & Schreiber, 2012:689).

According to symbolic interactionism, the social world (the interaction between people) is accessible to the collection of data through disciplined examination, the formulation of categories from those data, the construction of hypotheses relating to the categories, the development of propositions and the construction of a theory (Klunklin & Greenwood, 2006:34). People make sense of their social world and can communicate it to the outsider (researcher) (McCann & Clark, 2003a:8). For symbolic interactionist researchers, the meaning attached to objects (including human behaviour, interactions and social processes) enables the study of such objects (Yun-Hee, 2004:250).

The basic social processes of the lives of the participants that form the focus of research are embedded in society. "The actions and interactions of participants are framed within the social structures, meanings, and value systems of the particular society" (Milliken & Schreiber, 2012:692). The response of participants to a particular situation is influenced by the society that they live in (Aldiabat & Le Navenec, 2011:1067). The society is a complex and dynamic social context that is determined by the interaction between the members of the society (Klunklin & Greenwood, 2006:34).

In this study, the researcher assumed that peer pressure and coercion to sexual activity of adolescents are defined through the internal dialogue of the individual, in interaction with others, within a social world under the influence of a specific society. The basic social processes that apply to peer pressure and coercion to sexual activity and anticipatory guidance, are reflected in the theory. Through the processes of symbolic interactionism, the researcher and participants found a common ground for clarifying meanings (Burbank & Martins, 2009:27). Adolescents have a unique way of communication through symbols and gestures that are specific to their social world

and society (Roth & Brooks-Gun, 2003:95). The researcher acknowledged it and managed to develop a theory that can be used to understand the meanings that they attach to the studied phenomenon in order to anticipatory guide them to resist peer pressure and coercion to sexual activity.

### **3.3 RESEARCH METHODOLOGY**

Although it is tedious and time consuming, human and social scientists frequently use grounded theory (GT) research methodology to develop theory to improve their practice (Kolb, 2012:83).

#### **3.3.1 Research design**

The researcher adopted a qualitative research design and used the constructivist grounded theory approach in this study with the intention to develop a nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity.

According to Charmaz (2014:321), grounded theory studies involve interpretive and reflective processes and actions, whereby participants construct meanings and the researcher uses constant comparative methods to confirm the emerging data. Constant comparative analysis is a pillar of data collection and analysis to acquire new ideas that steers the study to the correct direction that yields rich data required for comparing concepts for theory development (Lingard, Albert, Levinson, John & Eaton, 2008:2). The advantage of using qualitative research is the room provided for the participants to express their subjective meaning according to their own experiences without limitations (Ulin, Robinson & Tolley, 2005:22).

#### **3.3.2 Research method**

This grounded theory study aimed to develop a nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity. Data were collected through intensive interviews; gathered data were analysed as it was collected (Wuest et al., 2010:798); findings of the initial data analysis were used to

guide further data collection (Watling & Lingard, 2012:852) and a nursing theory was developed (Charmaz, 1990:1162).

### ***3.3.2.1 Context of the study and study population***

The study was conducted in the City of Tshwane, in the Gauteng Province of South Africa. The study population in the first round comprised adolescent and nurse participants from six identified primary healthcare clinics that were managed by either the Gauteng Provincial Department of Health or the Tshwane Department of Health. The study population in the second round of theoretical sampling also consisted of other health professionals working outside the clinic setting, i.e. a Health Education Specialist and a registered nurse specialising in youth and adolescent development. Sampling in grounded theory studies follows the data, not the setting or people (Corbin & Strauss, 2008:157). The clinics were selected from four regions, namely Region 1 (one township clinic), Region 3 (one urban clinic), Region 5 (one urban clinic) Region 6 (one township clinic) and Region 7 (one township and one rural clinic). The chairperson of the Gauteng Research Ethics Committee suggested selection of the biggest and busiest clinics within the region as well as those that would provide a good mix of population across all of the socio-economic status.

For the purpose of anonymity, the clinics are not named. Some of the clinics serve disadvantaged communities and others affluent communities (refer to Table 3.1).

**Table 3.1: Study settings and description of communities where initial sampling of adolescent and nurse participants were recruited**

REGION	LOCATION OF THE CLINIC	SETTING	SOCIO-ECONOMIC STATUS
1	Township: Black African population	Semi-urban	Under-privileged community
3	City Centre: Mixed population	Urban	Elite area and mixed classes
5	Urban: Mixed population; Black African, white, and coloured South African population	Semi-urban	Mixed class community: Poor and middle class
6	Township: Black African origin	Semi-urban	Under-privileged community
7	Village: Black African population	Rural	Under-privileged community
7	Township: Black African population	Semi-urban	Under-privileged community

### **3.3.2.2 Study sample and sampling**

The sampling process consisted of an initial sampling phase, which was guided by the initial questions that were based on the sensitising concepts of the study (refer to Addendum A). Halberg (2006:143) refers to the process as open sampling and describes the reason to use open sampling as a means to ensure that a sample is selected which can provide the researcher with descriptions of variations in experiences. Researchers in grounded theory research opt to select participants who can provide comprehensive data concerning the studied social processes (Backman & Kyngäs, 1999:149; Cutliffe, 2000:1478), which in this study refer to pressure and coercion that adolescents experience and the anticipatory guidance that nurses should provide to adolescent participants. In this phase, the researcher selected 10 adolescent participants from the age group 16 to 19 to include data from the diverse range in the different developmental stages and life experiences of adolescents, as well as nine registered nurses.

The researcher believes that conducting 10 initial intensive interviews with adolescent participants about the peer pressure and coercion that they experienced, and nine



initial intensive interviews with nurse participants about the anticipatory guidance that adolescents require resisting peer pressure and coercion, would provide a reasonable insight and considerable amount of data for initial analysis (Charmaz, 2006:96). The adolescents participants in the younger groups may have witnessed peer pressure and coercion without having experienced it, while the older group may have experienced it as well as participated in it.

Inclusion criteria for adolescent participants was male and female adolescents aged from 14 – 19 years old, visiting the clinics for treatment of minor ailments or attending to access sexual reproductive health services. The adolescents input about peer pressure was important especially if they have witnessed it happen or personally experienced it. For nurse participants, they were supposed to have been exposed to working with adolescents at least for a year or more in the sexual reproductive health services or adolescent health care services or have had regular interaction with adolescents in the clinic setting. Such experience would enable them to provide the researcher with substantive data required to develop a nursing theory to support adolescents to resist peer pressure and coercion to sexual activity.

The initial sampling of adolescent and nurse participants took place at clinics, where the researcher sought authorisation and assistance from senior registered nurses to identify a particular nurse to work with the researcher. The nurses' role was to identify eligible adolescents as they met them during routine consultations for minor ailments and reproductive health services. They helped by identifying and recruiting possible adolescent participants. The nurses at the clinics identified eligible adolescent participants aged between 16 and 19 years who visited the clinics and were prepared to take part in the research. Most participants were adolescent females. The number of male adolescents was low, as they rarely utilise the clinics. They claim that they do not get sick or they brave it when they are sick. Another strategy to access male adolescents was then devised; the strategy involved requesting adolescent females to ask adolescent male friends to participate in the study, but this was also in vain. The adolescent males made it clear that they did not want to participate for free by not earning any compensation or a freebie such as free gifts e.g. T-shirts, squeeze bottles, pens, bags or purses for their participation. Providing any monetary tokens or

free gifts was not factored as part of the study as it was viewed as subtle coercion to participate in the study. Only four male adolescent participants were interviewed.

The nurse participants in the initial sampling of their interviews had varied experience and exposure of working with adolescents. They all had experience of working with adolescents in providing Sexual Reproductive Health services. In the theoretical sampling phase, four registered nurses were sampled. One of them was a participant in the initial sample. The researcher also approached a health educator employed at one of the clinics whose main responsibility was adolescent and youth health education. Through theoretical sampling, participants were included to enable the researcher to collect data to saturate categories in the emerging theory (Boychuk-Duchscher & Morgan, 2004:610) and terminated the process when no new data came out concerning the categories, and the relationships between the categories were adequately delineated (Moghaddam, 2006:57). Theoretical sampling is done to select participants that can elaborate a particular aspect of the emerging theory (Furniss, Blandford & Curzon, 2011:115).

Theoretical sampling is one of the strategic, specific and systematic processes in grounded theory research (Charmaz, 2014:199) to gather data needed to confirm the properties of the categories. In this study, the researcher also verified the categories of the emerging theory through theoretical sampling. In the process, the categories were adjusted to serve as theoretical categories (Charmaz, 2014:192). "Theoretical sampling in grounded theory is emergent and provides a valuable tool for developing your analysis and correcting trouble spots" (Charmaz, 2014:212). Participants are collected and interviewed to get additional data to build the theory and it is not an ordinary research sampling method to select a representative sample from the study population (McCann & Clark, 2003a:11; Corbin & Strauss, 2008:144). The research participants are regarded as sources of data and are selected to provide rich information sought for the development of the theory (Watling & Lingard, 2012:856).

Abductive reasoning in grounded theory research makes theoretical sampling necessary. When researchers discover surprising findings that he or she cannot fit into the pattern of their other findings and cannot explain, theoretically they have to select rich sources of data where they can find data to help them explain the 'surprising

finding' (Charmaz, 2014:201). Possible explanations of the 'surprising finding' are made and empirically evaluated by using data collected through theoretical sampling to find the best possible explanation in order to incorporate it in the sub-categories and categories of the emerging theory (Charmaz, 2014:202).

**A brief description of the adolescent participants in the initial sample follows:**

**Adolescent Participant 1** was a 19-year-old girl. She regularly visited the clinic for Sexual Reproductive Health (SRH) services. She was a Grade 10 learner at a township high school. She had eight siblings, all raised by a single mother who was a domestic assistant.

**Adolescent Participant 2** was a 19-year-old boy. He regularly visited the clinic for chronic condition management. He was a Grade 10 pupil at a township high school. He had one sibling and he was cared for by grandparents from paternal side because his mother had passed away. His father was still alive, but did not live with his son.

**Adolescent Participant 3** was a 17-year-old girl. She irregularly visited the clinic for treatment of minor ailments. She was a Grade 10 pupil at a rural high school. She had two siblings and still had both parents who were unemployed.

**Adolescent Participant 4** was a 19-year-old girl. She regularly visited the clinic for mother and child health services for consultation of her baby's growth monitoring and immunisation as well as her SRH services. She was a Grade 11 pupil at a township high school. She had one sibling and lived with both parents who were employed.

**Adolescent Participant 5** was an 18-year-old girl. She had just come to Pretoria from Limpopo. She ran away from her maternal family because of conflict. Her mother passed away. She attended the clinic for Ante-Natal Care (ANC). She quit school because of pregnancy. She was in Grade 10 at a rural school in Limpopo. She was emotionally not well, therefore was referred to the in-house Mental Health Services to be assisted for psychological support. She moved to the Johannesburg area and changed her phone numbers.

**Adolescent Participant 6** was a 19-year-old girl. She attended the clinic for an acute minor ailment. She had matriculated and was not in school at the time of the interview but was planning to go to a tertiary institution the following year. She was the only child and living with her single mother caring for them.

**Adolescent Participant 7** was a 19-year-old boy. He rarely visited the clinic because he claimed that he never became ill. He was accompanying his girlfriend for consultation and treatment of a minor ailment. He was a student at a tertiary institution in an affluent suburb. He had one sibling and they were cared for by their single mother.

**Adolescent Participant 8** was an 18-year-old boy. He very seldom visited the health facility. He was a Grade 12 pupil at a rural high school. He had an older brother and they were both cared for by their single mother.

**Adolescent Participant 9** was an 18-year-old boy. He rarely visited the clinic. He was a Grade 8 pupil at a rural high school. He was from a polygamous family and had three siblings. His parents were still alive, his mother was unemployed.

**Adolescent Participant 10** was a 16-year-old white girl. She was the only participant from this racial group. She regularly visited the clinic for SRH services. Her mother accompanied her. She was a Grade 8 pupil at a suburban high school in a mixed-race community. She had two siblings and both parents were alive and living together.

The researcher selected an initial sample of 10 registered nurses who were employed in the clinics described under the heading 'Context of the study', but could interview only 9 of them. The researcher believed that nine nurse participants' from initial interviews were sufficient to get an overview of how nurses viewed the support that adolescents required for resisting peer pressure and coercion to sexual activity. Due to staff shortages at the clinics, appointments often had to be re-scheduled.

**A brief description of the nurse participants in the initial sample follows:**

**Nurse Participant 1** worked at a rural clinic. She was an enrolled nurse who qualified in 2009. She had two years' experience in providing SRH services to the adolescents because she was young and experienced in youth friendly services.

**Nurse Participant 2** worked at a township clinic. She was a registered nurse who qualified in 2009. She had five years' experience of working at PHC level. She had two years' experience in rendering SRH services to adolescents at this particular health facility. She was directly involved in implementing YFS in 2011 & 2012.

**Nurse Participant 3** worked at a PHC health facility located in an affluent suburb. She was a qualified enrolled nurse who qualified in 2008. She had been working at this clinic since she was interviewed in 2010. She was regularly requested to assist in the SRH section when there was shortage of staff. She had been awarded an opportunity to study for a four-year diploma in Nursing Science and Art in 2015.

**Nurse Participant 4** worked at the National Department of Health. She qualified as a registered nurse in 1986. She had been involved in youth and adolescent health programmes at primary healthcare level for more five years and at national level since 2003. She was supporting the roll-out and implementation of YAH programmes across South Africa.

**Nurse Participant 5** worked at a township clinic. She was an enrolled nurse who had qualified in 2011. She had experience of providing SRH services for four years. She had not been exposed to YFS training.

**Nurse Participant 6** worked in School Health Services within the district. She was qualified as enrolled nurse in 1991 and later as registered nurse in 2009. She was qualified in primary healthcare. She was oriented in YFS. She was linked to the PHC facilities and supported the SRH services because her programme was responsible for prevention of teenage pregnancy in schools.

**Nurse Participant 7** worked for an international organisation to coordinate youth and adolescent health programmes across South Africa. She qualified as a professional nurse in the late 1970s and had more than 17 years' experience in Youth and Adolescent Health (YAH) programmes. She was involved in designing and developing youth and adolescent health programmes and training service providers or target populations on YAH programmes.

**Nurse Participant 8** worked at a township clinic. She was a qualified nurse by profession who was registered as professional nurse in 1997. She had been working at the clinic where she was first interviewed since 1998. She was responsible for coordinating SRH services at the clinic since 2000, also trained on YFS in 2015 and implementing YFS within the clinic and at local schools.

**Nurse Participant 9** worked at the suburb clinic catering for a mixed race population, being predominantly Afrikaans. She was a qualified professional nurse who was registered in 2012. She had been rendering SRH services since 2013. She also offered mother and child health services. She was not YFS trained.

**In the theoretical sampling phase, another five participants were interviewed:**

**Theoretical Sampling Participant 1** was an educator by qualification but had more than 10 years' service in the health fraternity supporting youth and adolescents health services as a Health Education Specialist. She had extensive experience of working in youth and adolescent health programmes to improve the health of adolescents and youth, both at international and national level. She was involved in coordinating and supporting the 1<sup>st</sup> National Youth Risk Behaviour Survey in South Africa in 2002.

**Theoretical Sampling Participant 2** was a registered nurse by profession. She had extensive experience in managing primary health services and had been overseeing implementation of SRH services for more than 10 years. She also had exposure of working with youth and adolescent health programmes at a health facility level, community level and through NGOs.

**Theoretical Sampling Participant 3** was a registered nurse by profession. She had experience in managing primary health services and supervising the implementation of PHC and SRH services. She had more than five years' experience in managing PHC services. She collaborated with local schools to increase accessibility of health services to adolescents because they didn't use the PHC facility.

**Theoretical Sampling Participant 4:** The fourth theoretical participant was a registered nurse by profession. She had extensive experience in managing the youth and adolescent health programmes at international and national level. She was involved in developing the youth and adolescent health policy guidelines and the implementation of youth friendly services in South Africa.

**Theoretical Sampling Participant 5:** The fifth theoretical participant was a registered nurse by profession. She had vast experience of implementing primary healthcare services for more than 20 years. She supervised the provision of SRH and youth and adolescent health programmes. She also participated in rendering school health programmes at high schools in various local communities including churches.

### **3.3.2.3 Data collection**

Once permission was obtained from clinic management that staff could participate in the research and the clinics' facilities could be used (refer to Addendum 3.1), and after the nurse participants had given informed consent (refer to Addendum D1), the parents and guardians of the adolescent participants had given informed consent (refer to Addendum E1), and the adolescent participants had given informed consent (refer to Addendum E), the data collection commenced. Flicker and Guta (2008:4) emphasise the importance of practising and recognising the required ethical approaches for adolescent participation in research.

The researcher had meetings with clinic management and staff to inform them about the research with emphasis on the processes of identification of possible participants, the selection of participants and the data collection process. Their responsibilities during the data collection process were discussed. The clinic management and staff

agreed to help the researcher to identify eligible adolescent participants based on the inclusion criteria.

In this study, intensive interviews were the chosen method for data collection. Such interviews provide the researcher with opportunities to gain 'deeper views' of the studied processes than what structured or informational interviews can offer (Hallberg, 2006:146; Charmaz, 2006:25). The researcher's choice of using intensive interviews as a data collection strategy is ideal in qualitative research design. The advantage of using intensive interviews in grounded theory methodology is that it emphasises the interpretative process and interaction between researchers and participants (Charmaz, 1995:58). An iterative process consisting of "simultaneous data collection and analysis in which the results of the ongoing data analysis inform the subsequent data collection" (Kennedy & Lingard, 2006:103) was used. Although the researcher led the interviews, the participants' responses and the analysis thereof set the scene for subsequent interviews (Charmaz, 2014:85). Successive levels of data collection and analysis, including the development of categories (Charmaz, 2005:507), enabled the researcher to construct the nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity.

Empathetic relationships were built with the participants and multiple visits were made to obtain a good understanding of the participants' understanding of peer pressure and coercion and anticipatory guidance to enable adolescents to resist such pressure and coercion. In grounded theory research, the relationship with participants takes priority over the data collection process (Charmaz, 1995:59). Without an empathetic relationship, data are collected without an understanding of the processes that the participants experience (Charmaz, 1995:58).

In intensive interviews, open-ended questions are used to enable participants to provide descriptive answers (Charmaz, 2006:26). The researcher had an opportunity to receive information on the first-hand experiences of the adolescent and nurse participants as well as their concerns and suggestions to address the situation under exploration (Charmaz, 2014:85). The initial questions in the interview guide became more focused and new questions were added as the data collection progressed (Coyne & Cowley, 2006:508). In the latter half of the data collection process, when



theoretical sampling was used to select four registered nurses and one adolescent health specialist, the questions were determined by the categories of the emergent theory (Charmaz, 1990:1167). The researcher verified and clarified the descriptions that the participants provided of peer pressure and coercion and the anticipatory guidance to help adolescents to resist it throughout the data collection process (Charmaz, 2006:26). From when data collection commenced, and after every interview, the researcher embarked on data analysis. When using grounded theory methods, data collection and analysis happen concurrently (Kolb, 2012:84), followed by theoretical sampling and memo-ing (Elliot & Lazenbatt, 2005:50). In the theoretical phase, researchers should collect data until theoretical saturation occurs (Charmaz, 2014:103). The researcher verified the tentative categories and made sure that their properties could be described comprehensively before data collection was terminated.

Interviews should not be considered as the only valuable method of data collection in grounded theory research, as it might derail the researcher from exploring other ways of unearthing rich interpretations of data other than voiced personal experiences (Benoliel, 1996 as cited in McCann & Clark, 2003b:20). It should be noted that in grounded theory, a variety of methods can be used to collect data for the purpose of getting many ideas from many sources, as long as it responds to the research question (Kennedy & Lingard, 2006:103). Therefore, field notes were taken while the researcher observed and listened to the participants' responses during the interviews.

The researcher audio-recorded the interviews with the permission of the participants. The recordings served as evidence of what transpired for reference after the verbatim data transcriptions were completed.

The data collection process was conducted either at the clinics (refer to 3.3.2.1) in space where the interviews could not be disrupted or at other venues selected by the participants. In a few cases, appointments had to be re-scheduled to accommodate the participants' wishes.

The data collection interviews commenced in October 2014 and carried on through mid-May 2015. It took place in three phases. In the initial sampling stage for adolescents, 10 adolescent participants were interviewed; in the initial interviews for

nine nurse participants of the initial sampling were interviewed; and in the third phase four nurse participants and one health educator participant from the theoretical sample were interviewed. At the time of the interviews, the nurses and health educator participants had experience in working with adolescents and had been involved in health education of adolescents. The interviews were conducted in English with explanations in other languages when necessary. English is the medium of communication that is also used in most community schools within the areas where the study took place. The researcher personally collected and analysed data thus English was ideal for the logistic purposes and timing available.

The interview guide (refer to Addendum A) was designed from sensitising concepts included in the conceptual framework (refer to Figure 1 in Chapter 1). The researcher used the guide to remain focused on the topic under exploration. Interview guides are useful to ensure that comprehensive descriptions of processes under study are obtained (Charmaz, 2014:64). During the interviews, responses from participants lead the researcher to readjust questions to ensure that comprehensive descriptions are gathered. During interviews of the theoretical sample the emerging categories determined the questions that were asked of the participants (Cowley, 2006:508).

The questions that were asked of the adolescent participants focused on their experiences of peer pressure and coercion to sexual activities, while the questions that were put to the initial sample of nurse participants focused on how they foresee they could anticipatorily guide adolescents to resist peer pressure and coercion to sexual activities. Probing questions were asked to clarify the responses of the participants.

#### **3.3.2.4 Data analysis**

Data analysis in grounded theory is an iterative process that occurs concurrently with data collection (Kennedy & Lingard, 2006:106). In this study, data collected after each interview were transcribed immediately and analysed. The researcher embarked on data analysis using grounded theory methods to explore the meanings on “what was happening in the data” as experienced and expressed by the participants in their social world (Charmaz, 2006:46). Although it was a tedious process, it was necessary to get

the explanation, meanings and interpretation of the data as the participants related their realities in their social world (Charmaz, 2005:508). Grounded theory method assisted the researcher to have a deeper understanding of the interpretations and meanings of the concepts being studied without just describing what they are; but through using credible strategies for data analysis to co-create meanings through an interpretive process (Watling & Lingard, 2012:855).

Grounded theory researchers use data from individual participants to compare data for similarities and difference during analysis to develop categories for the development of a theory (Charmaz, 2006:188). These researchers seek to gain conceptual understanding of social processes (in this study it refers to the peer pressure and coercion processes as well as an anticipatory guidance process) in order to develop grounded theories (Watling & Lingard, 2012:855). The interest of the researcher is more on gaining interpretative understanding than providing an explanation of the selected processes (Hallberg, 2006:146). In data analysis in grounded theory research knowledge is “actively constructed and co-created as the product of human interactions” (Watling & Lingard, 2012:852). Researchers are allowed to bring their own background to the analytic process (Watling & Lingard, 2012:853).

Throughout the process of analysing data, the researcher asked questions about what was said or implied by the data. She questioned the truth and value of the data rather than being complacent and accepting participants' views as it was (Charmaz, 2006:51). Grounded theory researchers interact with their participants and the data that their participants provide them with in order to construct codes (Charmaz, 2006:54). There are common questions asked in grounded theory research to further data analysis and to enhance theory development. Those are sensitising (at the beginning of data collection and analysis) and theoretical (during the final stages of data collection and analysis) of which each served its purpose at a different stage of data analysis for theory development (Corbin & Strauss, 2008:72).

Data analysis in grounded theory research starts with coding that is done to label words and sentences for further use (Moghaddam, 2006:55). It is defined as a process whereby concepts are derived and developed from data to extract properties and

dimensions of the categories (Corbin & Strauss, 2008:66). The coding process provides labels that categorise and summarise data for use during memo writing (Charmaz, 2006:11) and the development of the theory. Gerunds were used in coding to enhance theoretical sensitivity “because these words nudge us out of static topics and into enacted processes” (Charmaz, 2014:245). Gerunds prompt thinking about actions and labelling of the actions is prevented.

Researchers in grounded theory research are also required to decode hidden data (from observation of behaviour during the interview) to explore what is meant by specific cues during data collection (Charmaz, 2006:47). In this study, the researcher was cognisant of observing the participants closely and taking field notes in order not to miss any hints about their social world (Charmaz, 2006:53).

Once the interviews from the initial sampling interviews had been transcribed, hierarchical coding processes were used. Initially open line-by-line coding was done (refer to Table 3.2 below for an example); followed by conceptual and selective coding (refer to Annexure GG1 for an example); and axial or theoretical coding to specify relationships between categories (refer to Annexure GG2 for an example) (Hallberg, 2006:143; Walker & Myrick, 2006:550).

At the beginning of the analysis (and data collection, as the processes happen simultaneously) the codes reflected the words of the participants to ensure that it is grounded in the data which is the core of grounded theory research (Elliot & Jordan, 2010:32). As the initial codes are derived from the transcripts of the interviews, grounded theory researchers refer to them as in-vivo codes (Charmaz, 2014:134; Charmaz, 2006:55; Harry et al., 2005:5). The in-vivo codes were derived from the adolescent participants’ experiences and the nurses’ ideas on guidance obtained during the first round of data collection.

Although line-by-line coding is considered as tedious by grounded theory researchers and some of them prefer not to do it (Fendt & Sachs, 2008:435), the researcher followed this method in order to obtain a level of abstraction of the interviews and the processes that she studied. Holton (2010:np) acknowledged that line-by-line coding is a useful approach to assist researchers to focus in pursuing meaningful and valuable

data that explain what is happening in the data. This exercise enabled the researcher to explore what the data was all about and to derive a meaningful sense out of it (Charmaz, 2014:125). The process of line-by-line coding helped her to think analytically, to generate creative ideas about the data at hand, and also to determine what data needed to be collected during interviews with the next participants to be interviewed (Charmaz, 2014:121).

During the process of initial coding the researcher explored what was happening in the data, what was being said by the data; and she continued to look for the direction the data suggested as basis for the theoretical categories (Charmaz, 2006:50). The researcher went back to the research question and the conceptual framework (described in Chapter 1 of the thesis) to avoid deviation from the aim of the study. The concepts of the framework were used to sensitise the researcher to identify initial codes that could lead to the development of the envisaged theory (Charmaz, 2014:30). The sensitising concepts gave direction in initial coding, but did not prescribe the initial codes (Bowen, 2006:20; Coyne & Cowley, 2006:514).

In this process, initial codes were developed and compared with each other. Initial codes that appeared frequently and had relevance were grouped together to develop focused codes (Charmaz, 2014:138) (refer to Table 3.2).

**Table 3.2 Line-by-line coding from initial coding to develop focused codes**

Participant (N-Vivo) Quotes	Initial Coding	Focused Coding
<b>Researcher: What was it that you forced her to do?</b> Participant: Me and my other friend... she said she was dating but <u>afraid to have sex</u> with her boyfriend. <u>We forced her to have sex.</u> (AP #1)	Dating but not ready for sex Putting pressure on a friend to have sex	<b>Compelling adolescent to conform to peer expectations</b>
<b>Researcher: Hmm, some of the things are illegal! Which are those?</b> Participant: Some <u>maybe say go and steal that thing from that person, go beat that person to show that you are one of us</u> and in turn it might make you face jail time or land you in trouble. (AP#6)	Doing bad deeds to prove allegiance	
<b>Researcher: What was happening?</b> <b>Participant: <u>It was those guys forcing a guy to date a girl.</u></b> (AP #8)	Being forced to date a girl	
<b>Researcher: When you say 'stuff' what stuff are you referring to?</b> Participant: Like <u>smoking, drinking, drugs and having sex.</u> (AP #8)	Doing bad deeds	

Focused coding deals with larger segments of data; determine the adequacy and relevance of sub-categories (and ultimately categories); and get constructed when data are sifted and sorted, and initial codes are synthesised, analysed and grouped (Charmaz, 2006:57; Charmaz, 2014:138 and 343). The focused codes are those codes that appear frequently and have more significance than initial codes. Focused codes are categorised and taken to a theoretical level for conceptual development. Focused codes guide researchers in theoretical sampling (Charmaz, 2014:188). It helps them to identify who to give more information and to obtain theoretical saturations of the sub-categories and categories.

After focused coding, axial coding followed to develop categories. Axial coding involves relating sub-categories to categories; comparing categories with data; describing the properties of the categories; and exploring any variations regarding the

categories (Moghaddam, 2006:58). During axial coding the categories are lifted to a conceptual level in order to generate theory (Watling & Lingard, 2012:853). For the purpose of this study, the relevant categories were developed from sub-categories that were developed from focused codes. Take note that the initial codes are from the nurses' and adolescents' in-vivo codes; the focused codes are from grouped initial codes and are related to what nurses should do while the axial codes are categories of what nurses should do to help adolescents to resist peer pressure and coercion to sexual activity. As the codes recurred, the indicators of the codes were checked for similarities and differences and grouped accordingly to form sub-categories (Wuest et al., 2010:798). Theoretical sampling and constant comparative analysis were conducted for confirmation of the sub-categories that were required for description of the properties and dimensions to discover the theory grounded in the data (Reed & Runquist, 2007:119)

The researcher continued by constantly comparing in-vivo codes to identify incidents from the data worth comparing to develop initial codes, then focused codes that were thematically grouped together to develop categories. The researcher guarded against an over-reliance on in-vivo codes as it can limit the level of analysis to description only. She used the in-vivo only to "ensure that the conceptual development is firmly embedded in the narratives provided by the participants" (Elliot & Jordan, 2010:32). The categories in this study were thus grounded in the codes that were identified through line-by-line coding, but are also the product of the analytic thinking of the researcher (Saillard, 2011:np) (refer to Figure 4.1).

The sub-categories and categories needed verification, thus theoretical sampling was conducted to confirm the concepts required in order to build the nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity. When categories and properties are not explicit, theoretical sampling is a strategy that provides more information to substantiate it. It is the only sampling strategy in grounded theory that gives direction to clear assumptions or questionable categories in order to saturate them. Through theoretical sampling, data analysis is taken to a level of revealing the properties of categories (Charmaz, 2014:197) (refer to 3.3.2.2. for more information regarding theoretical sampling in this study).

The categories were refined through the collection of more data by means of theoretical sampling and constant comparison between data and categories. Constant comparative analysis is the strategy that is consistently applied in coding of data for theory development (Boyчук-Duchscher & Morgan, 2004:607). During constant comparative analysis data are compared for similarities and differences (Charmaz, 2006:54). It is done on data with data, data with codes, codes with codes, codes with categories, categories with data, categories with categories to build new theory (Fendt & Sachs, 2008:431). The researcher used constant comparison to ensure that the properties of the categories were explored, saturated, distinguished and clarified the relationships between the categories (Charmaz, 2006:104). The issue of negative cases was noted with its multiple possibilities to provide alternative explanations that may influence the study otherwise (Charmaz, 2006:101). Negative cases are perceived as conflicting ideas that might need to be pursued, as they may form a big part of the data collected (Charmaz, 2014:198). However, in this study the researcher did not encounter any negative cases. Data collection and analysis were discontinued when the categories were saturated and no new theoretical insights were gained through the collection of more data. Through theoretical sorting, theoretical links were created and refined between categories to construct the emerging theory (Charmaz, 2006:113 & 115).

Grounded theory researchers with a “constructivist stance emphasise the use of analytic tools such as writing theoretical memos” to enable them to develop a theory and indicate the context in which the theory was developed (Furniss et al., 2011:113). Theoretical memos and coding also enable researchers to move from a descriptive level to a theoretical level in order to raise the level of abstraction in the emerging theory (Wuest et al., 2010:799). These are valuable steps “to saturate the categories” (Charmaz, 2014:199; Charmaz, 2006:103).

Although memo-writing is associated with lifting coding to a theoretical level, the researcher in this study started with the process already during initial coding. According to Birks, Chapman and Francis (2008:70) the mnemonic ‘MEMO’ means “**M**apping research activities; **E**xtracting meaning from the data; **M**aintaining momentum; **O**pening communication”. The initial memos in this study were descriptive and in some case repetitive of the actual statements of the participants. Such memos



helped the researcher to document what was happening in the data and to keep a record thereof. This exercise assisted the researcher to think through and capture the ideas as they emerged for development of integrated arguments and data analysis (Birks et al., 2008: 69). It also helped the researcher not to drown in the data but to process what was grounded in the data and document it in the form of different memos (Corbin & Strauss, 2008:118). Memo-writing makes it possible for researchers to put ideas on paper “allowing the researcher breathing space and time to sleep” (Milliken & Schreiber, 2012:691). Over time, the memos became more theoretical (Coyne & Cowley, 2006:508) as the memos connected the data and the emerging theory (Eaves, 2001:659) and eventually the researcher wrote memos that served as drafts of the emerging theory (Charmaz, 2006:96) (refer to Annexure GG3 for examples of the initial and advanced memos).

Theoretical coding was in this study used to raise the level of analysis from a descriptive to a theoretical level. Theories consist of theoretical categories and sub-categories on an abstract level (Wuest et al., 2010:799). Although it is generally accepted that initial coding results in the development of descriptive codes, Walker and Myrick (2006:550) remind researchers that the levels of coding in grounded theory research often happen concurrently. The researcher experienced the same and often had to move backwards and forwards during data analysis. She made use of a “constantly comparative and intentionally circular analysis” process (Boychuk-Duchscher & Morgan, 2004:608) to ensure that the emerging theory corresponded with the aim of the study, namely to develop a nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity. She also followed a “cycle of comparison and reflection on old and new material”, repeated it several times and only terminated the process when new cases did not bring new information that could lead to changes in categories and their relationship with one another (Boeije, 2002:393). Theoretical saturation of the categories was thus accomplished (Glaser & Holton, 2004:np). This type of saturation does not refer to a repetition of the same data, as is the case in other types of qualitative research. In grounded theory research, it refers to the situation when “gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories” (Charmaz, 2014:213).

Through theoretical coding theoretical sub-categories, as well as categories and relationships between them get developed. Theoretical literature is used to enhance the level of abstraction of the sub-categories and categories (Charmaz, 2014:150) during theoretical coding. In this study, the researcher used symbolic interactionism in the compilation and understanding of the theoretical sub-categories, categories and the relationships between them (refer to Chapters 4, 5 and 6 of the thesis). According to Charmaz (2014:284) constructivist grounded theory research and symbolic interactionism provide researchers with a “theory-methods package” for the development of grounded theory (Charmaz, 2014:284).

The theoretical sub-categories and categories of this study were sorted by hand to create a ‘picture’ of the emerging theory. The theoretical links between the sub-categories and categories were confirmed and the logic of the emerging theory developed. When a sorting was created that the researcher considered as a possible part of the emerging theory, she diagrammed it to obtain a visual representation of the categories and their relationships (Charmaz, 2014:216; Mills et al., 2006b:5). The memos associated with the categories were also integrated with one another to support the links between the categories and to add explanatory value to the propositions of the categories (Charmaz, 2014:220). The integrated memos form the draft nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity. The symbolic interactionism approach to study human life and conduct provided the core aspects related to the self, society and interaction with others in the society (Blumer, 1969:62) (refer to Chapters 4, 5 and 6).

Theories consist of abstract concepts (sub-categories and categories); descriptions of the properties of the concepts; indications of the links between the concepts and in the case of interpretive theories (such as the one in this study) an understanding of the meanings and actions and how people construct them (Gray, Grove & Sutherland, 2016:139; Hallberg, 2006:143; Walker & Avant, 2011:60). The purpose of interpretive theories is not to indicate causality and to formulate hypothesis (Charmaz 2014:230). These theories are influenced by the researchers’ views and do not and cannot stand outside if (Charmaz, 2014:239). Theory construction is not a mechanical and linear process, as theorising means to stop, ponder, and think afresh about the studied processes that in this study refer to peer pressure and coercion and anticipatory

guidance (Charmaz, 2014:244). It allows the researcher the opportunity to use data obtained from participants who experienced the processes as well as theory (in this study symbolic interactionism is used) to construct a theory (Charmaz, 2014:245; McCann & Clark, 2003a:16).

In grounded theory, a literature review is not done intensively at the beginning of the study as it is not good practice to get into the study with preconceived ideas (Goulding 2005:296). The researcher was weary not to bring bias into the study from information collected prior to the start that could have tempted the researcher to force known concepts from existing literature to match and fit the current study (Coyne & Cowley, 2006:514). As much as it is agreed that conducting a literature search to verify what was out there worth researching, Backman and Kyngäs (1999:148) warn that it could bring some bias to new researchers either by plagiarising or force fitting concepts into research findings. Literature should rather be used to enhance newly discovered findings (Furniss et al., 2011:121). In this study literature was used to contribute to the construction of the theory and to incorporate the theory into the existing knowledge base (Walls, Parahoo & Fleming, 2010:13). It was important for the researcher as a novice in the field of grounded theory research to note the debate on use of literature in grounded theory research, to be able to motivate and justify with full understanding why and at what stage in theory development she used it. The use of it in theoretical coding enabled her to lift sub-categories and categories to an abstract level (McGhee et al., 2007:341).

Guidelines of Walker and Avant (2011) regarding theory construction in nursing were used to structure the nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion as a middle-range theory. The sub-categories and categories were used as concepts in the theory. Statements between concepts were compiled from the relationships between sub-categories and categories. Non-relational statements rather than relational statements were focused on as an interpretative theory was constructed. Theoretical definitions were written to describe the attributes of the concepts. A synthesis strategy was used in the construction of the concepts, statements and theory (Walker & Avant, 2011:153). In Chapter 6 the process of theory construction is described.

### **3.4 RIGOUR OF THE STUDY**

Crooks (2001:22) highlighted that in grounded theory studies research is conducted to explore the participants' understanding of social processes (peer pressure and coercion and anticipatory guidance) rather than validating whether the researcher understood them correctly. However, the researcher should prove how the data obtained from the participants respond with the sub-categories and categories of the theory (Elliot & Jordan, 2010:33). The theory should be grounded in data (Aldiabat & Navenec 2011:1070). According to Glaser (2002:1), data is information gathered in different formats, be it through interview, observation and from reports, In-vivo codes are used to indicate the link between data and direct quotations from participants' words (Birks & Mills, 2015:10). In this study, the researcher used examples of the processes she followed in the study and the use of in-vivo codes and included these in the form of addenda.

Reflexivity is in grounded theory research considered as a tool for researchers to identify the effect of self in their relationships with participants and the data that got collected during the relationships (Neill, 2006:257). Relationships of trust provide researchers with a greater chance of acquiring validity of findings in grounded theory research (Hall & Callery, 2001:258). Research journals are considered as a valuable tool for reflection on the research process (Bringer et al., 2006:247) and was used by the researcher in this study. In the article authored by Payne and Williams (2009:297), the importance of recognizing the other approaches to determining the rigour of qualitative studies where generalization is concerned, is highlighted. Raised emphasis of developing original work with quality and high standard that warrant it to be used in other settings as long as it meets the criteria of validity and reliability consistent with thick descriptions and theoretical generalization found in grounded theory studies.

Charmaz (2014:337) prescribes four specific key criteria for evaluating constructivist grounded theory research. The researcher adopted and used these four criteria to ensure rigorousness in the study. These criteria are credibility, originality, resonance, and usefulness.

**Credibility** implies that the depth and range of data collections are sufficient to support the sub-categories and categories of the developed theory. It depends on a systematic process of comparisons to ensure that the findings are logical and can be linked to the data. In this study, sufficient data were collected to back the claims made that the sub-categories and categories are grounded in the data (Charmaz, 2014:337). The emergent categories and relationships between categories were justified and matched through a systematic process of constant comparison.

**Originality** implies that the research offers new insights and that the analysis is theoretically and socially significant (Charmaz 2014:337). While much research has been done on teenage pregnancy, the researcher opted to focus her research on anticipatory guidance to help adolescents to resist peer pressure and coercion to sexual activity. Instead of encouraging adolescents to use measures to prevent pregnancies and the spread of sexually transmitted infections, the researcher constructed a nursing theory focused on enabling adolescents to take control of their sexual lives. The researcher's originality appeared when naming the categories that emerged from the data and making sense of what it meant to report the fresh ideas in the research findings. The sub-categories and categories are original and were derived from data and not from previous research (Douglas, 2005:52). Existing literature was not used prematurely and only once the theory had started emerging to ensure that "fresh conceptual understandings" (Charmaz, 2006:182) were reflected in the categories. The sensitising concepts of the conceptual framework facilitated a point of departure and did not direct the data collection and analysis.

**Resonance** implies that the theory captures the essence and fullness of the experiences of the participants. The researcher ensured that the questions asked during data collection made sense to the participants and that the fullness of their experiences was captured and reflected in the codes and categories (Charmaz, 2014:337). The researcher used a probing question guide with the 'what and how' questions. Where participants were not clear, the questions were re-run to ensure they understood and were able to give their informed response or view. The participants' responses were audio-recorded and transcribed verbatim.

**Usefulness** implies that the theory should be user-friendly (Charmaz, 2014:338) and in this case for nurses to anticipatorily guide adolescents to resist peer pressure and coercion to sexual activity. In the absence of anticipatory guidance to support adolescents to resist peer pressure and coercion to sexual activity at the clinics where the study was conducted, this initiative can lead to improvement in nursing practice.

The researchers should test if the data collected are relevant and address the theoretical concerns that made it fit to be used for theory development. The data collected in this study met the four theoretical concerns to be noted, namely theoretical plausibility, direction, centrality and adequacy (Charmaz, 2014:87). In aligning to theoretical plausibility; when data were collected for theoretical sampling the participants repeatedly shared similar ideas to confirm categories which made the data to sound believable. On theoretical direction, there was a pattern that emerged from the data collected from adolescents and nurse participants which guided the next data collection and analysis as the study progressed. Certain inputs and responses had theoretical centrality that anchored the study to follow on specific categories to confirm their properties and dimensions through follow-up interviews. Finally, the theoretical adequacy followed through in theoretical sampling where relevant questions were asked to ascertain the theoretical adequacy of the categories. Theoretical concerns normalise the timing and content of the study to strengthen categories for developing the theory (Charmaz, 2014:90).

### **3.5 SUMMARY**

Throughout this chapter, the process of data collection and analysis underlying the grounded research methodology towards developing a nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity, was explained in detail. The next chapter focuses on the findings of the data collected and analysed based on the constructivist grounded theory, using constant comparison to reveal the properties of the categories and sub-categories to discuss the findings of the study in detail. Chapter 4 will focus on storyline, integrating the extant theory and contemporary literature to describe the findings of this study, validated with participants' quotations. It will also outline the results of the realistic explanations and

interpretation of the participants' views regarding peer pressure and coercion to sexual activity and how the intervention should be done.

## **CHAPTER 4**

### **DESCRIPTION OF FINDINGS AND EMERGENT THEORY**

#### **4.1 INTRODUCTION**

In this chapter, the researcher describes findings of the study as they relate to the input gathered from both groups of participants, namely the adolescent and nurse participants. Only a description is provided, as in grounded theory, research findings are “presented in isolation of both extant theory and contemporary literature and then discussed in relation to each other” (Birks & Mills, 2015:130). In the next chapter, the findings as reflected in the categories, will be discussed. Existing theory and contemporary literature will be used in Chapter 5. The process of constant comparison that had been used during data analysis to reveal categories and sub-categories, will be used to debate the contribution that this theory makes (Furniss et al., 2011:121) to the knowledge base of anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity.

The findings seek to answer the following research questions:

- What are the experiences of adolescents with regard to peer pressure and coercion to sexual activity?
- How can nurses support adolescents to resist peer pressure and coercion to sexual activity?

Five categories and 10 related sub-categories were identified, namely 1) substituting for parental shortcomings; 2) addressing negative peer pressure vulnerability of adolescents; 3) addressing risk behaviour vulnerability; 4) optimising nurse-adolescent interaction; and 5) enabling responsible decision making. Refer to Figure 4.1 for a diagrammatic presentation of the categories and sub-categories. Categories are not isolated concepts, but are rather interdependent (McCann & Clark, 2003a:14) and this chapter demonstrates the interrelationship between the categories. The categories and relationships, with an integration thereof with existing theory and contemporary literature, will form the theory (Birks & Mills, 2015:115) for anticipatory guidance of adolescents to resist peer pressure and coercion sexual activity. The theory is presented in the last chapter of the thesis.



The relationships between categories are covered in the properties of the categories. The researcher explored the properties through theoretical sampling and coding. It was done to ensure that the analysis moved beyond a narrative description towards theoretical conceptualisation (Watling & Lingard, 2012:856). Through theoretical sampling, sufficient information was collected from appropriate sources to saturate the categories and properties (Elliott & Lazenbatt, 2005:50), while references to symbolic interactionism and grounded theory were used in the theoretical coding to ensure that the analysis moves beyond narrative description to generate theoretical concepts (Elliot & Jordan, 2010:37). Throughout the chapter, reference is made to the perspectives of Mead (1967) and Blumer (1966) regarding symbolic interactionism.

Properties define the categories and the conditions under which the categories arose and were maintained (Milliken & Schreiber, 2012:691). In this chapter, the properties are described as they surfaced during memo-writing. Memos were written as proof of the integration of the processes of data collection, coding and conceptual analysis (Glaser & Holton, 2004:np) to conceptualise the theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity.

Memos are used to form the basis of the storyline of the findings (emerging theory) (Charmaz, 2014:285). In this chapter, the findings are described in the format of a storyline. Storylines have a dual function in grounded theory (Birks & Mills, 2015:114). They assist in the production of a theory and are also a means to convey the theory to the reader. A storyline should be “digestive for the reader and reflective analysis” as it is an “abstraction of what has been constructed through careful and grounded analysis” (Birks et al., 2008:409). The categories and relationships between the categories form the constructs of the emerging theory that will become the theory once the discussion of the emerging theory with literature has been completed (Birks et al., 2008:410). The constructs are validated through grounding in the data by means of the use of quotations. As the storyline is an abstraction, a limited number of quotations are used. Too many quotations force the presentation of the constructs into a description of the phenomenon and the emerging theory takes second place (Birks et al., 2008:411).

## **4.2 CATEGORY AND SUB-CATEGORIES**

In this study, five categories and 10 sub-categories emerged from the analysed data collected from adolescent and nurse participants' in-vivo quotes. The sub-categories are focused codes which were derived from grouping the initial codes with similar themes. The categories were developed from several sub-categories (refer to Figure 4.1 for a diagrammatic presentation of the categories and sub-categories); both the categories and sub-categories outlined what the nurses should do for the benefit of adolescents.

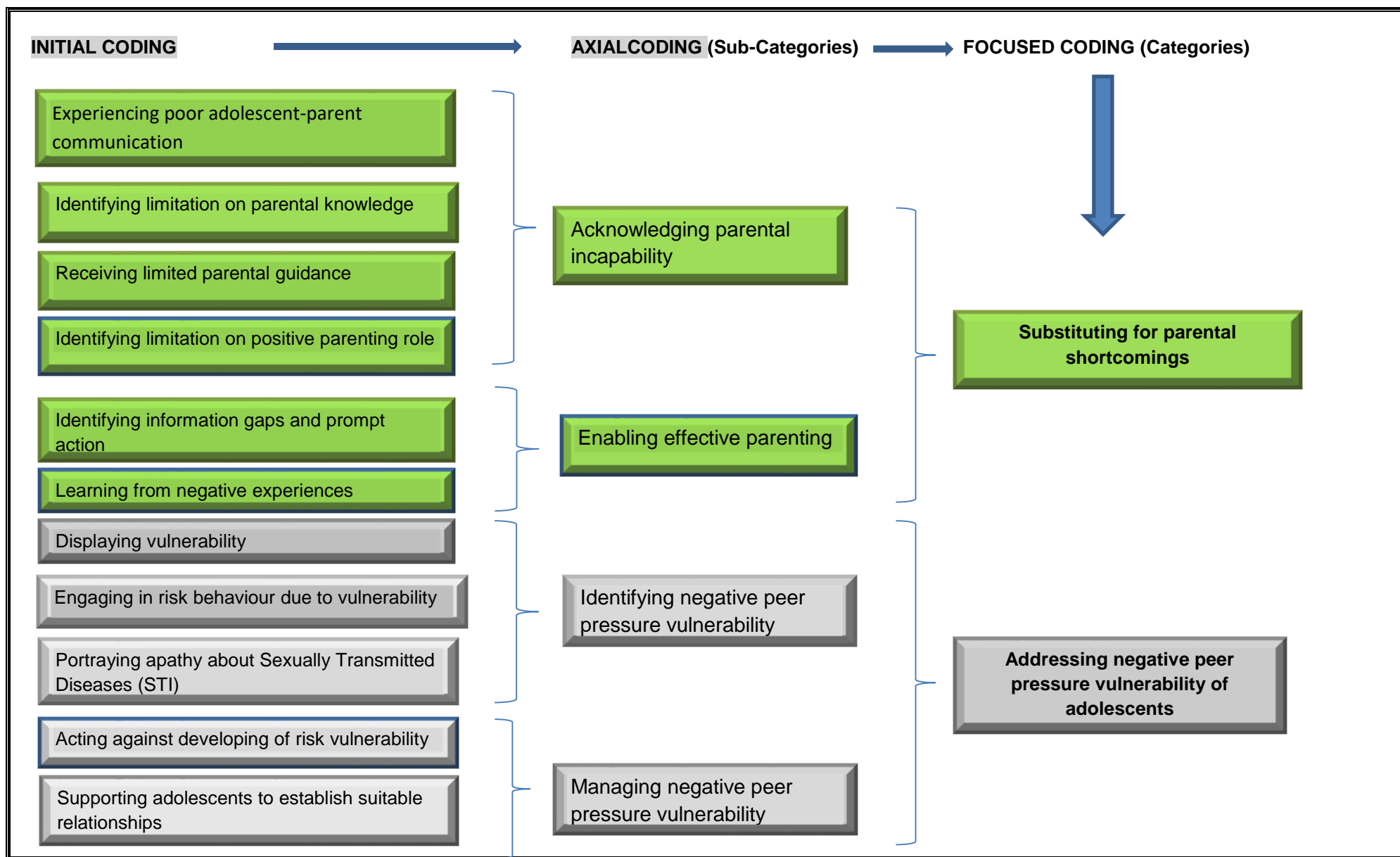
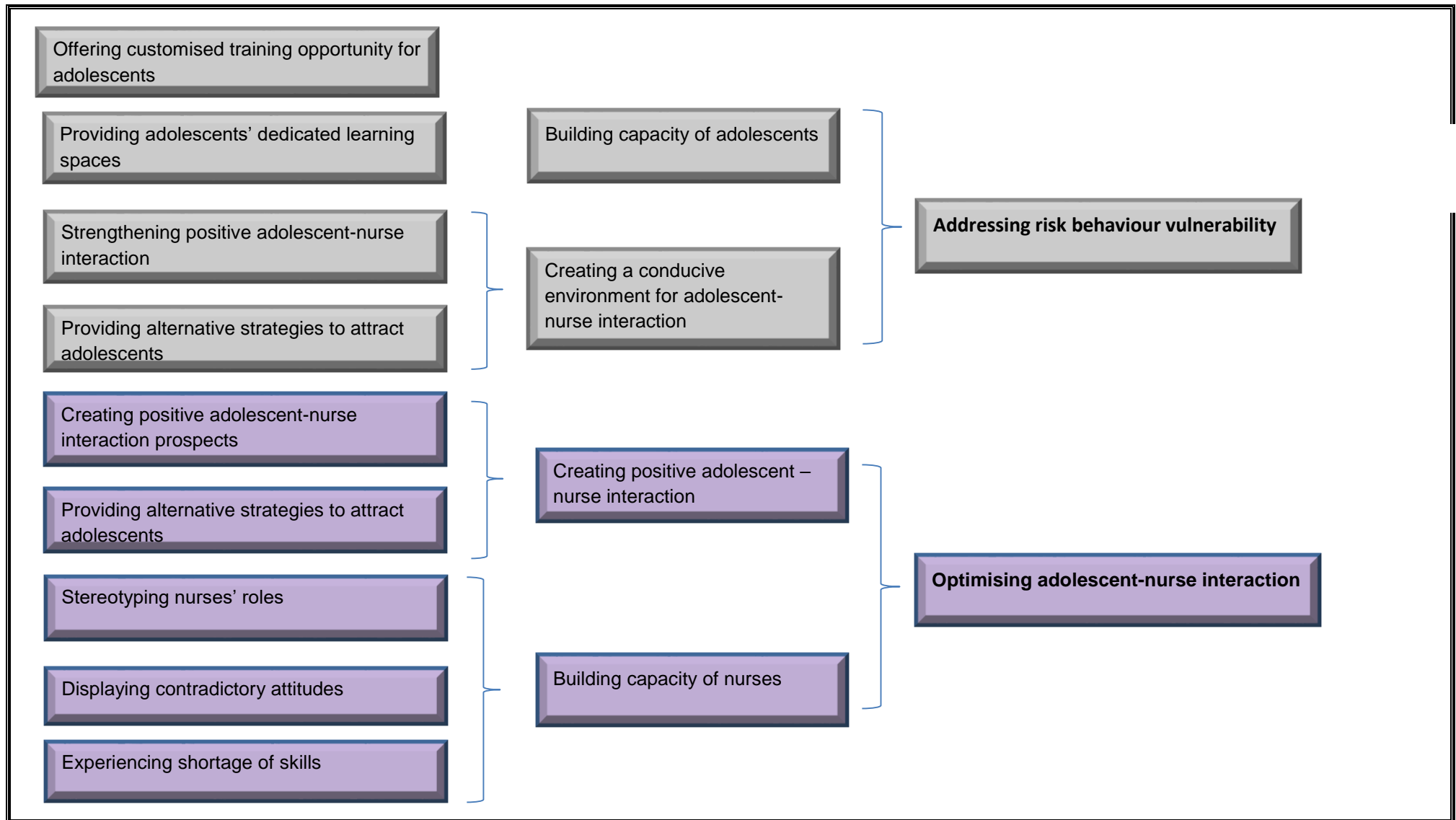


Figure 4.1 Diagrammatic presentation of the categories and sub-categories

## INITIAL CODING

## AXIAL CODING (Sub-Categories)

## FOCUSED CODING (Categories)



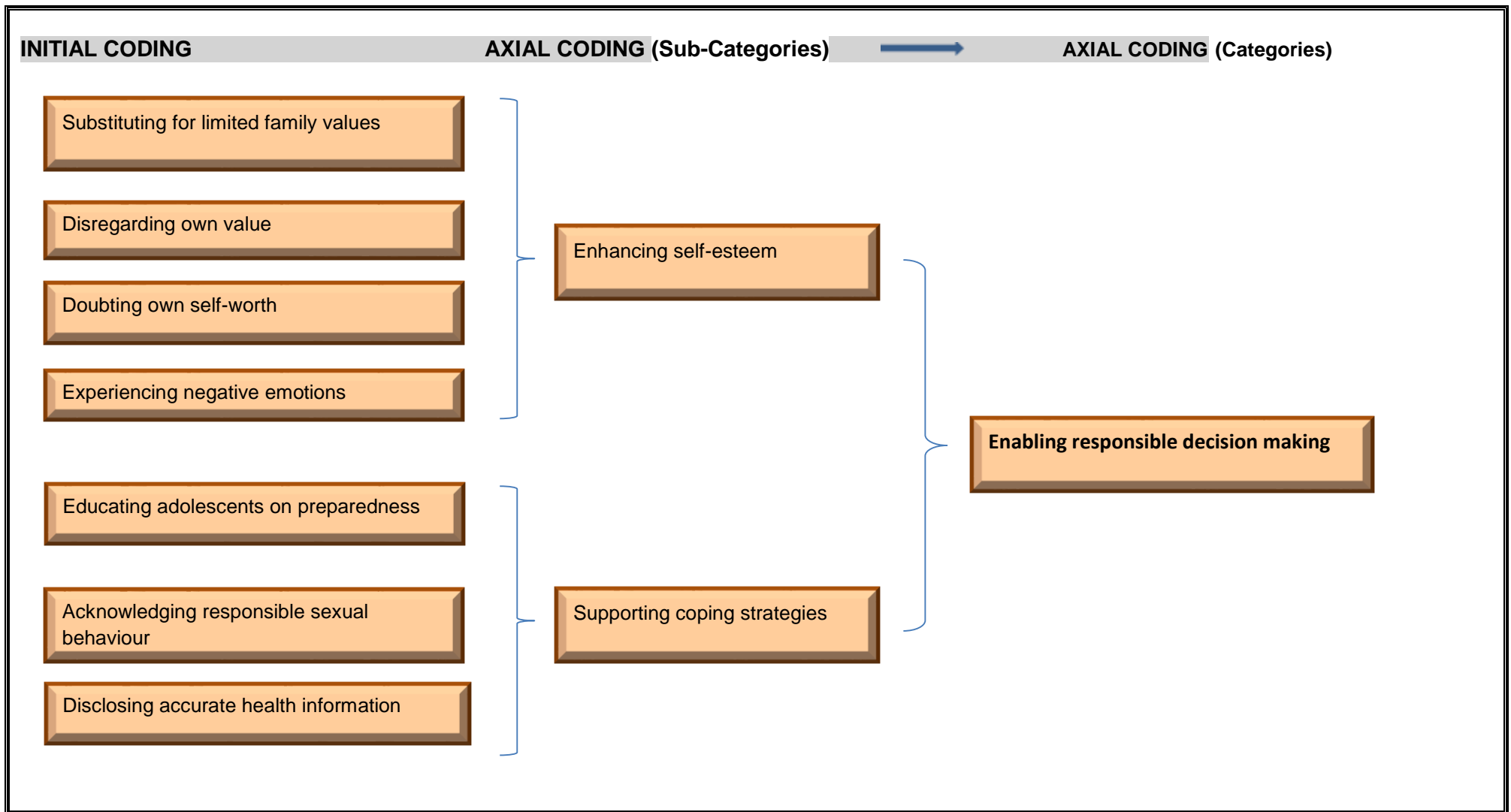


Figure 4.1 Diagrammatic presentation of the categories and sub-categr

The first category is 'substituting for parental shortcomings' with its two sub-categories, namely 'acknowledging parental incapability' and 'enabling effective parenting'. The second category is 'addressing negative peer pressure vulnerability of adolescents', which emanated from two sub-categories, namely 'identifying negative peer pressure vulnerability' and 'managing negative peer pressure vulnerability'. The third category that emerged is 'addressing risk behaviour vulnerability', derived from 'building capacity of adolescents' and 'creating a conducive environment for adolescent-nurse interaction'. The fourth category is 'optimising adolescent-nurse interaction', which emanated from two sub-categories, namely 'creating positive adolescent-nurse interaction' and 'building capacity of nurses'. The fifth and last category is 'enabling responsible decision making', which is developed from two sub-categories, i.e. 'enhancing self-esteem' and 'supporting coping strategies'.

Adolescent participants defined the manifestation of peer pressure and elucidated their experiences with regard to peer pressure and coercion to sexual activity. The nurse participants articulated their proposed interventions to support adolescents to resist peer pressure and coercion to sexual activity.

The adolescents are constantly engaged in social interaction with their peers, their parents and nurses. During that process, they are personally forming relationships, acting together and interpreting what they experienced through symbolic interaction and non-symbolic interaction levels. The adolescents understood the language used amongst their peers as they jointly interpreted the meanings amongst themselves. Thus, through the data collected and analysed from the transcribed interviews, it emerged that they interpreted 'peer pressure' in a similar fashion, irrespective of their ages and geographic location (Blumer, 1966:537).

The findings of the data revealed that nurses identified parental incapability and parenting inadequacies that predisposed adolescents to vulnerability. On the other hand, they acknowledged their own incapacity that hindered nurse-adolescent interaction towards having a relationship conducive for provision of anticipatory guidance of adolescents to resist peer pressure to sexual activity. They also revealed the necessity and importance of developing and supporting adolescents towards being responsible in decision making.

From Mead's point of view, the parents, nurses and adolescents all have an imbedded character that makes them act in a certain way when faced with a certain situation. The parents acted in a certain manner that indicated to the nurse that they might be incapacitated. The parents' attitude towards their adolescent children lead to them being perceived as lacking knowledge, who acknowledged being incapable, which then warranted them being an object that is valueless (Mead, 1967:5).

As illustrated in the diagrammatic presentation in Figure 4.1, the categories and sub-categories were developed on completion of data collection and analysis. The categories with their relevant dimensions are described in detail.

The researcher used Glaser's "Six Cs: Causes, Contexts, Contingencies, Consequences, Co-variances and Conditions" (Charmaz, 2014:151) during theoretical coding to enhance clarity of the categories and sub-categories (refer to Table 4.1 for a b)

**Table 4.1 Conditional Matrix applying the 6 C's in theoretical coding to Glaser (adapted from Scott, 2004:118)**

Category	What is the category about/Using participants' words	When does the category occur?	Where does the category occur?	Why does the category occur?	How does the category occur?	With what consequence does the category occur or it is understood?
<b>Substituting for parental shortcomings</b>	<p>"There is a gap that has been identified and we need to substitute"</p> <p>"We need to do other things like maybe interview, which will ensure that the young people are informed about the information they need"</p>	<ul style="list-style-type: none"> <li>...during the absence of parental guidance</li> </ul>	Home Community Health facility Church	<ul style="list-style-type: none"> <li>... because parents have parental inadequacies</li> <li>...because parents have limited knowledge on health information</li> <li>...because parents lack parenting skills</li> </ul>	<ul style="list-style-type: none"> <li>By not communicating with parents</li> <li>By having limited parental connectedness</li> <li>By lacking parental guidance</li> </ul>	<ul style="list-style-type: none"> <li>Being susceptible to vulnerability to peer pressure and risk behaviour</li> <li>Sexually transmitted infections</li> <li>Drug abuse</li> <li>School drop out</li> <li>Teenage pregnancy</li> </ul>
<b>Addressing negative peer pressure vulnerability</b>	<p>"To build a close relationship with your child so that the child is free to talk to you about sensitive issues"</p> <p>"Parent talk to the child about the pressure they will encounter outside home, to enlighten them that they are going to undergo certain pressures from friends or peers"</p>	<ul style="list-style-type: none"> <li>...during teachable moments when they experience such incidents happening on TV</li> </ul>	Home Health facility Church Community	<ul style="list-style-type: none"> <li>...because of poor self-esteem</li> <li>...because of lack of accurate information</li> <li>...because of ignorance</li> <li>...because of peer influence on adolescents</li> </ul>	<ul style="list-style-type: none"> <li>Getting incorrect information from peers</li> <li>By being told what to do by peers</li> </ul>	<ul style="list-style-type: none"> <li>Having poor self-esteem</li> <li>Taking irresponsible decisions</li> <li>Making wrong choices</li> </ul>
<b>Addressing risk behaviour vulnerability</b>	<p>"Means a child is exposed to risks. They are at risk because nobody talks to them about values"</p> <p>"Being vulnerable to risk behaviour due to the situation they find"</p>	<ul style="list-style-type: none"> <li>During interaction with their peers.</li> <li>During the absence of parental communication</li> </ul>	School Community	<ul style="list-style-type: none"> <li>...because adolescents are getting involved with older men because their peers tell them to do certain things</li> </ul>	<ul style="list-style-type: none"> <li>By not getting correct information and education</li> <li>- By early sexual activities and</li> </ul>	<ul style="list-style-type: none"> <li>Poverty</li> <li>Ignorance</li> <li>Lack of knowledge</li> <li>Teenage pregnancy</li> </ul>



Category	What is the category about/Using participants' words	When does the category occur?	Where does the category occur?	Why does the category occur?	How does the category occur?	With what consequence does the category occur or it is understood?
	themselves in, having nothing else to do"	<ul style="list-style-type: none"> <li>During the absence of money for food at home</li> </ul>		<ul style="list-style-type: none"> <li>... because their peers are wearing nice clothes, nice phones and there is poverty at home</li> <li>...because they want to get money to look like their friends</li> </ul>	joining groups that are taking drugs	
<b>Optimising nurse-adolescent interaction</b>	"More chances to be made for nurses and adolescents to meet"	<ul style="list-style-type: none"> <li>During consultation at the clinic</li> <li>During school primary health services</li> <li>During community awareness workshops and campaigns</li> </ul>	Health facility Community	<ul style="list-style-type: none"> <li>...because nurses have a judgmental attitude towards adolescents</li> <li>...because nurses should improve their attitude to reach out to adolescents</li> </ul>	<ul style="list-style-type: none"> <li>By treating adolescent with dignity and respect</li> <li>By not treating adolescents as children but as clients in need of healthcare services</li> </ul>	<ul style="list-style-type: none"> <li>Poor utilisation of adolescent services</li> <li>Lack of correct health information</li> </ul>
<b>Enabling responsible decision making</b>	"By informing and giving them correct knowledge"	<ul style="list-style-type: none"> <li>During time when people support them</li> <li>When they realise they are growing older and will be a young adult and they prepare to face adulthood</li> </ul>	Home School Community Church	<ul style="list-style-type: none"> <li>...because adolescents have a low-self-esteem they are even scared to stand in front of people.</li> <li>... because when you stand on your own; you can make your own</li> </ul>	<ul style="list-style-type: none"> <li>By encouraging them and building their self-esteem</li> </ul>	<ul style="list-style-type: none"> <li>Making wrong choices</li> <li>Having negative life consequences</li> <li>Having poor future prospects</li> <li>Being vulnerable to risk behaviour</li> </ul>

Category	What is the category about/Using participants' words	When does the category occur?	Where does the category occur?	Why does the category occur?	How does the category occur?	With what consequence does the category occur or it is understood?
				responsible decision		

#### **4.2.1 Category: Substituting for parental shortcomings**

Substituting for parental shortcomings emanated from acknowledging parental incapability and enabling effective parenting. Substituting for parental shortcomings is a process undertaken by nurses to enable parents to address challenges in guiding adolescents to resist peer pressure and coercion to sexual activity. It also includes nursing activities to guide adolescents when their parents are not available or competent to do so. It involves acknowledging parental incapability and devising strategies to address the limitations that it causes in guiding adolescents to resist peer pressure and coercion to sexual activity. This process also involves taking measures to act on behalf of parents, should it be required. When parents cannot fulfil their parental responsibilities due to reasons beyond their control, nurses should support their adolescent clients and substitute for the shortcomings of their parents. Supporting activities involves assisting adolescents to develop confidence in making informed decisions regarding their sexual health.

Substituting for parental shortcomings involves acknowledging parental incapability and devising strategies to address these shortcomings. The process is about recognising the circumstances under which limitations occur and to act accordingly. According to the Merriam-Webster dictionary, substitution is “the act of substituting or replacing one person or thing with another”.

According to Mead (1967:136), people develop an awareness of themselves through interaction with others. They develop a sense of ‘self’ through social experience and activity. It refers to how other people respond to them during social interaction. The standpoint of others towards them, whether it is from individual people or from the generalised standpoint of a group, enables people to develop a perspective towards themselves. When people are responded to by other individuals or by the group, they become aware of the meaning of their actions. A requirement is that the action and the response that it provokes should have the same meaning for those who acted and for those who responded (Blumer, 1969:5). When the meaning is reflected in a symbol (words), symbolic interaction takes place (Mead, 1967:76).

People belong to different social groups and can fulfil different roles through their actions. According to Mead (1967:142), social circumstances demand specific actions.

Healthcare environments differ and demand different roles from nurses. When they work with adolescent patients who have needs regarding support to resist peer pressure that their parents are supposed to attend to, but cannot, nurses may step in and be parental substitutes. They should not replace the adolescents' parents, but can fulfil a role that complements the role of parents in order to anticipatorily guide adolescents to resist peer pressure that may lead to them taking part in risk behaviour.

When people (adolescents and nurses) come together and interact with one another, it is aligned with symbolic interaction. According to Mead's assertion (Blumer, 1969:5), individuals' attitudes start from within; they develop an idea about something and think thoroughly before acting. Nurses should take the lead and encourage the development of attitudes from both groups towards actions of substituting parental guidance. Nurses and adolescents need to attach the same attitude and meaning regarding the substitution in order for it to be effective. It cannot be forced on adolescents. The nurses and adolescents need to know the intentions of others to be able to effectively interact with one another (Blumer, 1969:8). Actions of individuals and interactions with others do not happen by accident and not in a vacuum. Human beings are capable of recognising issues, devising them and outlining the actions to be executed. When aligning the act to the attitude that initiated the act, according to Blumer (1966:536), it leads to interaction with others who attach the same meaning to the action.

In this instance, substituting for parental shortcomings with the aim of addressing identified threats to the well-being of the adolescents became the responsibility of nurses. According to the data obtained from the participants, parental shortcomings relate to a lack of parenting skills, poor communication of parents with their adolescent children, inadequate parental guidance and lack of positive parenting roles in the home. The parental shortcomings were identified by the nurse participants during interaction with parents and adolescents. The information was decoded from interpreted clues provided by the parents during interviews, as parents did not mention outright that they could not guide their adolescent children properly. The nurse participants were of the opinion that parental incapability was an important factor that leads to their children's involvement in risk behaviour. The adolescent participants were cognisant of their parents' limitations in communicating with them, especially on topics related to reproductive health and sexual activity. The adolescent participants claimed that their parents did not know about their challenges regarding relationships

and that they possessed limited information about their needs. This concern was raised by adolescents as they experienced limited communication and interaction with their parents regarding sexuality in general and specifically regarding guidance on sexual activity. Poor communication existed, as their parents refrained from talking to them about their sexual health.

#### **4.2.1.1 Sub-category: Acknowledging parental incapability**

The sub-category on acknowledging parental incapability is related to recognising the inability of parents to give adolescents guidance as expected. In this study, guidance is defined as a strategy for giving direction to adolescents to resist risk behaviour. It is a parenting responsibility that is essential for the survival of adolescents in their interaction with others. Some parents do not exercise their parental duty to provide the required parental guidance to empower their adolescent children to withstand peer pressure and coercion to sexual activity. In the absence of parental guidance, adolescents seek consolation from their friends and peers, which is sometimes misleading. In order for nurses to stand in for the parents of adolescents, they should first acknowledge that not all parents can guide their children and that parental incapability exists.

The nurse participants (**NP**) were aware that parents of adolescents often have limited knowledge and skills to guide their children towards healthy living, as they often send their children to health facilities in the hope that the nurses will intervene. On the other hand, the nurse participants believed parents should at least provide their adolescent children with basic information about their sexual health and how to resist peer pressure and coercion towards them being sexual active. It was expected that parents should teach adolescents about their sexual reproductive health and development. The nurse participants, however, realised that many parents on their own were not capable and knowledgeable in addressing the adolescent sexual health information needs. According to them, parents often need empowerment from nurses to enable them to guide their children towards healthy living. Nurse participant seven highlighted her thoughts about the limitations of parental knowledge:

*“I think we need...parenting programmes which will assist parents...in giving them the approaches or skills on how to communicate with their children...also*

*give them...information on sexuality education for parents...why does the body of the adolescent change and...say to their children if you become sexually active and practise unsafe sex...you will end up being pregnant...and...having sexually transmitted infections.” (NP7)*

Not all parents who refrain from educating their adolescent children about sexual health do that due to inadequate knowledge about the issue. Some experienced cultural barriers that hindered open communication with their children about peer pressure and sexual activities. The nurse participants also identified that culture played a major role in preventing adolescent-parent communication. According to the nurse participants, some parents were well informed, but found it difficult to divulge it to their adolescent children because of cultural barriers. They believed that discussing sexual-related matters is a taboo. One nurse participant reiterated the perception on adolescent-parent communication and how culture impacts on it:

*“Yes, I think parents have enough information to share with their children...just that some will feel somehow because of culture and whatever that will prevent them to talk to their children; but they do have the information.” (NP5)*

In the acknowledgment of parental incapability, nurses should be aware of the possibility that the incapability may be caused by cultural beliefs. Without knowledge and skills to address culturally sensitive issues, nurses may keep on teaching parents to guide their children with limited success as their cultural beliefs have not been addressed.

The nurse participants also experienced that adolescents did not want to talk to their parents about their sexual health. They rather relied on their friends for guidance. One adolescent participant recommended that parents should be taught how to educate their children to not become sexually active due to pressure from others. Adolescents should be empowered to decide for themselves and not to give in to pressure from others. It was also recommended that parents should help their adolescent children to seek guidance from other adults, should they feel that they are not capable of guiding their children. One nurse participant described how nurses could be approached to guide adolescents:

*“If you feel you are a parent but...can’t talk to your child about sex, and then come with your child to the clinic, say sister this is what I want you to do. I want you to talk to my child. (NP 2)*

Without effective ongoing communication between parents and adolescent children, limited opportunities exist for parents to warn their children against risk behaviour and pressure from others to take part in risk behaviour. Effective guidance of adolescent children requires open communication to encourage adolescents to approach their parents any time and for any reason without hesitation. When such communication is not possible, adolescents have no choice but to approach others in the community. The most readily available group is their peers. One adolescent participant **(AP)** had the following to say about the guidance that she received from her peers:

*“I experienced peer pressure through friends...because they expect you to be this...person; and sometimes you do not meet those requirements then you end up doing things just to please them.” (AP6)*

Poor communication manifested in the absence of a connection between the adolescents and their parents, as well as portraying a rebellious attitude when adolescents have disagreements with their parents. The adolescents who were not communicating well with their parents developed a different self-perception and resorted to peers to get validation for all sorts of problems with self-image, including affirmation of him or herself. Adolescents experience difficulty in expressing themselves and sharing their emotions and feelings with their parents, fearing to be ridiculed. In the absence of opportunities to share their innermost feelings with their parents, the adolescents felt insecure. They also pretended that they did not need their parents and could cope all by themselves. Adolescent Participant 4 described it as follows:

*“The thing is that I was not close to my mom or dad...I never...never been like with them or to share a story with them.” (AP4)*

In order to create opportunities for open communication between parents and their adolescent children, parents need to be skilled to identify their children’s needs. They should be approachable to their children, eager to help them and knowledgeable about

the challenges that adolescents have. When they do not have such skills and thus avoid opportunities to talk to their children about their sexual health and lifestyle, limitations in their parenting behaviour should be identified by nurses in healthcare settings. It should be done through assessment and timely interventions aimed at promoting effective communication between parents and children. It is difficult for parents to ask for such interventions as they may not know what parenting skills they require to guide their adolescent children. Nurses should take the lead in acknowledging parenting incapability instead of waiting for parents to approach them. One nurse participant described the predicament faced by parents with a lack of parenting skills:

*“Sometimes you find that parents use their parents’ position just to be defensive if they cannot answer those questions and sometimes you find the parents...they don’t have that confidence. We need to have parenting skills on issues of sexual reproductive health because it is taboo amongst our community. Sometimes if parents don’t have the information it is not going to be easy; that is why we find that adolescents don’t have that relationship with their parents.” (NP4)*

In communities where risk behaviour is common, parents are often the only potential positive role models for adolescents. When parents also take part in risk behaviour, a lack of positive role models exists. Even when parents do not partake in risk behaviour, but lack the skills to be role models to their children, adolescents grow up without such input to their development. Their exposure to and experiences of risk behaviour to them becomes the only way of living. The increasing occurrence of one-parent families leads to adolescents being exposed to only one parent and his or her lifestyle. With more women forming one-parent families, adolescents only learn from their mothers. A father figure role model is sought outside the family. Although some adolescents may find positive role models in adults in the community, these people may not be able to interact long enough with them to serve as positive role models. The prevalence of ‘absent fathers’ often contributes to poor parent-child relationships in families and that may lead to the adoption of risk behaviour by children. The inability of parents to be positive role models to their children should be acknowledged by nurses in order to address it according to the needs that may arise during interaction with adolescent patients. Nurse participant four attested to the absent father issue and how it impacts on the relationship of children and their parents:



*“Mostly in S.A we have absent fathers. It is only the mothers that are there. The adolescent boys also need to be groomed by their fathers; which is another challenge which contributes to parent-child/youth relationship.” (NP4)*

Poor relationships between parents and adolescent children contribute to parenting incapability. Parents who care for their children and who acquire parenting skills to guide their children towards a healthy and responsible living, make their children aware of the dangers of risk behaviour, including being sexually active at a young age. Parents who are not cognisant of their adolescent children's plight for effective parenting and guidance, are placing a wedge between them and their adolescent children, pushing them further away. When positive parent-child relationships exist, adolescents will approach their parents when they experience challenges. A nurse participant described the importance of talking to children as follows:

*“If you are a parent that talks to your children, they will know that if they have a challenge, they will go to mama first rather than going to a friend...” (NP2)*

In the case of poor relationships between parents and adolescents due to the parents being rude to their children, adolescents will avoid their parents. The rudeness is evidence of poor parenting skills that nurses need to warn the parents against. One nurse participant made the following comment:

*“...but then there are some parents, they are bullies; let me call them bully parents...the adolescent (children) do as they please because there is no communication between them and she (the mother) is going to shout at them. They rather do their own thing and she (the mother) will see when they are pregnant.” (NP2)*

In the case of adolescent-headed families, the complete absence of guidance by parents needs to be acknowledged by nurses. These adolescent participants experience a complete absence of parenting. Without interventions by nurses to acknowledge their needs, due to the lack of role models, the adolescents may follow the advice of others and become sexually active at a very young age without knowing what the consequences will be. In the absence of parents, nurses need to be willing

to become their substitutes. Before that can happen, they must first acknowledge the needs of their adolescent patients. One nurse participant (**TP** refers to the theoretically sampled participant) described the situation as follows:

*“They are at risk and vulnerable to these risks because there is nobody who is talking to them about values...There is nobody telling about...when seeing people having sex on TV they don’t show when they are going to use a condom and these are things parents need to talk to their children...if they don’t have a good self-confidence and self-esteem then they become vulnerable...” (TP4)*

One of the participants raised a very important concern, which is that as much as nurses should serve as substitutes in the absence of parents, some of the nurses are themselves young and do not have the necessary parenting experience. Therefore, they should be trained on parenting to prepare them to deal with adolescents when they assist them through their developmental journey. Upon receiving the necessary training, the young nurses and other nurses who would have been trained would be in a position to guide the adolescents with insight. Adolescents would be guided on the importance of respecting the family instructions and not violating them. For example, not going out late at night and sleeping out without their parents’ approval, as this is one of the biggest issues leading to adolescents disrespecting their parents. The youth specialist outlined the importance of implementing parenting training to empower those who are going to interact with adolescents:

*“Their own experience of parenting may not be perfect, but even if they just have to work from that perspective, you have to train them on what is parenting. They have to be convinced that they...on the one side help the adolescent to understand the importance of listening to their parents and then on the other hand to build their own capacity on guiding these young people in terms of what would they then as substitute parent do to assist this person with.” (TP1)*

People from the community whom the adolescents respect can also act as role models. When nurses feel too young to substitute parents and the parents do not have the skills and knowledge or are not available to guide their children, individuals and groups from the community can be involved. Therefore, a nurse participant suggested that support groups be established:

*“...the guardian, because we see most of the children their parents have died or the child-headed family, the support group or whoever is available...” (TP5)*

Like the support groups that should be trained by nurses on how to guide adolescents to resist peer pressure, parents can also be trained. It would be incorrect to assume that all parents are capable of parenting and that they all have the knowledge and skills to guide adolescents. One of the participants confirmed the need for substituting parenting and providing the relevant training to enable effective parenting:

*“...I am saying whoever is doing that needs to go to a parenting programme training themselves....to see what do young people require these days...so that we learn new ways of parenting...” (TP1)*

#### **4.2.1.2 Sub-category: Enabling effective parenting**

This sub-category refers to measures to be put in place by nurses to address limitations regarding parenting and to enable parents of adolescents to guide their children towards responsible behaviour that includes resistance of peer pressure to become sexually active. Parents should interact with their adolescent children and execute age-appropriate actions whenever they socialise their children. However, in this study the researcher discovered that parents sometimes experience challenges in guiding their adolescent children to resist peer pressure that may have detrimental consequences for their well-being in general and specifically for their sexual well-being. When nurses interact with such parents, measures must be put in place that will enable parents to fulfil their responsibility towards their adolescent children.

One nurse participant remarked that adolescents will approach their parents for guidance if they consider them to be approachable. Should their children consider them to be unapproachable, endeavours to increase their knowledge and skills to enable them to guide their children through the developmental tasks of adolescents, are of no value. The point of departure in designing programmes to enable good parenting should be helping parents to become approachable to their children.

*“I think it depends on the type of parent you are. If you are a parent that talks to your children, they will know that if they have a challenge, they will go to mama...”*  
(NP2)

Not all parents are reluctant to guide their children through adolescence. Some parents do play an active role in preparing their children for the challenges associated with peer pressure regarding their sexual and reproductive health. They take their adolescent children to healthcare services where they request nurses to talk to their children about sexual issues and when necessary, provide them with contraceptives. When nurses use such opportunities to offer anticipatory guidance to adolescents to make informed decisions regarding their sexual health, they work towards enabling the parents to be involved in their children's decision making. When nurses discover that there are gaps in the parents' knowledge and skills to do their parenting responsibilities, on the spot health education or formal programmes can be offered. Often the lack of skills of parents also includes skills to communicate with their children about sensitive sexual issues. Parents may find it difficult to talk about their children's sexuality, the sexual activities that they are engaged in and whether they should use contraceptives. Nurses identified that some parents were scared and anxious about their adolescent children's involvement in sexual activities, as they fear that their children may become pregnant:

*“The parents cannot talk to their children...Then some of them will say - I have just seen it is the time when they ask - if you can get pregnant what will you do to answer your parents because your parents are scared.”* (NP5)

The nurse participants were concerned about the limited knowledge of the parents of the adolescents about peer pressure and sexual issues. When non-knowledgeable people try to guide adolescents to resist peer pressure to be sexually active, it could be damaging to them. Parents and their adolescent children require accurate information. Thus, the nurse participants indicated that they would prefer to be responsible for educating parents on how to address this sensitive issue:

*“...because sometimes their parents might have limited knowledge as far as things are concerned, whereas with nurses they have almost if not most of the information based on scientific things.”* (NP3)

The nurses' role is to bridge information gaps when they identify it. Parents should be equipped in addressing adolescent issues. However, lack of information is a general problem in societies and needs to be addressed, as other members of society can assist the parents of adolescents to fulfil their parenting role. A concerted effort should thus not only assist parents of adolescents, but should also benefit other members of society. The nurse participants highlighted the importance of understanding the community background and the community needs to respond accordingly:

*“Looking also at the socialisation and the value system within that community...the next best thing would be for nurses to communicate with community members by means of having dialogues and focus group discussions so that we are able to identify needs in terms of parenting within that community. Then when we come up with programmes, it will best to come up with programmes that will address those needs that have been identified.” (TP2)*

As societies change, new challenges should be managed and new knowledge and skills are required. When parents of adolescents try to guide their children in the way that their parents guided them, inappropriate actions can be taken. When they do what they have witnessed when they were adolescents, they may do harm. Although parents may not communicate their need to be trained to assist their adolescent children to resist peer pressure, the need may exist and nurses should be proactive and offer such training to parents:

*“...to be able to see what do young people require these days...most...parent the way their parents parented; that is why they need training on parenting so that they learn new ways of parenting...” (TP1)*

Training of parents in groups and in well-planned formal programmes may be more successful than training of individual parents. The latter should be done when the need arises and should be complementary to the training programmes. One of the participants pointed out that parenting training should be done in groups where they can learn from each other. It should be a series of training sessions and measures should be put in place to ensure that the parents get ample opportunity to discuss their challenges:

*“...parenting (training) is best shared in a social learning environment, in bigger groups where they have discussions. They can hear what others say and possibly they can learn from each other and guide each other...you need multiple sessions so that there is time to learn and to absorb and sort of make this your own, that is not a once off.” (TP1)*

In this study, the researcher explored adolescents' views and experiences on peer pressure, what it was and how it manifested. Data revealed that some adolescents learned from negative experiences. Fortunately for some, it had a positive impact on their lives. They even abandoned the risk behaviour that they previously were engaged in. Although they did not blame their parents for not having guided them on how to resist behaviour that may pose risks to their well-being, timely parental interventions could have enabled them to better take care of themselves. The adolescents who managed to resist peer pressure without the support from others, developed a strong sense of self-confidence. Others learned from school-based projects how to resist peer pressure:

*“I stopped going out clubbing, moving at night, respect parents.” (AP2)*

*“I joined a Christian church...so I could avoid all of these things.” (AP7)*

*“Change bad friends.” (AP9)*

Nurses should support adolescents who managed to change their behaviour and to resist peer pressure in order not to engage in risk behaviour that can lead to being sexually active as a consequence of risk behaviour. Learning from negative experiences and changing risk behaviour took place after adolescents developed awareness of their actions. Being aware of actions involved taking time to self-reflect and undergo introspection about their actions to the self and towards others. Some adolescent participants were directly involved with peer pressure within their social circles; some were involved in bullying, some were perpetrating acts of peer pressure, and some boys were harassing girls sexually. They had an opportunity to be involved in support programmes which changed their lives, thus, they realised that they had made mistakes and they changed their behaviour for the better. They learned to distinguish between right and wrong acts; they learnt to refrain from any act of peer pressure and risk behaviour:

*“Because from what I have gone through, it was very bad and if maybe I share the story...They will realise that this thing was a bad thing so they will need to change...the stage.” (AP4)*

Unfortunately, negative experiences are not always reported due to situations at home. When parents are very strict and do not talk about the challenges that their adolescent children may experience, their adolescent children act behind their backs. They visit friends and clubs without the permission of their parents and when they get harassed or abused, they do not feel free to talk to their parents:

*“Friends were forced by gangsters to do things with them. They don’t know what to do because they promise them to beat them when they don’t do what they say.” (AP1)*

*“It has happened to me while I was in Grade 6...friends that go to the club, go and come at night every day...they want me to go with them and my mother is behaving like cheeky person...she did not want me to go there but some girls pushed me to do that...some girls were pushing me...I get forced...” (AP3)*

Parents may not know that their adolescent children will do whatever it takes to be accepted by their peers. Getting the approval of their peers becomes much more important than getting their parents’ approval. Sometimes, adolescents participate in these acts of peer pressure due to the fact they want to belong to peer groups. Risky as the act of peer pressure may be, they want to experience it and only later realise how negative those actions were as it sometimes came with negative consequences to their lives. The peer pressure acts are committed in a peer group setting because they want to impress their peers. Thus, adolescents engaged in perpetrating acts forbidden for their age like smoking and drinking alcohol. These forbidden acts of peer pressure are widespread during teenage stages. Adolescent Participant 4 explained what happened to her:

*“It was very hard for me because I had lots of friends that were drinking alcohol and smoking whereby I had to do same things like them...I started at the age of 13 years...I had four friends...the other one was the same age as me...and then*

*the others were 18, 19 and 23...I started to link with them...I started to feel cool..."*  
(AP4)

Parents may indirectly put their children in situations where their peers can put pressure on them to take part in risk behaviour. In their endeavour to assist parents to guide their children, nurses should point out to parents that they should be extremely sensitive to their children's needs. That can only be accomplished when parents create open lines of communication with their children. One participant indicated that her family wanted her to be viewed as an achiever. Much pressure was put on her to live up to the expectations of others:

*"I experienced pressure...doing things just to please them...I joined a rugby team and then they said that there is this initiation that you must do and then it turned out that those things are banned...so I had to do something that was illegal in order to fit in to that group because if I hadn't I wouldn't have made it into the team."* (AP6)

Parents need to be reminded that they should create opportunities for their children to talk to them. Nurses are resources in the community to whom they can talk and ask for guidance on how to approach their children. Providing parents of adolescents with accurate information will improve their parenting skills and enable them to interact with their adolescent children. One of the nurse participants remarked on what should be done to assist the parents to improve their parenting skills:

*"The main thing that affects the adolescents is fear of the parent...there should be parents' support groups where they meet and this issue is discussed...parents are given the guidance and support on how to go about being open to their adolescents on...issues and informing the adolescents about any changes that will take place in their bodies...and not being afraid to discuss sexual issues and answering questions on sexual issues asked by adolescents."* (TP5)



#### **4.2.2 Category: Addressing negative peer pressure vulnerability of adolescents**

The category on addressing negative peer pressure vulnerability of adolescents emanated from two sub-categories, namely 'identifying negative peer pressure vulnerability' and 'managing negative peer pressure vulnerability'. Negative peer pressure predisposes adolescents to risk behaviour whilst positive peer pressure provides protective influence towards risk behaviour (Suris, Berchtold, Jeannin & Michaud, 2006:10). Adolescents could be predisposed to risk factors or exposed to protective factors and therefore experience negative and positive effects.

Negative peer pressure enhances adolescents' vulnerability to take part in risk behaviour such as being sexually active to please their peers. Positive peer pressure can enhance their ability to resist temptations to partake in risk behaviour. Should adolescents develop a resistance to negative peer pressure, their vulnerability to taking part in risk behaviour could be decreased. In this study, the emphasis is on negative peer pressure and the vulnerability that adolescents who rely on others to reinforce their behaviour, develop.

Vulnerability is difficult to pin down in a simple definition. In general, it refers to being defenceless, weak and exposed to other people deciding for you (Hurst, 2008:192). According to the study commissioned by Suris et al. (2006:10), vulnerability depends on the adolescents' emotional well-being, parental relationship and educational level. It is something that is not tangible, however, it can be displayed through verbal and non-verbal communication. First and foremost, the signs of vulnerability should be identified to enable effective management thereof.

Nurses need to identify adolescents' vulnerability regarding negative peer pressure and assist adolescent patients to develop mechanisms to reduce it. The process of addressing negative peer pressure vulnerability of adolescents involves not only the adolescents, as they do not function in isolation. They are members of families, peer groups and are also members of societies. Nurses should involve the adolescents themselves, their parents, and significant others to identify their vulnerability to negative peer pressure and also to address such vulnerability. According to Blumer (1969:7), human beings act towards things which, in this case, refers to the

vulnerability of adolescents towards negative peer pressure based on the meaning that things have for them. A mutual understanding of what is meant with vulnerability, negative peer pressure and risk behaviour such as giving in to pressure to become sexually active just for the sake of pleasing others, needs to be clarified. The meaning of vulnerability, negative peer pressure and risk behaviour (being sexually active because of the demands of others) should be developed through interaction with others. Meanings are social products of interaction. Vulnerability and peer pressure derived their meaning through the interaction of people and can be changed through interpretative processes within interaction between people (Blumer, 1969:5). It can also be done by individual people during interaction with themselves. Individual people can revise or reformulate the meaning when the 'I' interacts with the 'me'. The 'I' represents the individual only, and the 'me' represents the part of the individual that forms part of the group and society and who has thus contributed to the meaning that the group and society have given to the thing under discussion (Mead, 1967:227).

When people come together and interact with one another within their society, it is aligned with symbolic interaction (Blumer, 1969:4). According to Mead's assertion (Blumer, 1969:5), individuals' attitudes start from within. People first develop an idea about something and then think thoroughly before acting. When individuals communicate with the self and interpret their experiences, this process is termed self-interaction and is important for making informed decisions. The group needs to know the intentions of others in society to be able to conform while interacting with one another (Blumer, 1969:8). For example, adolescents also participate in groups that fascinate them and they follow suit. They are part of families with members interacting with each other and are also part of larger societies who through digital media, influence their decisions. Nurses should thus interact with peer and family groups and individual adolescents to address the meanings and therefore implications of the vulnerability of adolescents for negative peer pressure and their involvement in sexual activity to meet the expectations of others.

Interesting information emerged from determining the properties and dimensions of the category of where and how the negative peer pressure vulnerability of adolescents could be addressed. It was discovered that the responsibility for addressing the negative peer pressure vulnerability should not be allocated to a single individual or group. It should be considered that taking care and raising a child (it also includes

adolescent children) is a joint responsibility and collective action within society. Societies are known to stand together, to act together for the good of the society, as a matter of principle, in fitting and merging their actions together (Blumer, 1969:71). Adolescents who are vulnerable regarding negative peer pressure, weaken the society. Their irresponsible behaviour may disrupt social interrelations in the society.

Nurses function in groups and in societies. They are members of healthcare teams and may also live in the society in which they work. In the healthcare setting they interact with adolescents, their parents or guardians and in society, with the groups that adolescents belong to. In the identification and management of the vulnerability of adolescents regarding negative peer pressure, they function as healthcare representatives and as members of society. Their intervention to identify and address their adolescents' vulnerability is therefore from a healthcare perspective as well as from a society perspective. Individuals (the adolescents), their parents and guardians and other members of society should be involved. During an intervention in which the role players are involved, symbolic interaction needs to be ensured. The same meaning should be allocated to vulnerability and negative peer pressure by all people involved. The consequences, when not addressed, also need to be clarified during interaction with the adolescents and the groups that they belong to as well as the community. Self-interaction of the adolescent with him or herself should be enhanced in order to help them decide what action would be good for them. Without such skills, adolescents would rely heavily on the opinions of others and unfortunately also when pressure is put on them to give in to behaviour just to please others. According to Mead (1967:142), the self should be developed so that the individual can develop a sense of what he or she prefers as well as what the consequences of their behaviour would be for themselves. When the self is well developed, the individual (the 'I') can decide what to do once he or she has interacted with his or her 'me' that represents the generalised other (the attitudes of the group to which the individual has contributed during interaction).

When the individual (adolescent) finds him or herself in a situation that he or she wants to react toward, they first interpret the situation, then develop a particular attitude towards it, then act according to the attitude, and leave their actions to others to decode and to react in line with the meaning that had been attached to the action (Mead, 1967:76). In the identification and management of adolescents' vulnerability

towards negative peer pressure, their interpretation of the situation and actions of others towards them need to be explored. The attitude of focusing on the self and engaging in all types of acts, open the possibility of vulnerability to adolescents. The adolescents may end up not recognising the danger of self-destructing due to their vulnerability, thus the importance of having significant others or adults becoming involved in identifying those acts; defining and interpreting them during interaction with the adolescents in order to address the negative peer pressure vulnerability (Blumer, 1966:540). Nurses should involve adolescents and work with them towards the allocation of meaning to their behaviour and measures to assist them to change their behaviour if needed, only according to the meanings that they attach to the acts.

Defining and interpreting acts (related to vulnerability and negative peer pressure) and social actions (in interaction with others) in a positive manner, amount to motivation for adolescents to resist negative pressure and to take part in positive pressure in interaction with groups and society members. They then do not only take responsibility for themselves, but also for others, including other adolescents. The same individual can be the actor and the receiver of the act, as interaction is both ways. Individuals act in ways that he or she feels others expect of them, but also determines the acts of others as others react in ways that he or she expects of them (Mead, 1967:151). Based on the complexity of risk behaviour due to the inter-linkages involved in the portrayal of risk behaviour, individual groups and society should jointly work together to provide a solution. A comprehensive approach is required to address the unique needs that may differ from situation to situation and from one adolescent to the other.

#### ***4.2.2.1 Sub-category: Identifying negative peer pressure vulnerability***

Identifying vulnerability regarding negative peer pressure emerged from the data as the first focused code linked to addressing negative peer pressure vulnerability of adolescents. The nurse participants identified the vulnerability of adolescents and acknowledged the indifferent attitude of both the nurses and adolescents towards each other, which did not help to reduce the vulnerability of adolescents regarding negative peer pressure.

Vulnerability speaks to proneness to attract danger or weakness or to relent to risky situations. Identifying risk behaviour vulnerability is significant for enabling nurses to

determine what they are dealing with, in order to make an informed decision for responding properly or taking prompt action. The adolescent participants described their vulnerability towards negative peer pressure that could lead to risk sexual behaviour. They also acknowledged that they are exposed to risk sexual behaviour at events where adolescents gather without parental supervision.

Some of the nurse participants had experience of identifying the vulnerability of adolescents during their interaction with adolescents at the health facilities. The nurse participants discovered vulnerability upon probing adolescents with relevant screening questions. During the process of identifying negative peer pressure vulnerability, the nurse participants interacted with adolescents and became aware of the challenging circumstances faced by them. The nurse participants were aware that adolescents faced multiple pressures in various forms that exposed them to risk behaviour. The risk behaviours were interlinked and one risk behaviour caused another risk behaviour. Citing from the data collected, misusing alcohol at unsupervised adolescent parties lead to unsafe sex practices with serious repercussions, such as sexually transmitted diseases and unplanned pregnancies.

A participant in theoretical sampling was asked about the issues regarding negative peer pressure risk behaviour of adolescents, and how nurses should help in addressing them. The response from the youth specialist was as follows:

*“I think the one thing will always be to remember that...the pressures that young people face are really in different forms...in other words it is not only one thing and it's so interlinked; meaning the issue on sexual level is linked to alcohol and substance abuse and is related to what is happening at the home and is related...unemployment...the guardians, parents and so on...” (TP 1)*

Nurses should thus be sensitive for a variety of factors that can indicate that their patients are vulnerable to negative peer pressure. Their parents' unemployment and the poverty that results because of unemployment can easily be overlooked. Adolescents from different backgrounds may attend the same schools and may participate in the same social events. Some of them may have parents who are very wealthy while others' parents may earn small salaries, or are unemployed. As far as new clothes and expensive technological equipment are concerned, all of them are

under the same pressure to have state-of-the-art cell phones and to wear branded clothes. Those who cannot afford it, may be tempted to accept money or gifts from older people (more often from men) in exchange for sexual favours. They enter relationships with older men and women solely for material gain (Odutolu, 2005:247; Bajaj, 2009:134). It is evident that material possessions are a driving factor for adolescents to relent to peer pressure that leads adolescents to engage in risk behaviour. There was a strong suggestion from one of the nurse participants that adolescents should be careful of doing what their friends are doing and to stop envying what their friends possess, because they do not know the origin of their peers' material possessions:

*“Another thing, when we check about risk behaviour we found that young girls are getting involved with older men. It goes back to the peer pressure, seeing their friends wearing nice clothes, having nice hair, and nice phones and then you find that at home...there is poverty. She will end up getting involved in risk behaviour wanting to get money to look like her friends. So, poverty also counts...That is why I said they should not follow the crowd. If their friends are having those cell phones and they don't know how they got those cell phones.”*  
(TP3)

A comprehensive assessment should be done of all factors that can directly or indirectly lead to the vulnerability of adolescents. Sufficient time should be spent with them to build rapport. It should take place in an environment in which the adolescents feel that they are accepted and not judged by the nurses. Healthcare services should attract adolescents as places where they feel that they can discuss their personal challenges that could be detrimental to their health. The more adolescent friendly healthcare services are, the more willing adolescents are to use it (Tylee et al., 2007:7). Although nurses claim that healthcare services are available to all members of society, the special needs of adolescents are not addressed and fewer than expected adolescents utilise the services. They cite health services that are aimed at all members of society as not always being youth friendly. Nurse participant eight explained how the current set up at their clinic affects service utilisation by the youth, because the health services are not youth friendly:

*“...because at our clinic it is difficult, we cannot separate the youth and adults...when you give health education you find that they are mixed ages there...so the adolescents cannot express themselves properly but then if we can have like youth centres and...nurses who are working there; I think we can target and educate them properly looking at their age, their needs but when we mix them like we do at our clinics, we can't reach them properly.” (NP8)*

The identification of negative peer pressure vulnerability should not be done at healthcare facilities only. Should the intervention of nurses be limited to healthcare facilities, many adolescents will not benefit from their endeavours to identify their vulnerability in order to enable them to deal with it. Healthcare should be rendered where the adolescents are, whether it is at school or at places where they socialise. In these places, adolescents experience peer pressure on an ongoing basis to take part in activities that will grant them the approval of peer groups. Much of the peer pressure is aimed at risk behaviour. When their vulnerability is addressed where the peer pressure happens, a comprehensive assessment of the situations where they feel vulnerable can be made. Nurse participant TP3 felt that healthcare should be taken to schools:

*“I think when we go and do primary healthcare services at schools that is where we are going to get them. The nurses...will educate them...they...need to speak about the risk behaviour.” (TP3)*

To identify the peer pressure vulnerability of adolescents, nurses should establish an environment that will encourage them to openly discuss their healthcare needs in general and more specifically the peer pressure to take part in the risk that they experience. The adolescent participants, however, reported that they were hesitant to speak out about their concerns because of the nurses' attitude towards them at healthcare centres. They perceived the nurses as hostile towards them and could therefore not discuss their challenges openly. Adolescent Participant 5 explained her perception of the nurses' attitude when visiting the clinic. She also highlighted that other adolescents perceive the nurses as being difficult and not approachable:

*“Some other nurses must learn how to talk to people well; like they don't have to take advantage...Even when you go to the hospital and clinic...for one to get help*

*it is very difficult...sometimes you will hear people talking while seated “this nurse is not okay...talk to that nurse because am scared of approaching her because of the way she is.” (AP5)*

When patients (in this case adolescent patients) do not feel free to talk to nurses, their vulnerability to peer pressure cannot be identified. Nurses should thus work towards creating environments that are conducive to open communication with adolescents. The developmental stage of adolescence is characterised by processes to develop an own self-image. During this stage, adolescents rely on feedback from others to reinforce their newly developed and still insecure self-image, which makes them prone to the input or pressure from others, including their peers (Birkeland et al., 2014:70)<sup>1</sup>. Nurses also form part of the ‘others’ who are in a position to influence adolescents and they should thus be sensitive not to portray negative feedback on the behaviour of their adolescent patients. Through negative feedback, they will discourage adolescents to make use of healthcare services and at the same time will make them feel insecure and more vulnerable to the pressure of their peers. When nurses treat them as valued healthcare users, they contribute to an open discussion of the healthcare needs that include the needs that they develop due to peer pressure and their vulnerability to it. A theoretically sampled participant indicated that the way the nurses communicate with adolescents is important, nurses should communicate in a positive manner to win attention of adolescents:

*“So, I think communication is a priority, the way that adults communicate with young people. It’s very important. Most of the time you will find that it is adults who kill the spirit of young people by the way we react to things that they say.” (TP2)*

The identification of peer pressure vulnerability of patients is not the sole responsibility of nurses. Members of the society which the adolescents form part of, should also take part in identifying the peer pressure vulnerability of adolescents. It, however, remains the nurses’ responsibility to educate society to fulfil this duty. A theoretically sampled participant made the following comment:

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<sup>1</sup>Bierkland, M.S., Brevik, . & Wold, B. 2014. Peer acceptance protects global self-esteem from negative effects of low closeness to parents during adolescence and early adulthood, *Journal for Youth Adolescence*, 43:70-80.



*“Like I said that it takes a village to raise a child. A village is made of different role models within communities and nurses are part of that village...I mean if you are at a community health clinic you already belong to that community. So, I think this theory...will include people who will be able to build the moral values within the community because basically we are talking about peer pressure.” (TP 2)*

#### **4.2.2.2 Sub-category: Managing negative peer pressure vulnerability**

The second sub-category is about managing negative peer pressure vulnerability. Risk behaviour tends to happen in peer group settings and is driven by peer pressure (Dumas, Ellis & Wolfe, 2012:918). Negative peer pressure vulnerability refers to the level of exposure to the susceptibility of individuals regarding what others expect from them and in this case, the expectation has a negative connotation. Adolescents tend to be very prone to peer pressure and risk behaviour vulnerability (Dumas et al., 2012:917). They need anticipatory guidance to develop the means to take responsibility for their own decisions and ultimately for their own lives. Nurses can support adolescents to resist peer pressure to risk behaviour in general and specifically to becoming sexually active due to the pressure of others. The pressures that they experience are diverse and interlinked and innovative measures must be found to address it. They should be enabled to resist the pressures although it may have a detrimental effect on their acceptance in friendship groups. One of the theoretically sampled participants described the process as follows:

*“...how do you assist them to resist...peer pressure...and how to stick to that...this will be very difficult to do.” (TP1)*

Adolescents need to be encouraged to accept that all people can make mistakes, that it sometimes happens due to peer pressure and that they can learn from their own mistakes. Peer pressure related to negative outcomes happens, and adolescents must develop mechanisms to resist it when it could have negative consequences. The youth specialist remarked that adolescents should look beyond their mistakes and downfalls in life, and find ways of change that so that they can move on with their lives:

*“While we should acknowledge that there is something like peer pressure...even if one got the best of the intention I may make a mistake; I may start using drugs for instance...work around what has happened in my life and not see this as a pit in which I have fallen and now am trapped there.” (TP1)*

Adolescents were perceived as not being hopeful for their future and they were seen as not engaging to prepare for their future prospects. Therefore, the nurse participants insisted that adolescents must be supported to look beyond their mistakes and focus on their future and ways to prepare them for their future. Adolescents should be helped to appreciate themselves and their potential to be responsible adults. The adolescents were perceived to be vulnerable to negative peer pressure and to engage in risk behaviour due to their poor self-esteem. It made them vulnerable to the influences of others. They require anticipatory guidance to develop their own self-esteem and to resist pressure from others. One theoretically sampled participant advised that adolescents should be guided as follows when they experience downfalls in life:

*“...in terms of this peer pressure...a big issue in South Africa is that our young people lack a real future orientation...they don’t see a future for themselves...So we need to start looking, not only at the peer pressure...why is this problem (no future orientation) occurring? And try and address some of the root causes of those problems...equipping our children with ways...should you experience a problem how do you work around the problem to get your life back on track again.” (TP1)*

Anticipatory guidance to manage peer pressure vulnerability cannot be limited to healthcare settings. All venues where adolescents gather and thus all adult people, namely professional and laypersons, should play a role in helping them to resist peer pressure that may lead to activities that may have negative consequences. At schools and places where they meet with their friends, the adults involved at these places can be encouraged and trained by nurses to support adolescents to resist taking part in behaviour that they may regret. Schools and recreation venues are the places where adolescents interact with their peers. These are thus also the places where they experience peer pressure that may have negative consequences. These are also the places where they should be empowered to reject peer pressure. Empowerment

cannot be limited to healthcare settings. It should be done where peer interaction takes place and where adolescents should learn to make informed decisions instead of giving in to pressure from others. The environment outside healthcare settings may be more ideal and appropriate for the empowerment of adolescents. It does not mean that empowerment should not be done at healthcare settings also. In such settings, formal programmes can be launched, while on-the-spot empowerment and formal anticipatory guidance programmes can be done at schools and recreation centres. Nurses should not wait for adolescents to access healthcare settings for primary care in order to find an opportunity to intervene. Adolescents can be invited to healthcare settings for formal programmes aimed at empowering them to resist peer pressure to develop and strengthen their own decision-making skills instead:

*“...use some of the people in the community to assist...so that the nurse starts playing the mentoring and overseeing role and then you can have more of these groups in the community but under the auspices of the nurse.” (TP1)*

Anticipatory guidance should, according to the participants, be done at different community venues such as churches and community halls. They also recommended that members from the communities should be used to guide the adolescents to resist peer pressure when it has negative consequences:

*“The setting should be the community...we should use community resources people are used to gather within their community. We can make use of churches, community halls, crèches after hours...you know whatever structures that are there within the community.” (TP2)*

Although it is recommended that nurses should take the lead in guiding adolescents, they are not the only people who should be involved. Other members of the community, such as professional people, can be involved and laypeople can be trained to equip them with the knowledge and skills to participate. A theoretically sampled participant shared her perception about who should help adolescents:

*“...I think the teachers (should be involved) they are the people who are always with the kids...I think other organisations must also help when it comes to peer pressure...most of the peer pressure happens at school and community.” (TP3)*

The adolescents who are vulnerable to negative peer pressure and risk behaviour have no hope and often do not see their future prospects. Adolescents should be equipped with relevant skills to help them develop resilience, problem-solving and decision-making skills that will teach them to look beyond their downfalls and do well with their lives.

#### **4.2.3 Category: Addressing risk behaviour vulnerability**

The category on addressing risk behaviour vulnerability was derived from two sub-categories, namely 'building capacity of adolescents', which evolved from the initial codes that talked to 'offering customised training opportunities for adolescents' and 'providing adolescents' dedicated learning spaces' and secondly the sub-category on 'creating a conducive environment for adolescent-nurse interaction' which evolved from 'strengthening positive adolescent-nurse interaction prospects' and 'providing alternative strategies to attract adolescents'. The initial codes were developed from in-vivo quotes (refer to Table 4.3).

Addressing risk behaviour vulnerability refers to being cognisant of danger and taking appropriate action to minimise the chances of engaging in risk behaviour. The adolescent participants experienced vulnerability as being susceptible to the influences from peers. It thus meant that they became susceptible to getting involved in risk behaviour that can threaten their well-being. The common risk behaviours among adolescents are often directly or indirectly linked to sexual activities. They are prone to pressure and coercion by others. The coercion does not only come from peers, but also from older people (Teten, Hall & Capaldi 2009:581). The so called 'sugar daddies' overpower adolescents to take part in risk behaviour in order to eventually have sex with them in exchange for their attention and expensive gifts.

People approach others with the intention of getting a response in return. The others are social objects that people want to interact with in a preconceived manner (Blumer, 1969:11). Long before they approach others, they already formulate in their minds the intention to interact and that intention has been influenced by the social interaction of the society that they belong to. When the respondents (in this study the adolescents who experience peer pressure) and the actors (in this study those who put pressure

on the adolescents) attach the same meaning to the actions that the adolescents hold, symbolic interaction takes place (Mead, 1967:9).

The triadic nature of the meaning of actions implies that the person to whom the action (peer pressure) is directed, should know what is expected; the person(s) who direct the action should be clear about what he or she wants the person (adolescent) to do; and the expected joined action (give in to peer pressure) should be clear (Blumer, 2004:25). Such interaction is referred to as mutual role-taking and implies that a person acts towards another person in a way that it has meaning for both of them. It is a dual process of indicating to another person how to act and of interpreting the actions of the other person. By doing that, own conduct is formed. Joint activity (of the peer group) and individual conduct (the adolescent) are formed through an ongoing interaction between them and human group life becomes a requirement for symbolic interaction (Blumer, 1969:10). In the case of peer pressure on adolescents, the receiver of the pressure originally contributed to the development of it. They contributed to the development of peer pressure as they are active members of the group. Were they not, the group would not have had the power over them that could lead to pressure to act in a specific manner.

When older men approach adolescents (male and female) to start relationships, they too do so with the expected outcome in mind of involving them in risk behaviour that may lead to own sexual pleasure. They develop skills to overpower the adolescents to make them do what they (the older men) want in the form of sexual favours, even if adolescents initially do not want to take part. Adolescents are aware of the 'sugar daddy phenomenon' and understand the meaning embedded in the name, namely that these men are willing to buy them gifts and spoil them with outings and transport, although they might not fully understand the power relation dynamics. The adolescents may be aware of the intentions behind the actions through non-symbolic interaction, but are not capable of interpreting the actions (that they will be sexually misused by the older men). They may lack the skills of symbolic interaction to interpret others' actions by giving it meaning (Blumer, 1969:11).

Adolescents are deemed vulnerable during this stage of their development because even their 'self' is still in the process of development. During this stage, they are experiencing interaction with the outside world, particularly with other people outside

their family circle. When exposed to other experiences that derail their conduct from the norms and values as expected or taught by their family, it is a challenge as they are likely to fall into risk behaviour. The 'self' develops over time through social interaction with others (Mead, 1967:136). Only once a reflexive 'self' has developed as a product of social interaction and becomes capable of perceiving the 'self' as an object to itself, a person can interpret his or her own actions, the attitudes behind the actions and thus the meaning of their own actions (Mead, 1967:137). As persons are also part of the society that determines their ability to interpret actions and to attach meaning to it, they thus develop skills to reflect on their own behaviour (Mead, 1967:138). As people (adolescents) take the attitudes (all acts start with attitudes) of others without taking it into consideration when they develop the 'self', not only their parents but also their peers may influence their interpretation of actions (the intentions of 'sugar daddies' and the pressure from peers) (Mead, 1967: 156). Possessing the self enables people (adolescents) to perceive the self, communicate with the self and act towards the self. They absorb the attitudes of others as they interact with others within the social setting (Mead, 1967:138). Their vulnerability can be caused through interaction with others and they (the adolescents) can also be supported by others to manage their vulnerability. In symbolic interactionism, the 'self' has a 'me' that represents what others expect of the 'I' of the 'self'. The 'me' is also considered as the set of attitudes of the group of which the individual is also part. The 'me' contributes to the expectations that the group has of the 'I' of the individual. The 'I' and 'me' can thus interact to explore how the 'I' should interpret the actions of the group and can also contribute to changes of the group. The individual 'I' can influence the generalised others and thus their expectation of him or her (the 'me' of the 'self') (Mead, 1967:203).

Nurses can facilitate the process to change the vulnerability of adolescents towards risk behaviour. The focus should be on enabling them not to give in and to take part in risk behaviour only because others expect them to do so. They are responsible for the actions of the 'I'. As they are also part of the generalised others (the 'me' of a person gives him the opportunity to be part of the society), they can also contribute to change in peer groups (Blumer, 1969:62). Through interaction with nurses, individual adolescents can be guided towards making their own informed decisions and by doing that, take responsibility for the actions of the 'I'. As the adolescents who interact with the nurses also represent the 'me', they are capable of changing the group that they belong to and thus work towards not putting pressure on others who are vulnerable to

take part in risk behaviour. The 'I' and the 'me' should be involved when vulnerability to risk behaviour is addressed (Mead, 1967:229).

Much as individuals who live, or work or play together tend to fit their conduct to that of the group in order to fit in and to be accepted by the group (Adesoji 2010:190), it does not mean that others have a right to influence them to expose themselves to risks. According to Blumer (1966:538), individuals need to interact, define and interpret their actions for maintaining interpersonal relationships, but also need to exercise their freedom to be different from others without prejudice.

Therefore, for adolescents to be supported and assisted to avoid or resist risk behaviour, they should be guided to identify risks and to acknowledge their vulnerability caused by a tendency to act collectively and in groups (Blumer, 1969:7). The acknowledgement should be followed by defining and interpreting the gestures that others communicate to them and that may lead to risk behaviour. To replace risk behaviour with non-risk behaviour, nurses who guide adolescents should acknowledge that all actions of people are interlinked. A new kind of joint action in the group life (of adolescents) never comes into existence apart from a background that exist (Blumer, 1969:20). In their guidance, the power that the group has on adolescents and the influence that individuals (adolescents) have in turn on the groups, need to be acknowledged. Activities in the larger community, in smaller social groups and in places where adolescents regularly meet, can be used to stimulate changes in the joint actions of adolescents (to address the 'me' factor) and to assist individual adolescents to change their behaviour on a personal level (to address the 'I' factor).

#### **4.2.3.1 Sub-category: Building capacity of adolescents**

In this study, the researcher wanted to understand the adolescents' perspective of how they would like to be supported and to explore how the nurses could support adolescents to resist peer pressure and coercion to sexual activity. The sub-category on building the capacity of adolescents emerged from in-vivo quotes. Building the capacity of adolescents is related to a process of helping them to gain knowledge on adolescent-related challenges and having to cope with peer pressure to become sexually active in order to meet the requirements of peer groups. It revolves around

empowering them with life skills in order to become self-confident. Building adolescents' skills can be done in different ways, namely through on-the-spot teaching as well as through formal programmes. When it is done in the latter manner, the learning opportunities are planned. The facilitator of learning determines the existing knowledge of the adolescents, and their readiness to take part in learning is determined. Interactive teaching and learning methodologies are preferred and adolescents want to participate in processes rather than to be passively listening to others. Learning should be reinforced by doing. Once-off teaching and learning is not recommended:

*“So, it again requires time so that you can give them the practical experience of really doing the role play...practising the skills and not only theoretically learning...it is different to apply negotiation skills and just know about it and we know that if you have done it once or twice...when the real situation comes...they will be able to apply that.” (TP1)*

The adolescents need skills and information to gain knowledge that will assist them to make informed decisions in order to avoid risk behaviour. When adolescents are adequately educated on how to promote their health, physical, social and psychological well-being, they will be cognisant of risks and the consequences thereof. Nurses should use all available platforms to offer customised education and provide dedicated spaces in healthcare services to build the capacity of adolescents to resist peer pressure and coercion through learning. In such spaces, adolescents can interact without fear that others may overhear them. Entertainment can also be mixed with health education:

*“...today we still have kids who will talk about their journeys (of edutainment) and how they were moulded by such community centres...where there is...life skills training and dealing with issues in a real way...the activities were meant to entertain and educate at the same time.” (TP2)*

Educating adolescents on the peer pressure and coercion to sexual activity provides nurses with opportunities to address their risk behaviour vulnerability. Adolescents need significant others to clarify the myths and misconceptions about their vulnerability. Should they agree that their parents can be involved in their education to



resist peer pressure when it is aimed at encouraging them to take part in risk behaviour, nurses should encourage them to talk to their parents. They should, however, always be assured that the nurses are available to educate and to support them. One of the nurse participants responded as follows:

*“It is best talking to your parent...or the professional somebody who can help both the parent and the child; because firstly the child can go to the father or mother asking for any advice or telling them whatever challenges...if the mother cannot answer appropriately...they can go for outside help...” (NP2)*

Adolescents should be made aware of the distinction between reliable and unreliable sources of information. Parents and healthcare providers (nurses) should be their preferred choice. Adolescents may find peers easy to consult with. It is important to point out to them that peers also lack information. A nurse participant concurred that adolescents preferred getting information from the parents and if they are fearful to approach them, they resort to their peers.

*“...I (adolescent) have trouble reaching out to my mother or my dad or parents...I am going to my peers, they are the ones I am going to seek advice from and obviously, I am not going to get the right advice.” (NP3)*

According to the nurse participants, health education is one of the core businesses of nursing practice. Each opportunity should be used to educate people to take care of their own health. The same applies to educating adolescents how to take care of their sexual health and thus also how to resist peer pressure to be sexually active. They should make such decisions regarding their sexual health in an informed manner. The importance of sharpening professional attitudes and communication skills was emphasised, as these are key skills required for nurses' conduct during education sessions:

*“...any kind of interaction...with...adolescents...because...we are dealing with people with different things, different perceptions, different whatever; but the core business of nursing is that we should educate.” (NP3)*

Building the capacity of adolescents to be less vulnerable can be done at healthcare services and elsewhere, for example venues where they spend a lot of time. Nurses can conduct education sessions at schools and also make themselves available for individual counselling and coaching:

*“I will see the adolescent if she is having a problem or will be able to see or give information to these kids only when we go once in the week for the school primary healthcare services. When we are there, we also need to give health education.”*  
(TP3)

The adolescent participants voiced their needs to be warned against peer pressure and the implications of giving in to peer pressure. They recognised the importance of getting information on peer pressure. A special information-sharing event for adolescents was suggested:

*“Maybe by creating an event for us young people, teenagers and to alert us about peer pressure.”* (AP7)

Technology and social media are means to build the capacity of adolescents to address their risk behaviour vulnerability. It can be used in healthcare services to educate adolescents while they wait for consultations and also in formal programmes to enable them to resist the temptation to take part in risk behaviour. It is important to have dedicated spaces in healthcare services where adolescents feel comfortable and where technology and social media are available:

*“...use technology. There are so many ways to communicate to the youth. Media can be used even in our own clinics when there is training...a group of young girls with same concerns and questions; they can come to the clinic...So and so is available to address them...time or space allocated just for adolescents.”*  
(NP2)

Dedicated spaces for adolescents ensure their privacy. They do not want to share venues with other people who may gossip about them. Once they feel that they are not treated in a way that ensures their privacy, adolescents are reluctant to take part

in endeavours to address their capacity to resist risk behaviour. One of the adolescent participants expressed her desire of having a separate waiting area for adolescents:

*“A ward (space) whereby they (nurses) put them (adolescents) in there. They must not include...like they must...not mix with others.” (AP4)*

The nurse participants agreed that specific spaces for education and entertainment are critical to address adolescents' risk behaviour vulnerability. Unfortunately, current healthcare services are not designed or built to ensure dedicated spaces for adolescents:

*“...our facilities by and large have not been developed or constructed or built in a way that is conducive for conducting youth and adolescent health activities. We are referring to elaborate models...I am not even referring to things like a chill room but just privacy for adolescents.” (TP1)*

One of the nurses suggested that the health facilities should have chill rooms where adolescents can learn through play. These rooms are comfortable areas where adolescents interact and communicate freely. They can share their 'life stories' with one another and with nurses. Their peers can give them feedback and the process can be monitored by nurses. The capacity of the peers is built, as well as that of the adolescent who shares his or her story. The importance of such spaces was emphasised:

*“...the chill room...specific for young people in the clinic settings.” (NP6)*

'Chill rooms' can be created in any building that adolescents feel free to visit. It can be at schools, churches and recreation centres. One of the theoretically sampled participants supported the use of schools for the training of adolescents and even the significant adults who were going to be involved in the capacity-building initiative for adolescents:

*“Personally, I feel anywhere in the community where there is a space where people can come together for example a school hall, or a classroom that is not utilised at that particular time, could be used.” (TP4)*

The risk behaviour of adolescents and their vulnerability to take part in such behaviour can be addressed by building their capacity to take responsibility for their own behaviour. They should be enabled to make informed decisions. Education opportunities for capacity building of adolescents in dedicated spaces in healthcare services, at schools and wherever they meet on a regular basis, should be created.

#### **4.2.3.2 Sub-category: *Creating a conducive environment for adolescent-nurse interaction***

This sub-category emerged from two initial codes, namely 'strengthening positive adolescent-nurse interaction prospects' and 'providing alternative strategies to attract adolescents'. In this study, creating a conducive environment is defined as a process of creating an environment in which nurses and adolescents can build relationships in which the pressure of peers regarding risk behaviour in general and specifically in sexual behaviour, can be addressed. In such an environment, nurses can use anticipatory guidance in assisting adolescents to resist peer pressure that is aimed at risk behaviour.

It is the responsibility of nurses to create conducive environments. They should reach out to adolescents, invite them to visit healthcare facilities, make sure that they feel welcome in the facilities, treat them with respect, and be willing to listen in a non-judgmental way to their health-related challenges.

The adolescent and nurse participants acknowledged that most adolescents, and particularly males, do not utilise health facilities as they should do. If adolescents do not come to healthcare services, it poses a challenge to interact with them and to provide the necessary guidance they require for resisting peer pressure and coercion to sexual activity. One reason for poor utilisation of health services is that some of the adolescents (both male and female) only visit the services when they are very ill. They do not feel confident to visit services for health education and other illness preventative care:

*"I think for us boys, the first thing about us, we don't like going to the clinic." (AP8)*

Male adolescents also try to prove their masculinity by pretending that they do not get ill and when they are ill, that they do not need healthcare. They believe that they will get better without healthcare as they are strong. This perception influenced male adolescents to become ignorant about healthy lifestyles. Such a situation makes it difficult for nurses to interact with them to provide anticipatory guidance. From the researcher's point of view, such incidences are missed opportunities for interacting with adolescents for education and guidance. Therefore, for nurses to reach out to them through adolescent health services, information and guidance to address risk behaviour, they should find innovative ways to attract adolescents to the healthcare services. They should also be willing to reach out to adolescents and to go to them where they congregate. Adolescent participants cited that they are found in numbers out at playgrounds. One of the adolescent participants expressed his thoughts about male perceptions and their rationale for not visiting the health facilities:

*“There is...this belief that says ‘men do not cry’...that makes us (adolescent males) to be stubborn not going to the clinic. If nurses they really want to help us; it will help to go out to the community...” (AP8)*

It is expected that nurses should be friendly to the adolescents. Being friendly to adolescents includes talking in a friendly manner and making them feel comfortable to approach nurses to discuss their healthcare challenges. The researcher reckoned that enhancing a therapeutic environment requires that the nurses should understand the emotional, social, physical, sexual need and sexuality of the adolescents. They are expected to be knowledgeable and at the same time should be able to talk to adolescents on their level as if they are adolescents themselves. They can use humour to communicate to adolescents and by doing so, create a friendly environment. Nurse Participant 5 shared an approach that worked for her towards interacting with adolescents in an attempt to enhance a therapeutic relationship:

*“I consider young people as my friends. I address them as friends when I call them. Then when they come to the clinic they say they want their friend...because I just make them feel free. I usually tell them my story so that they also tell me their story...Just be open and free.” (NP5)*

Without being prescriptive, nurses can in an anticipatory manner guide adolescents to change their behaviour. They may be the only adults that adolescents are prepared to talk to and they therefore have to work hard towards creating conducive environments for such interaction:

*“...the young people know all their rights but what about the responsibilities? ...young people don't just have the capability to see all the consequences they face. We expect the school also to play a role...they will be able to see the possible negative and positive results...so you need a nurse, an older person or a role model to open up those things for them to see the negative.” (TP1)*

The strategy of building a conducive environment to enhance adolescent-nurse relationships also requires communication. Communication is known as a two-way means of sharing information. In this study, the interaction between adolescents and nurses is a two-way communication, which involves listening to adolescents and addressing their needs in a non-judgmental and non-patronising manner. In this study, communication is envisaged as an effective means to identify various risks that the adolescents experience in their lives. Engaging in direct communication with adolescents was noted as an important strategy to maintain an environment that is conducive for interaction. The adolescent participants criticised the way nurses communicated with them, in a way that alienated the adolescents from the nurses, resulting in low utilisation of the health facilities by adolescents. The nurses acknowledged that adolescents do not appreciate being patronised about what to do and what not to do. One nurse participant suggested using focus groups and community dialogues as a communication platform with parents, adolescents and community members to identify risk behaviours and to address them jointly as a community:

*“...the next best thing would be for nurses to communicate with community members by means...having dialogues and focus group discussions so that we are able to identify needs in terms of parenting within that community.” (TP2)*

Successful communication with adolescents requires nurses to observe non-verbal communication. The adolescents' body language may display valuable messages that nurses can use to create conducive environments and to react timeously to their

needs. By being observant, the nurses would unearth implicit challenges that adolescents may not be able to communicate in a verbal manner. Nurses should observe the adolescents' body language to enable them to determine their emotional status. A nurse participant also emphasised the significance of taking non-verbal cues seriously and that it should not be overlooked:

*"How do we communicate with our children...that we can read between the lines? ...communication within a home...talking to them as a mother or just observing as a parent is very important to me? Observe your child's moments; observe...that your child reacts to you...non-verbal communication when you talk to your child." (TP2)*

Adolescent participants hinted that communication provides the opportunity for a positive relationship with adolescents. Open communication with adolescents relates to the nurses being free to talk openly to the adolescents. Having open lines of communication is required for building rapport and a good relationship between nurses and adolescents. Such rapport creates a platform for anticipatory guidance to address risk behaviour. The adolescents should be free to ask about any adolescent sexual health-related topic at any time, and the nurses should be open to respond without being judgmental. Adolescent Participant 1 aspired to being free as an adolescent to communicate with nurses without any restrictions. Thus, AP 1 reiterated the importance of the ability to express oneself at any given time.

*"By being free to adolescents. Maybe when adolescents ask something they must talk to them freely." (AP1)*

Evidence from this study revealed that the nurses should use every consultation with adolescents to create conducive environments for intervention. The researcher believes that nurses are considered as knowledgeable people in the community but if adolescents cannot relate to them and communicate with them, their knowledge is not helpful. Therefore, every clinic visit should be optimally used. An adolescent participant mentioned that nurses should advise adolescents during every visit to the clinic.

*"They can advise them every time as they come to the clinic." (AP4)*

The nurse participants indicated that through having the meetings, awareness campaigns or talking to the community, communication exchange took place. It is through such interaction that adolescents would establish a rapport with nurses. When the nurses have built a rapport, there is a possibility to address the vulnerability to adolescent risk behaviour. The nurses have an opportunity to deliver the correct information to disseminate accurate messages to the adolescents. Therefore, meetings could be an opportunity for creating adolescent-nurse interaction through which nurses could also redeem their reputation as being judgmental. Such meetings should be used to discuss specific issues that bother adolescents. Adolescent Participant 1 attested that holding meetings could be a strategy for attracting adolescents to discuss adolescent specific things that affected them.

*“By having a meeting and talking to adolescents about these things.” (AP1)*

An environment that is conducive for adolescent-nurse interaction requires that nurses should not treat their adolescent patients as if they are their children. Nurses who want to care for adolescents should be exposed to youth friendly training to sensitise them to the needs of adolescents. When nurses approach adolescent patients as if they are their own children, they may jeopardise the possibility of maintaining a conducive environment:

*“...most nurses, when they are in contact with an adolescent, they become a parent that is where they become hostile...they are thinking now of their own children...coming here looking for contraceptives...that is when the relationship get soured.” (NP7)*

In the pursuit of providing alternative strategies to attract adolescents in order to reach more adolescents, the health facility management opted for using locations outside the traditional health facility setting. There was consensus that nurses should go where adolescents converge in numbers, because they do not visit the health facilities. The identified area of convergence was the schools. The school environment was identified as the comfort zone for adolescents for discussing interesting matters. Therefore, the health facility management engaged in this joint plan of action and acted as a collective to agree and determine the suitable means to reach out to adolescents. They



collaborated to address the specific needs of adolescents and to align these with the mainstream health services to increase the prospect of adolescents-nurse interaction. The quote below attested to why adolescents should also be attended to outside the health facilities. Nurse Participant 1 supported one of the other nurse participants regarding the use of the schools for reaching out to adolescents.

*“...so why not use that educational setting for us to educate where they are most accountable. If they come here to the clinic they are most hostile themselves because they are already anticipating you to be hostile.” (NP1)*

The nurse participants were convinced that younger nurses may find it easier to create environments conducive for adolescent-nurse interaction. The adolescents also welcomed younger nurses as they believed that older nurses may find it difficult to understand them. One theoretically sampled participant advocated the use of ‘near peers’ in implementing adolescent health services, however younger nurses are not always available to provide adolescent health services:

*“A younger nurse would be ideal to provide the adolescent services because she is of that generation. She might have been there and experienced the same things as the adolescents, now she will understand better. The information that this young nurse might have the latest information and the things that are happening she is aware of.” (TP3)*

Another nurse participant remarked that older nurses also have a role to play in supporting adolescents and helping them with adolescent health issues. The adolescents also need exposure from experienced people and to learn from them. The older people should also learn about adolescent behaviour to be able to have an understanding and later interact effectively. A theoretically sampled participant explained that the experience of older nurses is valuable and they are also still learning to keep up with adolescents and their trends:

*“...the mind of a young person wonders and just because an older person is more mature, stable and more balanced they often think that...what you think is the only way that you think, they do not know that we also tap into their way of thinking; and...with technology around these days there are so many*

*things...learnt just by looking at the television you can see how global the youth behave and what they want..." (TP2)*

#### **4.2.4 Category: Optimising nurse- adolescent interaction**

The category on 'optimising nurse-adolescent interaction' emerged from two sub-categories, namely 'creating adolescent-nurse interaction' and 'building capacity of nurses'. Optimising nurse-adolescent interaction refers to improving the interaction between nurses and adolescents.

People's actions occur in relation to other people (Blumer, 1969:8). In order to enhance nurse-adolescent interaction, the perceptions of each other need to be positive. Should adolescents view nurses as judgmental towards them, they will refrain from interacting with them. On the other hand, when they view nurses as accessible and easy to approach, adolescents may feel free to interact with them. The same applies to the nurses. Should they experience adolescent patients as being respectful towards them, they may be eager to interact with them.

Interaction is required to create opportunities for the anticipatory guidance of adolescents to resist peer pressure that may lead to risk behaviour. It requires that nurses should ensure that they deliver a service that is adolescent friendly. People interpret the circumstances around them and construct their actions according to their interpretation and do not passively respond to it (Blumer, 1969:15). Healthcare environments are known to nurses and they thus feel comfortable there. Adolescents may not be comfortable in healthcare environments. They interpret healthcare environments as threatening due to previous negative experiences. People are capable of changing their attitudes that guide their actions (Blumer, 1969:16). Nurses and adolescents can change negative perceptions towards each other and work towards optimising their interaction. Nurses will, however, have to reach out to adolescents in order to anticipatorily guide them to resist peer pressure. They are bound to come up with various strategies to optimise nurse-adolescent interaction. Ongoing processes of social interaction that encourages individuals to work together and accommodate each other, are needed.

People continually follow up on how others react towards them (Mead, 1967:141). When people with whom they interact frown, they may stop talking or transform the message or even leave the situation. The way nurses react towards adolescents may either encourage them to interact with them or discourage them. In the latter case, the adolescents may develop a resistance to follow the guidance of nurses. When people find it threatening to expose themselves during interaction with others, they either adjust the message to the expectations of the others or they start limiting information about themselves (Mead, 1967:142). Under such circumstances, much is hidden from others. Open communication then no longer exists and the responsiveness of adolescents to the guidance by nurses to resist peer pressure becomes strained.

Human beings are part of societies that influence their perceptions of and behaviour towards others (Mead, 1967:227). Nurses form such societies within healthcare and are thus involved in the socialisation of others. They develop their own roles within the society and are also capable of influencing the role development of others. According to Mead (1967:253), human beings become conscious of themselves and others. The consciousness for him or herself and for other members of society is equally important for his or her own development and for the development of the organised society. Individual nurses who develop skills to guide adolescents have the opportunity to influence the larger group of nurses to follow their example. One nurse with skills in anticipatory guidance of adolescents to resist pressure to risk behaviour in general and more specifically coercion to become sexually active, can lead to the society of nurses to develop the same skills. The organisation of the self-conscious society (of nurses) is dependent upon individuals developing a joint attitude towards all members. The generalised other or the 'me' develops when the perspectives of the group becomes different from that of the individual, which is also called the 'I'. As the 'I' of the individual contributed to the development of the generalised other (the 'me'), all society members (nurses) can contribute to a positive change in attitude (towards adolescents) by the individual members. The 'I', under such circumstances, keep the 'me' in mind when he or she acts towards the other (adolescents) (Mead, 1967:254). In healthcare situations, the nurse society can thus work as a group towards optimising interaction with adolescents.

#### **4.2.4.1 Sub-category: Creating positive adolescent-nurse interaction**

The sub-category on creating adolescent-nurse interaction emanated from the following initial codes: 'creating positive adolescent-nurse interaction prospects' and 'providing alternative strategies to attract adolescents' (refer to Table 4.4).

The nurse participants defined creating positive nurse-adolescent interaction as working towards creating opportunities for nurses and adolescents to interact in a positive manner. During such interaction, adolescents can communicate their needs regarding peer pressure to be sexually active, and nurses can anticipatorily guide them regarding ways to resist such pressure. The concept of creating the nurse-adolescent interaction refers to social interaction between actors (nurses) executing acts (guiding adolescents) towards making informed decisions about sexual activities instead of giving in to pressure of others.

While adolescents are generally reluctant to attend to their health and to visit healthcare services (Dagnew, Tessema & Hiko, 2015:18), nurses often blame staff shortages as the reason why they do not spend sufficient time to build rapport with adolescents:

*"I think nurses are also experiencing some challenges where they are working...we all know that there is a shortage of nurses. So, nurses are looking at...do I have the time to sit and educate this adolescent while there is a sick child who is vomiting and needs care." (NP7)*

In this study, the participants revealed that the adolescents do not utilise healthcare services often. Some hardly ever visit healthcare services for primary care and to enhance their health. One of the reasons, according to the adolescents, is that the nurses are rude to them. The nurse participants, on the other hand, were aware of the situations in healthcare services that adolescents may interpret as not being adolescent friendly. Should healthcare services not be perceived as adolescent friendly, the nurses should not only work towards changing the situation in order to improve the use of the services by adolescents, but should also make use of venues outside the healthcare services to deliver quality care to adolescents. Schools may be settings such as these:

*“I think that schools are good settings for all the other young students...they are (there) in a comfortable setting...it is the best place to get them to talk...nurses can come and address them...or converse with them because they are in a comfortable setting.” (NP1)*

Following the interviews conducted, the researcher discovered through interaction with the nurse participants that the healthcare services management was concerned about the poor or non-attendance of adolescents, resulting in adolescent services being extended to run after hours and even on Saturdays in order to accommodate them. The adolescents still did not optimally make use of the arrangements. The adolescent service utilisation did not improve to reach the expected level. The health facility management decided to extend primary healthcare services to local high schools, as adolescents were not visiting the health facility as anticipated:

*“We agreed that we need to open the clinic after hours and during the weekend; Monday to Friday we close at 6pm and Saturday until 1pm, still we don’t get them...the service hours were extended to accommodate adolescents in school...but still the adolescents don’t come...Very few adolescents attend at the clinic. It shows that we need to go to them.” (TP3)*

This gesture by the health facility management to act collectively to improve interaction with adolescents contributed to increased nurse-adolescent interaction. In this case, the nurses and their manager collectively identified a situation and engaged in making the environment more user-friendly for adolescents. Innovative ideas need to be implemented to improve nurse-adolescent interaction. Time needs to be allocated on school rosters for nurses to interact with adolescents. It was suggested that it should be done weekly and adolescents should be given opportunities to discuss their concerns with nurses. The hope is that such situations will encourage adolescents to tell nurses about peer pressure and risk behaviour that they are exposed to:

*“Once a week, if we say then we cannot afford one (lecture) a week; it can be one a month...for the duration of a lesson that is 45 minutes...I have an experience that once you introduce yourself well to the adolescents...when they get used to you then it is a very nice place to work at with the adolescents.” (TP5)*

The adolescent participants supported suggestions that nurses should visit schools to support them to resist peer pressure and to teach them about taking responsibility for their own health and decisions regarding their sexual health:

*“If like, there were people...health people found all over and they always or maybe visit schools every month not every quarter. They should share vital information and give guidance to school children. I think it would be better for young people being informed about potential risks and consequences.” (AP7)*

Some nurse participants suggested that comprehensive primary care needs to be delivered at school settings to enhance the accessibility of such services for adolescents. When strategies to increase the utilisation of healthcare services for adolescents at clinics are not successful, nurses need to reach out to them and deliver services where they are. They indicated that it is important to provide consistent and regular services to improve nurse-adolescent interaction:

*“By being there providing services for them most of the time. I think of the time that we need to render primary health care services. We need to be there most of the time so that they can get used to us; not go there once and being away for a long time.” (TP3)*

Male adolescent participants rarely visit healthcare services as they want to portray the image of being strong. They place themselves under pressure by acting brave and being caught up in gender stereotypes such as ‘men don’t cry’, whilst suffering in silence. When they are sick with flu, common colds and other minor ailments they brave it by not visiting the clinics to prove their strength. Nurses therefore do not get the opportunity to interact or support male adolescents regarding peer pressure to be sexually active:

*“Because if I feel like I have flu, I just think it will pass. I am a strong person. There is this thing, this belief that says ‘men do not cry’...that makes us to be stubborn...not going to the clinic...if nurses they really want to help us; they will help to go out.” (AP8)*

Female adolescents tend to use healthcare services in order to get contraceptives, although it is not on a regular basis. This provides the nurses with an opportunity to work towards positive interaction with their adolescent patients. Male adolescents, on the other hand, only make use of healthcare services when they are very ill:

*“I think most of the girls they do...and the number of boys is minimal. You know with boys they just come when they are sick and for girls they have to come for family planning...” (NP2)*

The adolescents divulged that healthcare services did not offer them the privacy and confidentiality they required. They have to share waiting areas with adults who could be their parents' neighbours. They also complained that the healthcare environment was not welcoming to them and that some of the nurses were judgmental. These complaints need to be addressed in order to create positive adolescent-nurse interaction:

*“...our facilities by and large have not been developed or constructed or built in a way that is conducive for conducting adolescent health activities...I am not even referring to things like a chill room but just privacy for adolescents.” (TP1)*

The interaction between nurses and adolescents should take place in settings that the adolescents experience as comfortable and thus non-threatening: *“I think...we need to go where they are, at their comfortable space or zone” (TP3)*. Innovative strategies need to be designed to attract adolescents to anticipatory guidance sessions. There was concurrence between the adolescent and nurse participants about being creative to attract adolescents to attend adolescent-specific information sharing events. It was suggested that the nurses should work outside the healthcare services to enhance interaction between them and adolescents. They should use innovative methods to get the attention of adolescents:

*“If nurses really want to help us; it will help to go out to the community. They will really have to do kind of extracurricular activities like going to the playing field. That is where they will find lots of us.” (AP8)*

Anticipatory guidance of adolescents to resist peer pressure can be done where they socialise. When fun and health education are mixed, more adolescents may be attracted to anticipatory guidance sessions. By making use of venues where they socialise, 'comfortable environments' are created and learning how to resist peer pressure and fun activities are integrated:

*"...young people like recreational things, where you can form a group...But if you can say to them we are going to have a meeting where you can come so that we can talk. They are not going to come but then you say come we are going to have a fun day, there is going to be music...the youth will come because those are things they love...you are going to say in this fun-filled environment and 'happy environment' let us talk about what is it you think is it about peer pressure...You will be able to interact..." (NP2)*

The nurse participants asserted that some of their colleagues require training on how to approach adolescents for anticipatory guidance. Interaction with them has to be different from interaction with patients from other age groups. Adolescents want to feel respected. They are aware of their constitutional rights to healthcare in general and more specifically to sexual healthcare. When they perceive nurses to be judgmental, they may not make use of healthcare services for other reasons than illness, and valuable opportunities for health education get lost. To improve the interaction between nurses and adolescents, other communication and health education strategies are needed. Adolescents use social media technologies and prefer to be addressed in groups rather than a one-on-one basis:

*"Follow the change means follow the language and so that you are able to speak to them and even know that they do; they (adolescents) have changed, for example they are always seated in-front of TVs and they are always busy with the WhatsApp...You must know that and involve that in your talk." (TP5)*

Providing a dedicated space within healthcare services for adolescents is also a strategy to encourage them to use the services. The nurses were aware that the lack of separate spaces for adolescents contributed to the low utilisation of healthcare services by adolescents. Adolescents should not have to use the same waiting and consulting rooms as adult patients. Spaces in clinics and hospitals where they can



socialise with their peers may also help to increase the accessibility of healthcare services. A combination of education and entertainment, referred to as edutainment, may be an ideal way to improve interaction between nurses and adolescents:

*“...having the chill room...specific for young people in the clinic settings...adults here and adolescents there, so I think if they can do that...another thing is facilities like playing stations, library and so on for knowledge and entertainment.”*  
(NP 6)

A theoretically sampled participant also shared the same sentiments that adolescents should be attracted to healthcare services through programmes aimed at edutainment:

*“Like...centres where there is a lot of life skills training and a lot of dealing with issues in a real way...can overcome negative peer pressure...the activities were meant to entertain and educate at the same time.”* (TP2)

#### **4.2.4.2 Sub-category: Building capacity of nurses**

This sub-category emanated from the following initial codes: ‘stereotyping nurses’ roles’, ‘displaying contradictory attitudes’ and ‘experiencing shortage of skills’. According to the researcher, building the capacity of nurses refers to processes to facilitate learning with the aim of increasing their knowledge and skills to render adolescent specific care. According to Upvall and Leffers (2014:149), building capacity is a “process rather than single intervention that partners use over time to develop competency to achieve desired functions and goals”.

Overall communication and language used to interact with adolescents were identified by the participants as key issues that may communicate to adolescents that nurses judge them and do not respect them. When nurses and other healthcare professionals act and communicate in an authoritarian manner, it may scare adolescents and contribute to their reluctance to use healthcare:

*“Some nurses must learn how to talk to people well, like they don’t have to take advantage. Some they take advantage because they are nurses. Even when you go to the hospital and clinics...for one to get help it is very difficult. Sometimes*

*you will hear people talking...talk to that nurse because I am scared of approaching her because of the way she is.” (AP5)*

Nurses should develop skills to render non-judgmental care to adolescents. It can only be done once nurses acknowledge that they may seem to be authoritarian when they address adolescent patients in a disrespectful manner. Much emphasis should be on developing skills to interact with adolescents in such a way that they feel comfortable to discuss sensitive issues with them. Adolescent participants need to be treated like patients and not as if they are the nurses’ own children. Nurses may discourage their own adolescent children to use contraceptives, but cannot do that with their adolescent patients:

*“...most nurses when they are in contact with an adolescent...they are thinking of their own children...coming here looking for contraceptives...that is when the relationship gets sour.” (NP7)*

Nurses should be able to be substitute parents for adolescent participants who do not feel free to talk to their own parents, but cannot treat them as if they are their own children for whom they set rules, such as that they are not allowed to be sexually active. The focus in anticipatory guidance is to help adolescents to resist peer pressure to become sexually active, and needs to assist them to make informed decisions about their sexual lives. Nurses cannot forbid them to be sexually active. They can, however, help them to resist negative pressure from others. When nurses make decisions on behalf of their adolescent participants, they become judgmental when adolescents decide not to adhere to their prescriptions. In such cases, nurses judge adolescent patients who use contraceptives:

*“...if nurses can change their attitude toward adolescents and take them as clients and respect them...the more you respect them the more the more you gain respect from them and then that is when you will gain respect; they will talk to you.” (NP2)*

Nurses should show their understanding of the challenges that their adolescent patients face and should they not be able to do that, their lack of knowledge and skills need to be addressed. During in-service training, on-the-spot training and through

formal programmes, they should be made aware of the necessity to build open and honest professional relationships with adolescent patients:

*“...somebody who will not judge them...I think if they get somebody they (adolescent participants) can open up to that can help them a lot.” (NP2)*

On the other hand, nurses possess a position of authority in the community. Communities respect nurses and perceive them as knowledgeable and therefore trust them. The attitude of nurses plays a major role in the interaction between them and their patients. It can make or break the relationship. Nurse Participant TP2 highlighted the salient points about the nurses and their attitudes that are not favourable for adolescents' health services:

*“...nurses have that influence within the communities...an influence on community health and...they are more informed but...have got different personalities and attitudes. So, the first thing...is to capacitate nurses to deal with their own attitudes and their own skills in communicating with community members. Sometimes as nurses we are put into positions of power and we tend to abuse that kind of power through the way that we communicate with people. We tend to be very controlling.” (TP2)*

However, through proper introduction and good communication with adolescents, a good working relationship can be created. The nurse participants were convinced that they should be cognisant of not appearing rigid and controlling when dealing with adolescents. They should communicate with adolescents on their level in order to be effective. Adolescents are known to resent being patronised and preached at. Individuals who work with them should understand their behaviour and their interests. Adolescents were reported to admire an open and honest person who speaks freely and is approachable, so that they can openly discuss their challenges and problems with nurses. One of the theoretically sampled participants stressed the importance of setting aside judgmental attitudes when dealing with adolescents:

*“Nurses should overcome their judgmental attitudes. Nurses should be able to communicate effectively...that would make us (nurses) non-judgmental...if you open up and you become honest to an adolescent...if you communicate with*

*affection, you will receive affectionate communication from the young people.”*  
(TP2)

During data analysis, it became evident that nurses were aware of the limitations of skills regarding their interaction with adolescents. The nurse participants who were interviewed spelt out what made it difficult for the adolescents to utilise the health facilities. They cited concerns on deficiency of proper and specific training of nurses to deal with adolescents' issues and space constraints to accommodate adolescents in private and secluded areas where they would interact with others freely and confidentially. A theoretically sampled participant responded in this manner when asked about how to address the constraints in nurse-adolescent interaction:

*“They have to change their mind-set...we have to change the mind-set of the older nurses in...in-service training so that they can have new information. We need to try to update them.”* (TP3)

The unique needs of adolescents in healthcare necessitate nurses on an ongoing basis to critically review their own attitudes towards adolescents and also their skills to attend to their needs. Adolescents require primary healthcare services, as do all other people. In addition, they need guidance to improve their health and to prevent illnesses that are preventable. One such service is anticipatory guidance to assist them not to give in to peer pressure to be sexually active, but making informed decisions about their sexual lives. Adolescents do not want their problems to be communicated to others. They are adamant that information about them should be managed in a confidential manner. When they become aware of a possible information leak, they become reluctant to trust nurses. Not utilising the health facilities has greater consequences for adolescents because they will be more vulnerable to risk behaviour. Risk vulnerability is increased by adolescents' lack of knowledge and their beliefs that bad things will not happen to them. Nurses should work hard towards establishing 'adolescent friendly' healthcare services. If necessary, in-service training should be done to make them aware of the mistakes they have made in the past. One of the theoretically sampled participants attested to that fact.

*“...through training one can really help young people...nurses should understand what is happening in the country in terms of youth risk behaviour and then obviously, the need to prevent this.” (TP1)*

The integrated approach in healthcare services poses unique problems. In such an approach, all nurses attend to all patients. No specific services for adolescents are delivered. It thus happens that nurses who may not have developed a positive attitude towards adolescents, are tasked with taking care of them. In such services, the health education of adolescents towards risk behaviour, which is an important service in adolescent healthcare, does not get the needed attention of nurses. No time is allocated to that and it is only done when nurses can find the time. Adolescents have social problems that require focused health education and attention from nurses:

*“I don’t think the integrated approach is working well in our country...I understand the nurse cannot leave a sick person and attend to the adolescent who is not sick. So, more nurses need to be trained that is the first thing, and then secondly nurses that are not trained need to be sensitised to understand adolescents.” (TP4)*

While all nurses should be capable of managing the healthcare needs of adolescents, some should be encouraged to specialise in adolescent healthcare. This recommendation should be attended to in the training of pre-registration nurses as well as in the offering of postgraduate courses in advanced adolescent healthcare:

*“...we should be starting from the curriculum...a nurse that specialises in youth and adolescent health issues. So that...their work is solely to address adolescent and youth issues at a clinic level.” (TP4)*

Nursing is a caring profession and even more so should nurses who work with adolescents be passionate about their patients. Adolescents experience developmental issues that cause them to feel insecure at times. When they encounter nurses in healthcare services who they feel do not care for them, they may hide their needs regarding guidance to resist peer pressure to take part in risk behaviour. On the other hand, when they feel that nurses really understand their needs and the

challenges that they face, they may find it easy to discuss their needs openly. Adolescent Participant 6 shared her opinion about the calibre of persons who aspire to serve adolescents in the clinics:

*“...people who apply for nursing or who want to be nurses should have passion for that job because if you don’t and you are just doing it that’s where you start becoming judgmental.” (AP6)*

Nurse Participant 2 concurred with Adolescent Participant 6 that nurses should be passionate about helping others:

*“...nursing is a calling...where there is a calling there is love...if you love them (patients, and more specifically adolescent patients), they will be able to feel safe with you and they will be able to tell you what is inside them.” (NP2)*

Nurses should be enabled to engage in interactions with their adolescent patients to anticipatorily guide them towards taking responsibility for their own sexual health instead of giving in to pressure from others to be sexually active.

#### **4.2.5 Category: Enabling responsible decision making**

The category on enabling responsible decision making emerged from two sub-categories, namely ‘enhancing self-esteem development’ and ‘supporting coping strategies’. These sub-categories were derived from initial codes focusing on building the character of adolescents. These initial codes came from the adolescents and nurse participants’ in-vivo quotes.

Responsible decision making entails a process of helping individuals to make choices based on the current circumstances and conditions they find themselves in. Such choices could have positive results or negative consequences, however, if made carefully with forethought based on correct information, one stands to benefit.

Creating an enabling environment for responsible decision making is aimed at building the capacity of adolescents to become self-reliant and to gain confidence in themselves, in order to distinguish between right and wrong decisions as well as stand

firm on the choices they have made irrespective of other people's opinions. Self-reliant and confident individuals are capable of resisting pressure from others to do as others want them to do. Therefore, adolescents who have developed coping strategies and who believe in their own capabilities, may be able to resist peer pressure to engage in risk behaviour that may lead to or include sexual activities that are performed to please others. When an individual is capable of having sound judgment and making responsible choices, they become cognisant of the consequences of their actions.

The significance of the 'self', the 'I' and the 'me' plays a major role in decision making because these concepts form the foundations for the social attitudes that eventually lead to behaviour. They become significant in how an individual acts and responds toward the 'self' and others when faced by situations in society that they have to interpret and act upon. The 'I' takes centre stage of the 'self' when bound to react to other people and leads a person to thinking and deciding for him/herself regarding any action to be taken. Therefore, a person becomes fully aware of their actions. They know what they want to do in specific circumstances. While the 'I' represents what the individual does, the 'me' reflects the generalised other that the individual is also part of. When the individual has to determine how he or she will respond, it is done through the interaction between the 'I' and the 'me' of the 'self'. Whether the adolescent resists peer pressure or gives in to peer pressure depends on the interaction between 'I' and 'me' (Mead, 1934:174). Adolescents often require support in order to develop his or her 'self' and thus the ability to interact with him or herself (the 'I' and the 'me'). Through such support, responsible decision making is enabled.

Enabled through such decision-making skills, adolescents may reject behaviour that can be detrimental to their well-being. They may choose not to become involved in situations where they are challenged to take part in behaviour that they otherwise would not have considered. They may rely on themselves through an 'I' and 'me' interaction to decide how to react to peer pressure to take part in risk behaviour. Their self-esteem may develop to the extent that others do not determine how they feel about themselves. The coping skills that they develop while interacting with themselves in an 'I' and 'me' interaction, can prepare them to rely on themselves and not on others to prescribe to them what behaviour is accepted by groups within and by society itself.

Sound decision making is dependent on the development of the 'self'. When an individual has developed a 'self', he or she becomes an object to him or herself. In challenging circumstances, they find it easy to perceive themselves and be critical about themselves. It enables the individual to respond to circumstances through a process of "assessing the situation, think about it, come up with possible ways to handle it, have a picture of what a way to handle it may imply, think about how others will react and to make a decision about the way of handling it" (Blumer, 1969:62). Adolescents are in the process of developing a 'self' and thus need guidance regarding the development of the 'me'. It requires hard work and assistance of others as it is very challenging. The 'me' reflects the values of the group and society that the individual belongs to. It develops through interaction between people who set the rules for ways of interacting with the 'self' and others. The group that the individual wants to belong to, can thus influence the development of the 'me', as the 'me' is determined by the individual in interaction with the group. Should the group advocate for taking part in risk behaviour, the individual may over time internalise the attitudes of the other group members and as a result, develop a 'me' that will convince the 'I' to act accordingly. Adolescents need to be guided in anticipation that they may encounter groups of people who may put pressure on them to develop a 'me' that approves risk behaviour. When they then interact with themselves (the 'I' and the 'me' of the individual), the 'me' may convince the 'I' to act in a risky manner (Blumer, 1969:63).

Peer influence affects decision making of adolescents allied to peer groups. The silent pact in peer groups involves peer influence and association to maintain the peer relationship. That means that for an adolescent to belong to a particular peer group, they must do what the peers do and impress the group mates. Any deviation from the pact means an individual might be thrown out of the peer group for defaulting on agreed terms and conditions for belonging to the specific peer group. However, the fact that Blumer (1969:62) emphasised that a human being as "self is object to self and object to own actions", thus an individual qualifies to become the designer of his own life who can decide to behave whichever way he sees fit. Such behaviour includes defying peer influence and making choices to take responsible decisions on whether to participate in early sexual activity or not.

Blumer's assertion on enabling responsible decision is entrenched in the manner in which the individual interacts with 'self' to address things relevant to him/herself in



relation to others at any given time. People perceive things, interpret to give them meanings before deciding on action to be taken in response to the interpretation made by 'self' through the reflexive process (Blumer, 1969:63). Those people, especially adolescents, are inclined to act alone (when confident) in some instances or as a collective (when influenced by their peers). When acting alone, their decision is their sole responsibility and when they act collectively, they make a joint decision void of responsibility. However, decision making should be accompanied by responsibility irrespective of the way the decision has been made. Decision making depends on the social circumstances the adolescents find themselves in. When they are in social relationships, they tend to be influenced by the association (Blumer, 1969:10).

According to Mead (1934:158), "full development of the self" has two stages, which are characterised by the individual 'self' in relation to specific situations and the generalised 'self' in relation to the others. That means the ability of individuals to be their own person with their own decisions and readiness to belong to social groups and participate in social activities. When a person develops, they have critical stages to assert themselves in, including being capable of making decision to belong or not to belong. When an individual belongs to social groups, they are inclined to adhere to expected group norms, and when they choose not to follow these norms, they are thrown out or they dissociate with the group.

#### **4.2.5.1 Sub-category: Enhancing self-esteem**

The sub-category on enhancing self-esteem is related to encouraging adolescents to develop self-confidence to withstand peer pressure and coercion to sexual activity. In this study, it is meant to describe the strategies to assist adolescents to become self-confident and self-resilient towards peer influence to engage in risk behaviour. Some adolescents may not have developed their own 'self' and are thus dependent on others to prescribe socially acceptable behaviour to them. On their own, adolescents may find it difficult to develop self-esteem and thus need assistance and support from others, including nurses whom they consult for health-related problems. Nurses should exercise their educative role and provide guidance in anticipation that adolescents may already experience peer pressure to become involved in risk behaviour to gain acceptance of peer groups.

Adolescents are at a very critical stage of their development in all aspects of their lives. The capability of adolescents to develop emotionally and psychologically to make sound judgment, depends on the people around them. Families are important and form the first tier of people that adolescents interact with. However, at times families do not or cannot fulfil this duty. The second tier of people that has an impact in the adolescents' socialisation, is friends. When adolescents venture into other social relationships outside their home environment, they become friends with peers who may, in a positive manner, contribute to the development of the 'self' of the adolescent members. One adolescent participant described the ideal friend as one you have a healthy relationship with:

*"...they said you must choose perfect friends...the friend who will always be there you...not telling lies about you...not forcing you to do something bad." (AP2)*

Adolescents are challenged by their peers. They are all trying to develop self-esteem and challenge others in the process. Adolescents with a poorly developed 'self' and because of that a poorly developed self-esteem, are often exploited by others as it is believed that they will give in to peer pressure easily. They require more assistance from adults. Should this not be provided by parents, nurses and other reliable members of society have to intervene. Nurse Participant 7 emphasised the point of family socialisation and values during the process of grooming adolescents to become confident:

*"...I believe that you as a parent socialise your children, those children will know exactly what is expected of them and what are the values of the family..." (NP7)*

The nurse participants were of the opinion that parents should teach their adolescent children values and help them to act according to these values. When this is not done, the consequences are detrimental to the health and well-being of the adolescents. They may fall prey to other people with bad intentions such as older men and women who are interested in getting them involved in sexual activities in exchange for gifts. A nurse participant highlighted that parents should take responsibility for instilling values in their children:

*“...when it comes to values...the responsibility of the parent will be to ensure that adolescents have got positive values for the future...” (NP7)*

A nurse participant reiterated the fact that some parents were not doing well in teaching their children family or moral values. Not all homes are places where children are taught how to behave. Parents may be absent or may not have the knowledge and skills to assist their children to internalise values that can direct their behaviour and the way they respond to other people. Some parents were accused of not being involved in the development of their children:

*“Some parents...are not very involved in their children’s life and...are not going to teach their children...values and morals...that is why their children are doing as they wish and...It has to start from home...that is where the child comes from...if your parents are not going to tell the children about values and morals and if they don’t follow morals and values that they want (their children) to follow, how do they expect (the children) to do something they are not doing?” (NP9)*

Without guidance, adolescents may feel anxious about whether they can resist peer pressure to engage in risk behaviour. According to nurse participant guidelines on how to interact with others, it may assist adolescents to act and interact with peers:

*“And establish the values because the children want to know what the guidelines are; especially the adolescents like pushing back things it is because they are unsure. They want to know the guidelines...where is the boundary. If nobody is setting them they just fall into a trap.” (TP1)*

Adolescent participants agreed that guidelines help them to decide how to react towards others. They suggested that not only should their parents set limits, but that others such as significant adults in the community and guardians could also support them to develop their own decision-making skills to resist risk behaviour:

*“...I think it starts at home if parents could teach their kids while they are still young, I think that when they are growing they will make the difference; and the churches and also if the government can work with the community that would really help.” (AP6)*

In this study, enhancing self-esteem was stressed as a very important component for enabling adolescents to make responsible decisions. Adolescents with low self-esteem become vulnerable to peer pressure. Adolescents that were subjected to peer pressure portrayed having personal challenges ranging from disregarding their own value, doubting their own self-worth and explaining their negative emotions.

Some adolescents were viewed as disregarding their own value. They took part in risk behaviour as they do not appreciate their own abilities. They sought the approval of others instead of developing an own self-esteem and believing in themselves. Lacking the ability to value themselves, they became prone to negative influences from others. A nurse participant highlighted how disregarding their own value could surface in adolescents' lives:

*“...how can you love the next person if you have not started loving yourself...the more you appreciate what you have...why do you need somebody else to tell you that you are beautiful...” (NP1)*

When adolescents believe in themselves, they may not seek validation of their self-worth elsewhere. They will be satisfied with their personal attributes, who they are and what they have. Having a good self-esteem has a protective effect towards peer pressure. A nurse participant described the impact of a positive self-image to adolescents, their aspirations and what they should do to overcome the pressure of belonging:

*“They feel like if I do not look like this I will not be accepted...they have a sense of not belonging...image...is such an important thing...to love who you are...I am destined for greatness...I am all those things it builds the self-esteem.” (NP3)*

When adolescents doubt their self-worth, they become susceptible to vulnerabilities in their lives. They depend on others, particularly their friends, to validate them. When they have friends who engage in risk behaviour, their friends may put pressure on them to also engage in risk behaviour in order to get positive validation from them. The nurse participants agreed that adolescents who have a poor self-esteem are not confident to stand up and to make decisions that they prefer. However, with guidance

and support, adolescents may learn from their mistakes. A theoretically sampled participant highlighted the possible experiences in the adolescents' lives and motivation to boost them:

*"While we should now acknowledge that there is something like peer pressure especially both positive and negative and then in doing so to acknowledge that sometimes things will go wrong...make mistakes...so equipping our children (adolescents) with ways...should you experience a problem how do you work around the problem to get your life back on track again." (TP1)*

Poor self-esteem may lead to risk behaviour. Adolescents who doubt their own abilities, believe that they deserve the bad things that happen to them. They may lose their sense of self-worth when they are not taken serious by others. Two of the theoretically sampled participants concurred that adolescents needed to be supported with their life ordeals to help them move on without losing faith in themselves:

*"They will fall at one stage or another but they should learn methods of picking them up when they think nothing else matters, so that they don't look down upon themselves...and we (nurses) should teach them to acknowledge...that this (bad things) happens in life." (TP2)*

*"I may make mistakes; I may start using drugs...if I have done that or I did fall pregnant how do I work around what has happened in my life and not see this as a pit in which I have fallen and now am trapped there. I cannot get out of there and everything is just spiralling down. So, equipping our children with ways...should you experience a problem how do you work around the problem to get your life back on track again." (TP1)*

Adolescents often measure their sense of worth based on their peers' and friends' validation of their actions. They do what their friends expects them to do and then feel happy about it, irrespective of their parents' guidance. Their actions towards their peers are linked to being part of the social group and a sense of belonging against the odds of transgressing the parental rules. Friendship matters a lot to adolescents. It makes them feel that they are worth the attention that they get from their friends.

Adolescent Participant 3 described her predicament of belonging to a friendship versus deciding to stop the friendship:

*“...I cannot tell that friend that ‘No’ I don’t want to do this, because my mother doesn’t like to do this. Sometimes we love our friends too much...we love our friends...we think friends they are better than our parents.” (AP3)*

Sometimes parents may contribute to feelings of not being worthy of the love and attention of others. Parents can make derogatory comments to their adolescent children that cause them to experience negative emotions. It may have detrimental consequences for their self-esteem. Nurse Participant 3 gave an example of such negative remarks passed by parents to their children:

*“You see that is how I feel because you find instances where mothers are like ‘you are ugly...’ saying these things jokingly sometimes or playfully but somehow it builds into that young girl or young boy’s mind.” (NP3)*

Another nurse participant confirmed and concurred that negative remarks by parents or adults have a negative impact on adolescents’ self-confidence. These derogatory remarks, no matter how small they seem, may negatively impact the adolescents’ emotions. Sometimes, what the parents say cause their adolescent children to lose confidence and become what their parents condemned them to be. A nurse participant emphasised that negative remarks may plant seeds that can lead to a poor self-image:

*“ ‘You are a curse in my life.’ What does that say to the adolescent ‘I am unworthy’; I am nothing; let me continue to be nothing.” (TP2)*

#### **4.2.5.2 Sub-category: Supporting coping strategies**

The sub-category on supporting coping strategies emerged from the three initial codes, namely ‘educating adolescents on preparedness’, ‘admitting responsible sexual behaviour’ and ‘disclosing accurate health information’ (refer to Table 4.5). The adolescents understood what peer pressure was and its impact on their sexual behaviour and they outlined their expectations with regards to the inputs that nurses can make. They indicated that they need the support of nurses, but that healthcare

services are not always conducive for the health education of adolescents. They prefer settings such as schools and community halls:

*“...a hall or something like the place where we can have time to come as teenagers maybe a social worker comes and have a date and time...telling us don’t be pressurised by someone, don’t do this, don’t do that because it is wrong...” (AP3)*

Adolescents want to be given accurate health information and are prepared to use a variety of sources to get it. Being educated was commended as a way they can gain insight in peer pressure and how to resist it when it can lead to negative consequences. Being knowledgeable and having insight boost their confidence and encourage self-discovery and self-reliance. Adolescent Participant 6 stressed the importance of self-development in order to be prepared to resist peer pressure:

*“I think you need to be educated...find information not necessarily in school; but in clinics, libraries just do more research as a person. And then find yourself and stay true to yourself in order to resist peer pressure.” (AP6)*

The nurse participants believed that when adolescents have the appropriate information and have developed coping strategies, they would not allow other people to take control of them. One nurse participant highlighted the importance of teaching adolescents about their bodies, including physical make-up and physiological mechanics. She asserted that when adolescents are prepared, they would deal with those personal, sexual and physiological expectations thoughtfully:

*“...the most basic thing is that adolescents...do not really know what is happening to them...their bodies are changing...that kind of information can be used as a basis...this is going to happen...you might feel this way...you might be exposed to such things (pressure to have sex)...if you know something then you have ways to deal with it.” (NP3)*

Adolescents need to be prepared for body changes before they happen. As parents may be hesitant to address such topics with their adolescent children, nurses have the responsibility to talk to all their adolescent patients in a professional and open manner.

The preparedness for such physiological events is reliant on nurses educating adolescents to be ready when they develop sexual desires due to hormonal changes. It should not only be done with girls who start menstruating, but also with adolescent boys who may consult nurses on how to deal with it:

*“Most of the girls at 12 years of have started seeing menstruation and the hormones are raging, it is not their fault. It is the responsibility of the nurses to address that, to ensure that they don’t sent young people away when they visit the clinic but try to assist them.” (TP4)*

The second coping strategy for supporting adolescents for enabling them to make responsible decisions indicated in this study, was admitting responsible sexual behaviour. Admitting responsible sexual behaviour referred to adhering to safe practices that they might have learnt or seeking correct information before they engage in any type of sexual activity. For adolescents to embrace the support from nurses and significant others, they should be willing to disclose the relevant information or act responsibly. They should also acknowledge that they are sexually active and ready to be assisted in a responsible manner to prevent the consequences of being sexually active. They should trust that nurses and whoever are supporting, will treat them with respect and dignity.

In this study, one adolescent disclosed that sometimes adolescents become sexually active to feed their alcohol and cigarette habits. Adolescents do not depend on their parents to feed their expensive addictive behaviours. The addictive habits occurred as a result of peer pressure, and then being sexually active is linked to doing it for monetary gain to feed the addiction to substance abuse. Often, adolescents are offered money and other gifts like alcohol or cigarettes in exchange for sex. The adolescent also mentioned that adolescent girls go to the boys to feed their addictive habits in exchange for sex. Different types of risk behaviours are interlinked. It is thus important for adolescents to admit that they have been involved in risk behaviour, as different consequences may be experienced that need to be addressed appropriately. Through proper history taking, the nurses should identify the sexual practices the adolescents engage in to provide customised support. Adolescent Participant 4 attested to the development of risk behaviours due to the use of substance abuse.



*"I mean when you are drinking and smoking; you can't ask your parents to give that money...so you have to go and find boyfriends...to buy you things like that."*  
(AP4)

The nurse participants indicated that they encouraged adolescents to talk about their sexual health and provided health education in order to assist them to act in a responsible manner and make an informed decision to become sexually active.

*"Especially on sexual issues where they need to know that they are sexually active and for contraceptives...they want to know about it because they can get information from the street and it is not right for them to get information from the street...they can come to the nurses and whatever they heard from outside is not the same thing that the professional person is telling them."* (NP2)

The last coping strategy of the three strategies identified was disclosing accurate health information. Disclosing accurate health information refers to a process of divulging all the relevant information regarding a particular health topic. Consequently, enabling adolescents to be empowered to support them to make responsible choices, depended on their willingness to receive accurate health information from health practitioners or workers. In this study, most of the adolescents showed an interest in being educated in sexual health issues. Upon gaining new information, it was envisioned that they would act more responsibly.

The adolescents made several comments regarding the need for nurses to provide accurate health information. One adolescent participant emphasised that nurses should be unrestricted when addressing the adolescents and suggested that they should respond to the adolescents' information needs. They should provide adolescents with relevant health information. Adolescent Participant 1 indicated that nurses should act in an open-minded fashion towards the adolescents to enable them to disclose their health concerns in order to receive the relevant health advice:

*"By being free to adolescents. Maybe when adolescents ask something they must talk to them freely."* (AP1)

One adolescent admitted that nurses repeatedly provided them with health information wherever they met them, be it at school or at the clinics. The adolescents felt that the fact that nurses shared health information, meant that the information was important and provided with the aim of taking decisive actions to change their behaviour if needed. Adolescent Participant 3 remarked on the efforts nurses are making for disclosing health information:

*“...they are coming to school telling us about this and that even when we are coming to the clinic. They tell us...it’s wrong. You have to leave this.” (AP3)*

Adolescents welcomed receiving health education at healthcare services. They acknowledged that they need information so that they can make informed decisions. When providing individuals with what they need and have an interest in, they will assume responsibility towards it. They will then have a sense of ownership. Adolescent Participant 4 attested to that fact:

*“They can advise them every time as they come to the clinic.” (AP4)*

Nurses agreed that adolescents have a right to receive accurate health information. Adolescents need to know exactly what is happening with their bodies and the consequences thereof. Often, talking about sex and sexual health issues is not easy for some adults and more specifically the parents of adolescent children. Therefore, nurses are the only people who can bridge that information gap to provide an enabling environment for providing the correct health information about sexual reproductive health and peer pressure. Disclosing such information would help adolescents to make the right choices. Adolescents should be encouraged to know and understand their bodies. Nurse Participant 1 provided an example of information worth sharing with adolescents to enable them to be aware of their bodies and how to act responsibly towards their sexual feelings:

*“...when they feel pressured to do something...tell them that it is okay to have sexual urges...they are at that age where their hormones are...it is okay to have sexual urges and to promote that it is okay to pleasure yourself and there is nothing wrong with it...” (NP1)*

Parents and adolescent children may not be able to discuss sexual issues openly. Nurses should continue educating adolescents about sexual health.

*“Previously, people were not open and it was a taboo to talk about sex but now as we go along we know that they can talk about sex and they can talk to the nurse about this and that.” (NP2)*

The nurse participants appreciated that adolescents who are sexually active are confident enough to visit healthcare facilities for contraceptives. However, the adolescent participants were not sure about all the reproductive health services offered. Nurse Participant 3 confirmed how the adolescents communicated their desire to access accurate health information:

*“...isn’t it that they have their own perception about family planning...they are not yet sure what services are offered and how does it work...” (NP3)*

Enabling responsible decision making is the last category out the five categories developed in response to supporting adolescents to resist peer pressure. When adolescents are educated and well-informed about their development, sexual and reproductive health, rights and responsibilities and the consequences of their actions during their social interaction, they should be prepared to make responsible decisions. Nurses should be available to support and build the capacity of adolescents, their parents and significant others within the communities where adolescents reside. The nurses have a responsibility to empower adolescents and their parents to connect and work together.

#### **4.3 DESCRIPTION OF THE EMERGENT THEORY**

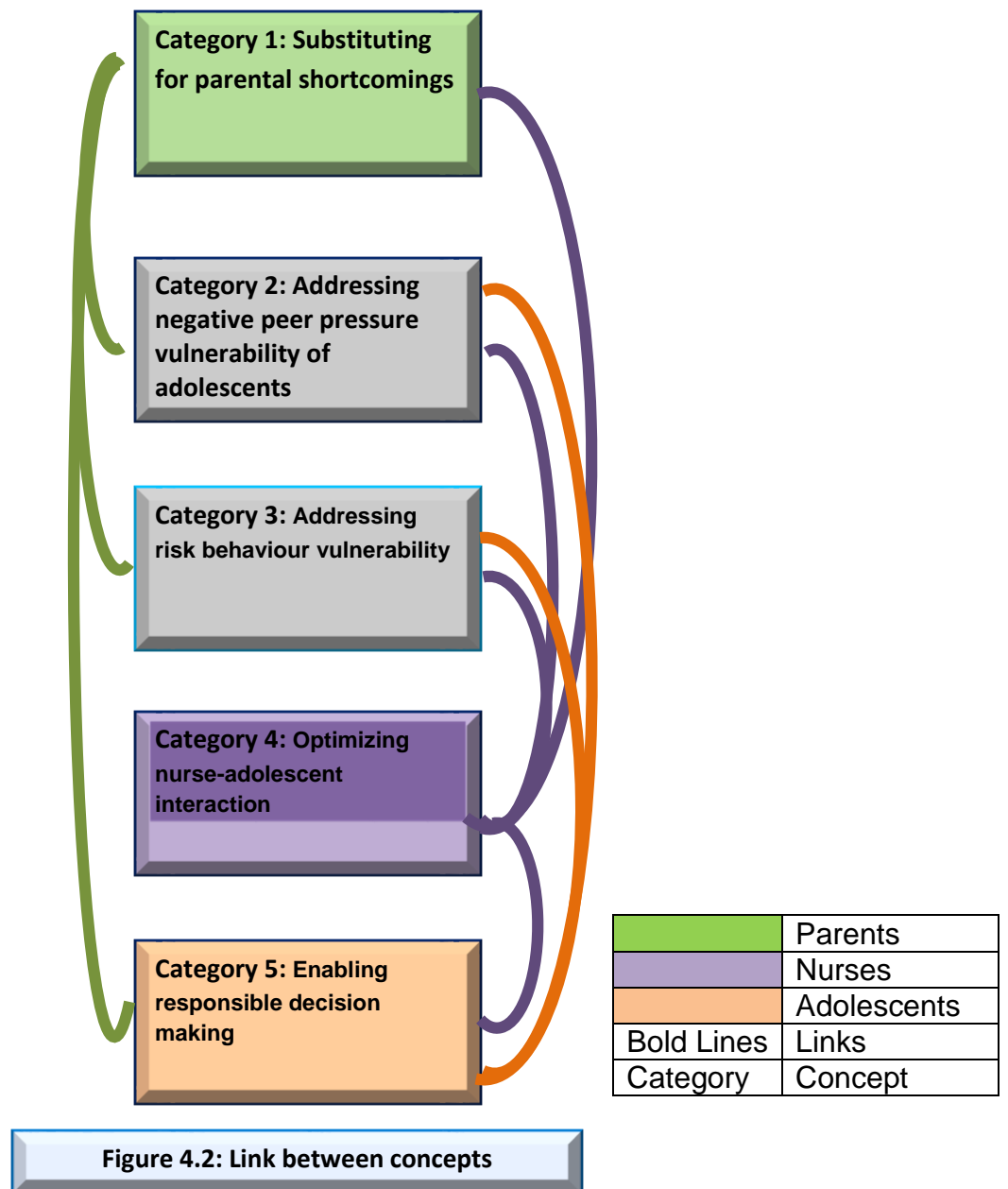
The following categories or concepts of the emergent theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity were derived from interviews with adolescent and nurse participants:

- Category 1: Substituting for parental shortcomings.
- Category 2: Addressing negative peer pressure vulnerability of adolescents.
- Category 3: Addressing risk behaviour vulnerability.
- Category 4: Optimising adolescent-nurse interaction.

- Category 5: Enabling responsible decision making.

Concepts are the building blocks of theories and are related and linked through statements that can be either directional or relational (Brink, Van der Wath & Van Rensburg, 2012:28). In this study, the statements are relational. According to Chinn and Kramer (2011:180), relational statements relate to concepts and do not indicate interactions between concepts.

The concepts directly and indirectly interlink with each other. In Diagram 4.2, bold solid lines indicate the relationships. The concepts that **are related to parents** (Categories 1, 2 & 3), **have a link to nurses** (Category 4) **and to adolescents** (Category 5).



**‘Substituting for parental shortcomings’** (Category or Concept 1) is aimed at improving parental capabilities following the acknowledgement of parental incapability identified through poor adolescent-parent communication, limited parental knowledge, lack of parental guidance and absence of positive parenting role-modelling. Evidence showed that there is a need for enabling effective parenting to assist parents and guardians to guide adolescent children efficiently and effectively to curb relying on peers. Their peers often provide them with incorrect health information that misleads them to engage in risk behaviours. Parents may not have the confidence to communicate with their adolescent children due to their own limited knowledge regarding health issues. Therefore, nurses should through anticipatory guidance empower parents and guardians to help adolescent children to be less prone to negative peer pressure and risk behaviour (refer to Figure 4.2 for the link between Concept 1 and Concepts 2 and 3). Parents should be supported to guide their children to learn from negative experiences and to use positive experiences to reinforce healthy behaviour. Empowered parents and significant others (guardians) could improve their communication with their adolescent children to guide them regarding responsible sexual behaviour.

**‘Addressing negative peer pressure vulnerability of adolescents’** (Category or Concept 2) refers to the adolescents’ vulnerability to give in to peer pressure. Once nurses manage to identify this, management strategies can be developed. Adolescents display their vulnerability to peer pressure by engaging in risk behaviour not out of own choice, but to gain acceptance by peers. At the same time, they expose themselves to getting infected with sexually transmitted infections. Out of ignorance or misplaced self-assurance, they often portray an apathy towards the risks of getting sexually transmitted infections. In anticipatory guidance, nurses should guide adolescents to establish relationships that support the development of coping skills and the building of a positive self-esteem to withstand negative peer pressure.

**‘Addressing risk behaviour vulnerability’** (Category or Concept 3) focuses on the building of the capacity of adolescents to avoid risk behaviour and the creation of a conducive environment for effective adolescent-nurse interaction. With anticipatory guidance, nurses should offer customised education/counselling/information sharing opportunities to adolescents during all interaction, whether it takes place in clinics or other community settings such as schools. All interested stakeholders within the

community like the church, schools and traditional leaders could be involved to guide adolescents to overcome risk behaviour vulnerability. A strong adolescent-nurse relationship could create sufficient opportunities for nurses to anticipatorily guide adolescents to avoid risk behaviour. Adolescents may be hesitant to visit healthcare services and thus nurses should make use of alternative strategies to attract adolescents to clinics.

**‘Optimising adolescent-nurse interaction’** (Category or Concept 4) is intended to improve the relationship between adolescents and nurses by creating positive nurse-adolescent interaction and building the capacity of nurses to become non-judgmental and to provide adolescent friendly healthcare services. Nurses are required to create opportunities for adolescents to freely access clinics without fear of prejudice. They should create interaction prospects by reaching out to adolescents where they converge in the community. Adolescent-nurse interaction should not only happen in clinics, but should also happen through awareness projects at recreation venues, churches and schools. Endeavours to optimise adolescent-nurse interaction should also include means to de-stereotype the nurses’ role as far as their responsibility regarding the health of adolescents is concerned. Mistrust should be replaced by attempts to gain the trust of adolescents who want to feel welcome at clinics as they require much support in dealing responsibly with their sexual health needs. Nurses could become facilitators of healthy behaviour by providing anticipatory guidance to adolescents. Anticipatory guidance should be tailored to address specific concerns that adolescents have, rather than telling them ‘what not to do’. If properly anticipatorily guided, the concerns of negative peer pressure and risk behaviour vulnerability will be addressed, thus enabling adolescents to identify the precursors of vulnerability in order to avoid them. Indirectly, their parents would benefit because the nurses would bridge the parenting shortcomings through supporting adolescents’ coping strategies and enhancing their self-esteem. Nurses’ interaction with adolescents could also facilitate a substituting role by adding value where there are limitations, for example instilling family values and disclosing accurate health information (refer to Figure 4.2 for the link between Concept 4 and 5). Responsible decision making relates to ways to overcome peer pressure and coercion to sexual activity.

**‘Enabling responsible decision making’** (Category or Concept 5) focuses on enabling adolescents to enhance their self-esteem and to develop coping strategies.

Nurses can enable adolescents through anticipatory guidance and can also involve other stakeholders in the community to strengthen their endeavours. It could be done through disclosing accurate health information and acknowledging their own or the adolescents' responsible behaviour regarding sexual activities.

The anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity includes the concepts described above. The concepts are focused on enabling adolescents in conducive adolescent-nurse interaction to be less vulnerable to risk behaviour, peer pressure and coercion to take part in risk behaviour and thus to take responsibility for their own sexual activity. Should it be required, nurses can substitute parents who lack the skills to guide their adolescent children towards responsible sexual behaviour.

#### **4.4 SUMMARY**

In this chapter, the description of findings that emerged from the participants' input was provided. The researcher provided the analysis based on verbatim quotes from adolescents and nurses recognising the interactive and interpretative approach of grounded theory methodology. The analysis only focused on the participants' views. A brief description of the emergent theory is provided and in the next chapter a discussion of findings and the subsequent emergent theory is provided. In line with the principles of constructivist grounded theory, literature was only consulted once the emergent theory had been described.



## **CHAPTER 5**

### **DISCUSSION OF THE FINDINGS AND THE EMERGENT THEORY**

#### **5.1 INTRODUCTION**

In Chapter 4, the findings of the study and the emergent theory were described in the form of a storyline substantiated with quotations from the interviews and with reference to symbolic interactionism as described by Blumer (1969) and Mead (1967). In this chapter, the categories and the relationships between the categories as emerging theory are discussed with extant theory and contemporary literature (Birks & Mills, 2015:130). Grounded theory research is an inductive approach that seeks to generate a theoretical contribution in order to add to existing theory. It is thus necessary to link the findings of the study with existing theory and literature (Birks et al., 2008:413).

Categories are not isolated but exist in relation to other categories. They are interdependent and are interrelated. They are built by concepts with properties that are positioned in various contexts and conditions under which the category was developed (Milliken & Schreiber, 2012:691).

#### **5.2 SUBSTITUTING FOR PARENTAL SHORTCOMINGS**

The first category that emerged following interviews with adolescent and nurse participants is on 'substituting for parenting shortcomings'. It was developed from two sub-categories, namely 'acknowledging parent incapability' and 'enabling effective parenting'. The category was discovered during the interviews from the initially sampled adolescent participants and confirmed during follow-up interviews with the nurse participants.

Adolescents interact with others and form social relationships at home, school and in the community through symbolic and non-symbolic means. Should there be parental shortcomings, others can act as substitutes. Nurses can thus be substitutes for the parents of adolescents; not to replace them, but rather to complement their parental endeavours. At times, the substitution can be aimed at rectifying mistakes and not only on complementing parenting. It can also imply that nurses could teach adolescents

the skills that their parents are not capable of teaching them. It refers to processes that nurses implement to enable parents to fulfil their responsibilities and also processes of guiding adolescents when their parents are not available or competent to do it. The parental shortcomings identified are associated with a lack of parental skills that lead to poor adolescent-parent communication and the inadequate guidance of adolescent children. Parents have misconceptions that educating their adolescent children about sex and sexuality will make them promiscuous (Kaljee, Green, Riel et al., 2007:3). A study conducted by Nkala, Khunoane, Dietrich, et al (2015,11) emphasized the importance of imparting effective parent-adolescent communication skills and SRH information to benefit adolescents and to improve their health and well-being.

As social circumstances, according to Mead (1967:142), prescribe the behaviour of people, it is appropriate for nurses to compensate for a lack of parenting (in the case of adolescent orphans) and limited parenting (in the case of parents who are available, but not capable to guide their children) in anticipatory guidance of adolescents. When the health needs of adolescents relate to the incapability of their parents, the circumstances require from nurses to render appropriate care, even when it requires from them to do 'parenting' interventions. Adolescents cannot be forced to accept the attempts of nurses to compensate for the lack of skills of their parents. A requirement is that nurses and adolescents should attach the same meaning to the intervention and both groups should accept the intentions of the other for them to interact effectively (Blumer, 1966:536).

Nurses have opportunities to interact with adolescents when they access primary healthcare as an entry point to comprehensive health services. Comprehensive screening should be conducted to detect adolescents' psychosocial needs that may signify parental shortcomings (Goldenring & Rosen, 2004:5). Upon identifying parental shortcomings while interacting with adolescents, nurses should step in and devise parenting interventions to provide consistent specific guidance to adolescents to resist peer pressure to sexual activity. Much as nurses cannot replace parents, they should play a substitute role to complement the parental role through providing anticipatory guidance to adolescents to resist peer pressure and coercion to sexual activity. Nurses are resourceful and can substitute parents who are not capable or not available to provide guidance and information to adolescent children (Mulvihill et al., 2005:95).

Sometimes, parents perpetrate certain negative behaviours in front of their adolescent children, unknowing that later their children will act it out. During interaction with such parents, nurses should warn them about the influence that it may have on their children's social adaptation to become responsible adults (Beck & Mishra, 2016:164). Through its representatives, communities can also become involved in guiding adolescents (Cooper, De Lannoy & Rule, 2015:66). Performing as substitutes to counteract parental shortcomings does not imply that nurses should become 'parents' to all the adolescents that they render care to. Through their endeavours, other members of communities could also fulfil the responsibility. Intervention programmes in communities managed by stakeholders from private and public institutions can assist nurses to empower parents and guardians to guide adolescents to avoid places where and people who can expose them to risk behaviour (Chandra-Mouli, Camacho & Michaud, 2013:518). Not all nurses can successfully substitute parental shortcomings. Some may need 'parenting training' as they may also have experienced a lack of parenting when they were adolescents (Atkinson & Peden-McAlpine, 2014:175).

### **5.2.1 Acknowledging parental incapacity**

Acknowledging parental incapacity is the first sub-category under 'substituting parental shortcomings'. It is related to recognising the parents' inability to provide the expected parental guidance. Parental guidance is essential to guide adolescents to resist risk behaviour.

Not all parents are capable or willing to discuss sexual issues with their children (Selikow, Ahmed, Flisher, Mathews & Mukoma, 2009:111). Nurses should thus not assume that all parents guide their adolescent children to resist pressure from others to become involved in sexual relationships (Chaisson & Shore, 2014:452). One of the obstacles may be poor communication. When parents and their children do not communicate openly, parents lose opportunities to share relevant sexual health information. Counselling of adolescents by their parents then do not take place and no guidance happens to enable adolescents to resist risk behaviour and peer pressure (De Vries, Hoeve, Stams & Asscher, 2016:285). Adolescents often perceive parents as authoritarian and not open for communication when they want to discuss important issues related to their well-being, health, physical and sexual development (Makofane

& Oyedemi, 2015:173). Parents have a tendency of warning their children about things that can go wrong instead of showing them that they trust them to make the right decisions, thus inhibiting open communication with their children (Kajula, Darling, Kaaya & De Vries, 2016:1471). Such actions have a negative influence on the development of the personality and personal outlook of their adolescent children (Schmiege, Feldstein Ewing, Hendershot & Bryan 2011:433). Adolescents also do not appreciate a prescriptive attitude of parents (Tilton-Weaver, Burk, Kerr & Stattin, 2013:12). Open communication and parental connection are required to cultivate a trust relationship between adolescents and parents to nurture positive behaviour (De Vries et al., 2016:291; Ying, Ma, Huang et al., 2015:7). Adolescents need their parents to guide and groom them to avoid risk behaviour (Kilanowski, 2013:165) and poor communication between parents and adolescents can limit the chances for effective information sharing on adolescent and sexual health facts (Malacane & Beckmeyer, 2016:30). Parents are not aware of the impact that poor communication with their adolescent children about sexual reproductive health has on the development of the adolescent children (Malacane & Beckmeyer, 2016:36). They need to understand the importance of engaging with their children from an early age for bonding with them throughout their psychological development and for future social competence (Ordway, Webb, Sadler & Slater, 2015:331). Adolescents who are not properly socialised may find it difficult to interact with others. Where nurses recognise parenting limitations, they should intervene to empower them to interact effectively with their adolescent children (Ford, Cheek, Culhane et al., 2016:160). Nurses should be able to identify such parents and help them to improve their parenting strategies (Ordway et al., 2015:333).

The nurse participants identified the lack of parental skills from the interaction they had with some parents during consultations. They outlined numerous explanations showing that parents had issues with their parental skills. The lack of parental skills was portrayed through the parents' evasive attitude in addressing the adolescents' concerns regarding sensitive sexual or developmental topics. As some parents accompanied their adolescent children to the health facilities, they requested that the nurses educate them on adolescent and sexual reproductive health. Some were frank and notified the nurses that they did not have the knowledge about the adolescent and sexual reproductive health information required by their children. Cultural beliefs hindered some parents to discuss sexual issues with their children. The discussion of

sexual issues is taboo in some cultures (Makofane & Oyedemi, 2015:171) and premarital sex is stigmatised (Remez et al., 2014:6). The parents, however, assumed that their adolescent children were sexually active and therefore asked the nurses to provide them with contraceptives. Following conversations with the parents of adolescents, the nurse participants concluded that some parents have limited skills to address their adolescent children's health and well-being needs, including providing them with correct sexual and reproductive health information. Coincidentally, adolescents are keen and interested in getting health and well-being information from their parents (Dittus, 2016:134). Adolescents need their parents' assistance and guidance to resist peer pressure that predisposes them to risk behaviour. They also require guidance to respond in positive ways to developmental challenges (Young & Dietrich, 2016:693). Nurses should be observant to identify those parents who did not verbalise their lack of parental skills, because without the relevant knowledge they pose a threat to the upbringing of their children (Balsells, Pastor, Molina, Fuentes-Pelaez, Vaquero & Mundet, 2013:230).

Adolescents receive inadequate parental guidance when there is no-one to talk to or guide them about family and moral values. Such adolescents may be orphaned or have a parent who does not take part in his or her upbringing (Beck & Mishra, 2016:156). In some instances, the children are left with a single parent due to the death of a parent or because the mother never married the father of the child (Franklin, Makiwane & Makusha, 2014:48). In such a situation, the children usually grow up with just one parental role model. When the parent(s) are absent in the adolescents' life, be it physically or emotionally, the adolescents miss out on parental guidance and nurturing with potential detrimental effects on their development. They may later experience problems of self-confidence and maintaining intimate relationships (Makofane & Oyedemi, 2015:161), subsequently becoming vulnerable to risk behaviour and peer pressure seeking validation and peer approval (Loos, Nostlinger, Murungi, Adipo, Amimo et al., 2013:157). The nurse participants indicated that the absence of parents or their guidance in the adolescents' life often impacts negatively on the adolescents' behaviour. Adolescents who grow up in the absence of a parent, particularly the father, miss out on his involvement in their development of mental, emotional and social well-being (McLanahan, Tach & Schneider, 2013:15). Lack of parental guidance has potentially serious negative implications for adolescent development. As more fathers than mothers abandon their families, more boys than

girls experience challenges to cope with expectations of others regarding their sexual behaviour due to the absence of male role models (Beck & Mishra, 2016:157).

Parental vigilance is another tactic that enables parental guidance to take place. Shumow and Lomax (2002:130) cited that parental monitoring is a strategy that is good for adolescent development devoid of risk behaviour. This strategy encourages parents to follow-up the whereabouts of their children to prevent them from engaging in risk behaviour (Fosco, Stormshak, Dishion & Winter, 2012:203). Parents, however, must consider the unique needs of their adolescent children as they have different challenges based on their age and gender (Cottrell, Li, Harris, D'Alessandri, Atkins, Richardson & Stanton, 2003:192).

In their endeavour to render optimal care to adolescents, nurses should comprehensively assess adolescent patients to ascertain to what extent their parents are involved in their development into adulthood (De Sanctis, Soliman, Fiscina, Eledfy, Elalaily, Yassin & Kholy, 2014:4). Adolescents require the support of responsible adults to develop into responsible adults themselves (Kristjánsson & Sigfúsdóttir, 2009:492).

### **5.2.2 Enabling effective parenting**

'Enabling effective parenting' is the second sub-category under the category 'substituting for parental shortcomings' that relates to measures required by nurses to address parenting limitations and to enable parents to provide guidance to their adolescent children. This sub-category refers to measures to be put in place by nurses to address limitations regarding parenting and to enable parents of adolescents to guide their children towards responsible behaviour that includes resistance of peer pressure to become sexually active. Parents are expected to interact and socialise with their children using age-appropriate actions.

Family structures create potentially ideal environments for effective parenting. According to Beck and Mishra (2016:156), a family is a psychological unit characterised by the caring and supporting of children to enhance their development. To fulfil this responsibility, parents require knowledge in child development and skills in guiding children to develop optimally (Chu, Bullen, Farruggia, Dittman, & Sanders,

2015:619). When such knowledge and skills are lacking, other adults, including health professionals such as nurses, should enable parents to take responsibility for their children's development. Parenting programmes should have broad strategies which include being approachable to provide adolescents with correct sexual and reproductive health information (Kalmus, Blinka & Olafsson, 2015:131) and enabling adolescents to survive psychosocial challenges associated with risk behaviour (Loos et al., 2013:158). In health facilities, nurses can enable parents and provide anticipatory guidance to adolescents to make informed decisions regarding interaction between them (Tsai, Chou, Lin & Lin, 2013:13). Not all families and not all adolescents visit health facilities often enough to provide opportunities for parenting programmes and anticipatory guidance of adolescents. Nurses thus have to intervene where parents and adolescent children are, be it at home or at other venues. Representatives from communities and NGOs are also potential sources of support for adolescents and their parents and could be trained by nurses to enable effective parenting of adolescents (Ford et al., 2016:160).

Parenting should be aimed at preparing adolescent children to positively react to the challenges of changing societies. Parenting skills that had been effective some years ago, may no longer enable adolescents to resist peer pressure to become sexually active (Ford et al., 2016:160). Sutan & Mahat (2017: 2) assert that parenting skills is a skill required to nurture children to become mature individuals who are aware and act responsibly towards sexual health risks. New challenges require new methods of support and parenting. It is thus necessary to determine exactly what knowledge and skills are to be included in parenting programmes in order to train nurses to deliver such programmes (Denno et al., 2015:S39). The value of parents' involvement in their children's development should always be emphasised (Shumow & Lomax, 2002:129). Parents who are not fully involved in their adolescent children's development need to be convinced that they can assist their children to resist peer pressure to risk behaviour (Beck & Mishra, 2016:157). Malacane and Beckmeyer (2016:35) suggest that parents should also be introduced to existing parenting resources in their communities and encouraged to use them effectively to improve their parenting tactics.

Parenting training can be conducted through well-planned formal programmes of structured sessions over scheduled periods (Chu et al., 2015:618). Should it be needed, workshops can be arranged to empower parents to interact with their children

to guide them regarding responsible sexual behaviour (Haggerty, McGlynn-Wright & Klima, 2013:2). Parenting training can also be done in a less informal way during individual consultations. Each opportunity should be optimally used to anticipatorily guide adolescents (and their parents) regarding responsible sexual behaviour (Cooper et al., 2016:61). The value of individualised nursing interventions according to the needs of the individual and his or her parents should not be underestimated (Barkin, Scheindlin, Brown, Finch & Wasserman, 2005:376). Whether the training is done formally during workshops or in a less formal way during individual sessions, such interventions can prevent adolescents from resorting to friends for information about sexual practices (De Vries et al., 2016:285). Adolescent children want their parents to be approachable and to understand the challenges that they experience (Haggerty et al., 2013:3).

It is important to conduct a pre-training assessment and situation analysis to ascertain the extent of the limitation regarding parenting skills in a community (Balsells et al., 2013:321) when formal workshops are going to be arranged (Ford et al., 2016:160). A study conducted by Salari, Ralph and Sanders (2014:47) recommend that parents should not only be trained to support their adolescent children to resist risk behaviour, but also to empower them to make informed decisions.

### **5.3 ADDRESSING NEGATIVE PEER PRESSURE VULNERABILITY OF ADOLESCENTS**

This category on 'addressing negative peer pressure vulnerability of adolescents' was developed from the sub-categories namely 'identifying negative peer pressure vulnerability' and 'managing negative peer pressure vulnerability'. This category was discovered during the initial interviews and confirmed during follow-up interviews with nurse participants.

When adolescents are influenced by negative peer pressure, they tend to engage in risk behaviour and ignore the related negative consequences. Risk behaviour includes early sexual activity, binge drinking, smoking and using illicit drugs. Positive peer pressure involves being motivated to do good things and steering away from risk behaviour. It involves being influenced to engage in positive deeds. Adolescents who are under the influence of positive peer pressure are less vulnerable and they can



make informed choices because they are aware of their vulnerability, whereas those who are vulnerable of peer pressure are ignorant of the consequences of their actions. Those who are negatively influenced have a tendency of doing what their negative friends are doing or allowing themselves to be shunted around by others to act in allegiance to the peer group (Boislard et al., 2009:266).

Vulnerability renders adolescents defenceless to peer pressure and exposes them to become easily influenced by others (refer to Chapter 4 in the same document for a description of the findings). Their emotional status and relationship with their parents influence their susceptibility to vulnerability. Nurses can detect their vulnerability and also help them to reduce it. The first step is usually to assist them to acknowledge their vulnerability towards peer pressure. Efforts to address it can be individual interventions as well as through group interventions. Adolescents, their families and the community can get involved in such nurse-initiated interventions.

In order for adolescents to resist negative peer pressure and for their parents to help them to be less vulnerable to negative peer pressure, they need to have the same understanding of what it means to cooperate as a unit. There should also be no misunderstanding between the adolescents, their parents and the nurses who guide them in an anticipatory manner about what is meant with peer pressure vulnerability, the consequences of it, and ways to manage it. Group interventions can only be successful when all people involved share the same understanding of what is expected. Human beings (adolescents, their parents and nurses) live in communities and engage in joint action through symbolic interaction (Blumer, 1969:4). The nurses and parents' actions to help adolescents to resist peer pressure are vital as they must collaborate for a common cause. People are only able to act on something if they know what it is (understand the meanings of social products) and how to manage or address it (using interpretative processes) in order to resolve it (Blumer, 1969:5). Adolescents can also undertake by themselves to overcome negative peer pressure by revising the meaning to allow the 'I' to interact with the 'me' and by doing that, work towards changing their behaviour. Therefore, adolescents' changing behaviour within their communities add value as they are part of the group and society and contributing towards making communities a better place for them to grow devoid of risk behaviour (Mead, 1967:227). Change of attitude starts from inside (Blumer, 1969:5), followed by interacting with the self and interpreting your thoughts before making a choice to act.

Therefore, the attitude to change behaviour starts with the person, they have to internalise the desire to change their behaviour, verbalise their ideas and then act accordingly. When adolescents participate in groups it sometimes becomes difficult to act in their own way as the unspoken group rules command standing together for groups to act together in order to fit in and participate in joint action (Blumer, 1969:71). When that means that people give in to peer pressure, reference is made to peer pressure vulnerability.

Nurses as community healthcare workers should be involved in identifying and managing negative peer pressure vulnerability within their communities. When nurses interact with adolescents and their parents, symbolic interaction comes into play. Nurses should attach the same meaning and understand the concepts for consultation in the same way that the community defines them to be able to help them. The nurse should be capable of making professional decisions that can benefit the adolescents and their parents. Such can be achieved when the self is developed and the nurse is ready to participate in group action to interact with others (Mead, 1967:142). Nurses, parents and the community are required to collaborate to help the adolescents to overcome negative peer pressure and create an enabling environment for adolescents to resist peer pressure into risk behaviour.

Nurses are expected to support their adolescent patients and their parents in addressing negative peer pressure vulnerability. The ability to identify risk vulnerability is important and providing skills to avoid them is also required. When poor family circumstances overwhelm parents and they become incapable of providing the proper nurturing required to build the resilience of their adolescent children to withstand negative peer pressure vulnerability, input from others such as nurses is needed. Unstable living or home conditions render adolescents vulnerable (Oza, Silverman, Bojorquez, Strathdee & Goldenberg, 2015:170) and the trauma that they get exposed to can impact negatively on their ability to interact responsibly with others. It can also lead to involvement in risk behaviour (Ahern, Kemppainen, Belk & Thacker, 2016:6) and even deviant activities with detrimental effects on their development into responsible adulthood (Rowe, Zimmer-Gembeck & Hood, 2016: 90). Their vulnerability regarding negative peer pressure needs to be identified early and managed properly to minimise the negative effect on them and their relationships with others (Oza et al., 2015:172). Addressing the occurrence of negative peer pressure

and the impact thereof on the vulnerability of adolescents requires a multi-disciplinary approach (Cooper et al., 2015:65). Parents could be assisted by stakeholders in the community and healthcare professionals to identify the vulnerability of adolescent children (Chaisson & Shore, 2014:458) and to acknowledge the impact that their own involvement in risk behaviour may have on their children. When parents take part in risk behaviour their children may perceive it as normal and it is thus difficult for them not to follow the example that is set at home. Parents can address the vulnerability of their children regarding peer pressure to take part in risk behaviour by being positive role models for them (Enebrink, Danneman, Mattsson, Ulfsdotter, Jalling & Lindberg, 2015:1919). Nurses should thus involve parents in endeavours to address the negative peer pressure vulnerability of their adolescent patients. Without the support of parents, adolescents are vulnerable to influences, such as negative peer pressure, that cause them to become involved in risk behaviour that includes irresponsible sexual activities.

### **5.3.1 Identifying negative peer pressure vulnerability**

The nurse participants became aware of negative peer pressure vulnerability of their adolescent patients during consultations with adolescents and their parents. They also acknowledged that reaching out to adolescents is challenging and that it is difficult to identify adolescent patients' vulnerability, although their patients were aware of their own behaviour that could lead to involvement in health risks, they (the nurses) did not identify their patients' negative peer pressure vulnerability.

Hurst (2008:201) asserted the difficulty in defining and identifying vulnerability. Certain age groups tend to be more vulnerable than others. Adolescents are such a group. Their vulnerability is associated with developmental tasks and impulsive actions that predispose them to danger (Wisnieki, Sieving & Garwick, 2013:33). Adolescents who engage in romantic relationships at an early age are predisposed to early sexual activity, which is sometimes forced by their peers or partners (Wisnieski, Sieving & Garwick, 2013:38). They conform to early sexual activity for the wrong reasons, as it makes them feel loved and safe (Wisnieski et al., 2013:37). Nurses require the ability to identify adolescents who are at risk of negative peer pressure vulnerability to intervene as early as possible to prevent them from experiencing the negative consequences arising from lack of knowledge. Pamoja (2005:1) supported providing

adolescents with accurate health information and proper guidance to safe-guard their well-being and interest. Educating adolescents about the dire consequences of negative peer pressure (Reddy et al., 2013:7) is paramount to raise their awareness of detrimental consequences. Warning adolescents about friends who engage in negative behaviour as they have the affinity to pull others into their negative actions (Boislard et al., 2009:266) can help them to choose right friends.

Some nurse participants identified the adolescents' exposure to negative peer pressure during consultation visits. They discovered that adolescents are challenged by pressure from peers that makes them vulnerable to risk behaviour. The risk behaviours facing adolescents are many and interlinked as risk behaviours are known to cause other risk behaviours in a continuous circle. The nurse participants recognised that their adolescent patients were exposed to misusing alcohol and illicit drugs, which lead to unsafe sexual activities that might be accompanied by STIs and unplanned pregnancy. A study by Erlandson, Nordvall, Ohman et al. (2012:48) also cited the incidence of adolescent risk behaviour like alcohol consumption leading to unprotected sex which might result in STI and unplanned pregnancy. Risk behaviors also involve having a series on sexual relationships compromising their sexual and reproductive well-being rendering SRH services planned for them ineffective.

Whenever nurses interact with adolescent patients, they should be alert to circumstances that could cause negative peer pressure vulnerability. One example is poorly functional families that cannot support adolescents through their development into responsible adults. A study conducted by Rowe et al. (2016:107) revealed that adolescents who come from dysfunctional families are more vulnerable and prone to early onset of intimate relationships. Adolescents who grow up in poverty may engage in sexual risk behaviour when they are offered gifts from partners (a form of peer pressure) (Bajaj, 2009:13).

Social networks are often used by peers to influence adolescents. They are exposed to activities that they feel obliged to take part in, in order to be accepted by others in the network. The activities are often risky as the members of the network try to get others to admire them for taking part in dangerous activities (Hunter, 2002:99). Some adolescents solicit their peers to join in experimenting with romance and sex without knowledge of what they are doing (Wisnieski et al., 2013:38). Opportunities to do

comprehensive assessments to identify facts that may directly or indirectly lead to adolescents being vulnerable for peer pressure should be used optimally (Dumas et al., 2012:925).

Interviews to identify peer pressure vulnerability of adolescents should be conducted in private venues. Adolescents want to be treated with respect. They are sensitive and need to be reassured that confidential matters would not be divulged to external parties (Chaisson & Shore, 2014:453). Reassuring adolescents about confidentiality plays a major role in improving adolescent access to health services for future utilisation. During consultations, nurses should be sensitive for signs of negative peer pressure vulnerability of their adolescent patients. Efforts should be made to identify and address the vulnerability of adolescents in order to help them to resist peer pressure that may lead to them getting involved in risk behaviour (Reddy et al., 2013:7).

According to the nurse participants, their adolescent patients were more concerned about using contraceptives to prevent pregnancies than being concerned about the possibility of getting infected with sexually transmitted infections. The adolescents did not consider themselves to be vulnerable regarding getting infected when they have sex with multiple partners. In identifying the peer pressure vulnerability of adolescent patients, nurses should also be vigilant to the possible lack of knowledge regarding the transmission of sexually transmitted infections (Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu, Labadarios, Onoya, D et al., 2014:48).

### **5.3.2 Managing negative peer pressure vulnerability**

Managing negative peer pressure vulnerability emerged as the second sub-category for 'addressing negative peer pressure vulnerability of adolescents'. It was discovered in this study that some adolescent participants perpetrated risk behaviour activities when they were in their peer groups because of peer pressure. Adolescents are exposed to risk behaviour due to their adventurous attitude linked to their developmental stage. Adolescents need support to be less vulnerable to peer pressure in order to resist risk behaviour.

Advising parents not to use punitive strategies against adolescents to manage peer pressure vulnerability is imperative, otherwise they will deter adolescents to confide in them (Kajula et al., 2016:1471). Sharing alternative ways of managing vulnerability is required to enable parents to take care and communicate better with their children to reduce their chances to engage in risk behaviour due to peer pressure. Parents need knowledge and skills to effectively deal with adolescent vulnerability. They also need to know the whereabouts of their children and guide them accordingly (Ahern et al., 2016:7). Good parenting strategies are required, as building the adolescents self-worth can shield them from being vulnerable to negative peer pressure. It will also encourage them to engage in positive enrichment activities (McAdams, Rijdsdijk, Narusyte et al., 2016:2). To facilitate shielding adolescents from negative peer pressure vulnerability, parental involvement and empowerment to execute their parenting duties and enabling communication with their adolescent children should be considered (Enebrink et al., 2015:1918). Adolescents need to be aware of negative friends and their negative influence on them. Should it be necessary, they could be encouraged to choose to associate with friends who do not take part in risk behaviour (Ahern et al., 2016:11). Parents who do not have the skills to guide their adolescent children, could be assisted by nurses in training programmes to develop such skills.

During the interviews, the nurse participants confirmed that they do not spend enough time with adolescents and that they often do not consider them to be a vulnerable group who requires more attention from them. Nurses in clinics spend far more time on the elderly and on ante- and postnatal care. The adolescent participants agreed with the nurse participants and added that they did not feel that nurses consider them to be a priority group. The adolescent participants confessed that they did not feel welcome at the clinics and therefore they rarely used the health services offered at the clinics. A need has thus been identified regarding the assessment of adolescent participants regarding peer pressure vulnerability that could be addressed with anticipatory guidance.

Efforts by nurses to address the vulnerability of adolescents regarding negative peer pressure should start with building relationships with adolescent patients that will ensure that they visit the clinic on a regular basis for SRH, health promotion, illness prevention and treatment of minor ailments including STI (Ybarra, Rosario, Saewyc & Goodenow 2016:313). The adolescents' mind-set should change for them to perceive

the health facilities as places where they can be freely welcomed to discuss their personal life challenges without prejudice (Tylee et al., 2007:3). To alleviate adolescents' vulnerability to the negative influences of peers, the healthcare services should be youth friendly to optimise service utilisation and to increase accessibility of health services (Klingberg-Allvin, Nga, Ransjo-Arvidson & Johansson, 2006:417; Tangut et al., 2015:27) especially to the male adolescents who rarely visit the health facilities (Marcell, Klein, Fischer, Allan & Kokotailo, 2002:40). Nurses can assist adolescent patients to reduce their vulnerability regarding peer pressure to take part in sexual activities (Livingstone, Testa, Windle & Bay-Cheng, 2015:155). The nurses can also involve parents in programmes to help them to address their children's vulnerability (Cottrell et al., 2003:181). Targeted intervention activities (anticipatory guidance) can be implemented in clinics, schools and other community organisations where adolescents gather. They can be helped to build their self-confidence and to ignite their potential to become capable adults (Chaisson & Shore, 2014:461). Constant parental monitoring and good interpersonal relationships between parents and adolescent children enable parents to track and know their children's whereabouts and also discourage adolescents from engaging in risk behaviour to get the approval of their peers (Enah, Vance & Moneyham, 2015:8).

Not all nurses can assist parents and their adolescent children to reduce adolescent vulnerability. Nurses may thus require training and clinics may need to be re-organised to ensure that enough time and resources are allocated to services to support adolescents to resist peer pressure to be sexually active. Instead of waiting for adolescents to get sick, nurses should offer programmes at clinics focused on illness prevention and health promotion of adolescents (Secor-Turner, Randall, Brennan, Anderson & Gross, 2014:539). Lui et al (2015:26) suggested provision of evidenced based intervention sexual reproductive health services which include education and treatment and preventative vaccination in their early teens. Programmes to train nurses to render adolescent friendly services at clinics should be implemented and attendance of nurses should be compulsory (Tylee et al., 2007:7). Denno et al. (2015:S24) recognised the need and importance of empowering nurses to become adolescent friendly to increase service utilisation.

Health facilities are not the only place where adolescents could be reached for guidance on how to manage pressure from their peers to take part in risk behaviour,

and nurses should thus not wait for adolescents to come to the health facilities. Anticipatory guidance should not be targeted for implementation at health facilities only and should be taken to schools and venues where adolescents congregate (Cooper et al., 2015:64). At schools and places for recreation, nurses, other professional people such as social workers and teachers, and even laypeople can manage the programmes. It should, however, be done in a coordinated way to ensure that the programmes are sustainable and that contradictory information is not provided (Svanemyr, Amin, Robles & Greene, 2015:S8). Nurses should create adolescent friendly environments for these programmes to be successful (Chaisson & Shore, 2014:454). However, adolescents feel more comfortable in recreational areas at school than in clinics, as there they can be who they are. It thus creates ideal venues for them to receive guidance on how to manage their vulnerability regarding negative peer pressure (Denno et al., 2015:S36). Nurses and significant adults can empower adolescents to reject peer pressure and educate them to make informed choices. Upon being properly trained, community representatives can guide adolescents to be less vulnerable to negative peer pressure (Pamoja, 2005:1). Through the training of parents of adolescents and community representatives, nurses increase the number of people who can assist adolescents to develop their self-esteem and to rely on their own judgment and not the approval of others (Enebrink et al., 2015:1923). Through the support and cooperation of nurses, formal anticipatory guidance programmes should be developed and implemented where adolescents meet to reduce their vulnerability towards peer pressure and risk behaviour (Shisana et al., 2014:141). Engaging their parents to assist adolescents to overcome their vulnerability to peer pressure may strengthen the endeavours of nurses (Svanemyr et al., 2015:S9) as parents can contribute information regarding circumstances that are unique to their children (Kristjánsson & Sigfúsdóttir, 2009:491).

#### **5.4 ADDRESSING RISK BEHAVIOUR VULNERABILITY**

The category on 'addressing risk behaviour vulnerability' was developed from the sub-categories 'building capacity of adolescents' and 'creating conducive environment for adolescent–nurse interaction'. This category emerged following the interviews the initially sampled adolescent participants and was confirmed during follow-up interviews with nurse participants. In the previous category, adolescents' vulnerability



regarding negative peer pressure was addressed. In this category, the focus is on their vulnerability regarding risk behaviour.

In this category, the focus is on how adolescents can be anticipatorily guided to resist risk behaviour by being less vulnerable to it. Risk behaviours that they are vulnerable to take part in, include irresponsible sexual relationships, illicit drug use and abusing alcohol. The latter two are often associated with irresponsible sexual behaviour. Adolescents are not only pressured by their peers to engage in risk behaviour, adults may also exploit them for their own sexual pleasure. Older men may exploit adolescents in exchange for expensive gifts. Adolescents from poor families are more prone to such exploitation than adolescents from affluent families. By virtue of their developmental stage, adolescents are vulnerable regarding risk behaviour and require guidance from responsible adults. Nurses can offer them that guidance.

Human beings interact socially with others with preconceived ideas about the interaction (Blumer, 1969:11). They get involved in social interaction knowing what they want out of it. It is thus imperative for both parties to attach meaning to their actions and the actions of others and to have a certain level of agreement about the meaning of the actions and interactions. They should attach the same symbolic meaning to their actions for successful interaction (Mead, 1967:9). Peer pressure is directed upon adolescents who are expected to understand what is required of them and they are expected to participate in the joint action (risk behaviour). Both adolescents and the people who pressure them enter into mutual role-taking because they attach meaning into the interaction they are planning to undertake. During the peer pressure process, there is interaction that encompasses joint activity and individual contact resulting from this ongoing interaction between the adolescents and their peers during symbolic interaction (Blumer, 1969:10). Adolescents are in the stage of self-development and social interaction processes mark who they will become (the 'I') and how they will realise that stage of developing a 'self' required to interact with others. During their interaction with others, adolescents may miss the meaning of some actions due to their incapability of interpreting the meanings of actions involved that may predispose them to risk behaviour (Blumer, 1969:11). Adolescents require skills to be aware of the 'self' to act accordingly and to avoid being taken advantage of by others. They will be able to take care of the 'self', then become cognisant of the action by interpreting actions of others and their intentions and then attach relevant

meanings in respect of symbolic interaction (Mead, 1967:137). The adolescents will become self-reflexive and gain self-control that will enable them to perceive the self, communicate with the self, and act toward self. Once this has been achieved, they may handle attitudes of others with ease during social interaction (Mead, 1967:138).

Adolescence are often associated with risk behaviour (Isiugo-Abanihe, Olajide, Nwokocha, Fayehum, Okunola & Akinbade, 2015:102) and it takes place as adolescents learn to establish their own identity and their roles in society. Interactions between adolescents are aimed at getting approval from others. Without such approval, they feel inferior and vulnerable. According to Baron and Bell (2015:887), adolescents plan their actions towards their peers. They anticipate specific counteraction from them. Adolescents are lured or invited to join their friends in risk behaviour to obtain affirmation of their status in the group of peers (Harrison et al., 2005:260).

Adolescents require support from adults such as their parents and nurses at clinics to develop the courage to resist risk behaviour and to take responsibility for their own actions. Parents with good relationships with their adolescent children and nurses at clinics who create adolescent friendly environments can support adolescents to reduce their vulnerability regarding risk behaviour. When adolescents develop their self-esteem and no longer depend on their peers to approve their behaviour, their vulnerability decreases (Fosco et al., 2012:203). The closer the parents get to their adolescent children, the more robust their input in guiding their children can become. A trusting relationship between parents and their adolescent children enables adolescents to learn how to resist risk behaviour (Haggerty et al., 2013:11). Good communication skills of parents with adolescent children are a requirement (Centres for Disease Control and Prevention, Department of Health and Human Services, 2009:11).

Nurses need to include parents in their endeavours to address their adolescent patients' risk behaviour vulnerability. Support from parents help adolescents to develop their self-esteem and to become less vulnerable (Rowe et al., 2016:106). Parent-nurse collaboration can be established during interaction between the parties and ways to cooperate can be developed during workshops (Wang et al., 2016:236; Malacane & Beckmeyer, 2016:32).

Safe environments for adolescents, where their vulnerability could not be exploited, should be created by organisations and community representatives that include nurses. In such situations, programmes can be presented to empower them with knowledge (Bingenheimer et al., 2015:13); to keep them away from opportunities to take part in risk behaviour (Abels & Blignaut, 2011:260); and to help them to develop healthy lifestyles (Hargreaves, Morison, Kim, Bonell, Porter, Watts, Busza, Phetla & Pronyk, 2008:118).

#### **5.4.1 Building the capacity of adolescents**

Building the capacity of adolescents entails a process of helping them to gain knowledge on adolescent-related challenges and to teach them strategies to cope in resisting risk behaviour that includes being sexually active to please others.

Knowledge and skills are fundamental in communication and social interaction with others. It helps one to manoeuvre out of challenges and speak out for oneself. Adolescents need knowledge and skills to take responsibility for their own behaviour and health. Confidence in themselves and their abilities can enable them to make informed decisions about their health and well-being (Drolet, Arcand, Durcharme & Leblanc, 2013:538). Without self-confidence, adolescents easily rely on others to guide them and therefore become involved in risk behaviour on recommendation of others. Nurses can play a vital role in providing education and training to the adolescents regarding challenging situations that predispose them to risk behaviour. Adolescents can benefit from such educational sessions particularly if they are organised in spaces where adolescents converge or where they spend most of their time (Moore, Awusabo-Asare, Madise, John-Langba & Kumi-Kyereme, 2007:15). Capacity building can happen through on-the-spot teaching at health facilities and formal structured programmes at organised venues in the community. They need to be engaged in the planning of learning opportunities so that they take ownership of their capacity building (Atkinson & Peden-McAlpine, 2014:175). It is important to determine the adolescents' existing knowledge and readiness to learn to ensure that their training is pitched at the correct level of teaching. Adolescents prefer interactive participatory learning where they are actively being involved. They can benefit from age-appropriate training with opportunities for experiential learning over a period of

time (Ford et al., 2016:158). Once-off training is less successful when behaviour needs to be changed (Chu et al., 2015:618).

On-the-spot training in clinics is done when adolescents require knowledge and skills to manage specific challenges (Ford et al., 2016:158). Without such opportunities to gain knowledge, adolescents may become so worried about these challenges that they consult their peers; with detrimental results (Malacane & Beckmeyer, 2016:35). Quality health education can enable adolescents to manage their health challenges (Kennedy, Bulu, Harris, Humphreys, Malverus & Gray, 2013:9). In such interventions, sexual reproductive health promotion needs to be attended to (Malacane & Beckmeyer, 2016:32). Clinics should function in collaboration with other community resources to optimally build the capacity of adolescents. Coordinated interventions are time and cost saving and prevent misconceptions of adolescents. Nurses should take the responsibility to manage such coordinated endeavours in the community (Kalmus et al., 2015:131). Adolescent dedicated learning spaces in clinics and in other community resources are needed where they can interact with other adolescents to develop their interpersonal skills. When they share spaces with adults in clinics, they feel uncomfortable and they shy away from interacting with others (WHO, 2012:5). Learning spaces can also be created in other settings where adolescents socialise (Mathews, Eggers, De Vries, PJ, Mason-Jones, Townsend, Aaro & De Vries, H, 2015:2). Schools and churches can also be used as adolescent dedicated learning spaces (Patton & Temmerman, 2016:S2) where they can learn from other adolescents and from adults who had been trained to do capacity building of adolescents (Dittus, 2016:133; Kennedy et al., 2013: 9). Harrison, Newell, Imrie and Hoddinott (2010:10) supported the idea of reaching adolescents by intensifying adolescent friendly programmes in schools and other areas where they converge in numbers. Should it not be possible to create spaces in clinics, schools and churches where adolescents meet for capacity building, their meetings should be scheduled on dates and times when adults do not make use of the buildings (Denno et al., 2015:S26; Jonas, Crutzen, Van den Borne, Sewpaul & Reddy, 2016:12).

#### **5.4.2 Creating conducive environments for adolescent–nurse interaction**

Creating conducive environments for adolescent-nurse interaction is related to establishing an environment in clinics that makes adolescents feel comfortable in and

developing alternative strategies to attract adolescents to use the clinics. When adolescents visit clinics, nurses get the opportunity to provide anticipatory guidance for adolescents to become less vulnerable to peer pressure and to resist risk behaviour. When nurses want adolescents to consult them at clinics, a conducive environment at clinics should be created.

The majority of adolescents (particularly the males) do not use health facilities as expected because of the organisational and structural set-up that makes them feel unwelcome and uncomfortable (Haberland & Rogow, 2015:S19). They often complain that nurses are judgmental when they enquire about sexual and reproductive health issues (Alli, Maharaj & Vawda, 2012:3). They also become embarrassed when they have to reveal health challenges caused by risk behaviour (Kennedy et al., 2013:6). When nurses treat them as if they are children and not patients who have the right to use the clinics, they rather stay away from healthcare service (Chilinda, Hourahane, Pindani, Chitsulo & Maluwa, 2014:1712). Should nurses want them to feel free to consult them at clinics, nurses must treat them with respect (Chilinda et al., 2014:1711). Having a friendly approach and extending invitations to adolescents to visit the health facilities at times that suit them can increase clinic utilisation (Kennedy et al., 2013:9). Their dignity should be respected and their privacy ensured in the clinic environment (Geary et al., 2014:4; Schriver et al., 2014:3). To maximise adolescents' reach and service utilisation, nurses require proper training in creating an environment where adolescents feel comfortable to talk about sexual matters that they themselves feel awkward about (Geary et al., 2014:6; Lawrence, Struthers and Van Hove, 2016:133).

The environment for adolescent-nurse interaction must be inviting and the nurses should work hard to build rapport with their adolescent patients (Isiugo-Abanihe et al., 2015:109). Adolescents may find nurses who appear authoritarian as judgmental and they may refrain from using clinics (Chilinda et al., 2014:1708). Adolescents feel insecure in clinics and thus over-sensitive towards the attitude of nurses. They also need constant assurance that their personal matters are treated with confidentiality and that the clinic environment is a safe space to discuss matters that they do not feel free to discuss in other venues (Geary et al., 2014:5).

In environments conducive for adolescent-nurse interaction, all opportunities for the training of adolescents should be used optimally. Training can be done on health-related issues such as life skills (Salam, Faqqah, Sajjad, Lassi, Das, Kauman & Bhutta, 2016:S24) and on health specific issues such as sexual and reproductive health (Avery & Lazdane, 2010:S64). Posters and digital media should be used to create a health-oriented environment in clinics (Kennedy et al., 2013:10). Should nurses require training to create conducive environments for interaction with and training of adolescents, such opportunities should be made available by clinic management (Tylee et al., 2007:7).

The nurse and adolescent participants appreciated venues at clinics where adolescents could meet without supervision from adults. The adolescent participants were adamant that only in such venues can they talk freely and not be concerned that friends of their parents may overhear them and tell their parents. The adolescent participants recommended that comfortable venues be established in clinics where they do not feel threatened. They also did not want to use the same waiting spaces as adults.

Nurses can use different creative platforms that are attention-grabbing to attract those adolescents who are not interested in using clinics. Education sessions can be done in the form of edutainment to make health education interesting and to attract adolescents to the clinic (Veale, Sacks-Davis, Weaver, Pedrana, Stooove & Helaard, 2015:2; Svanemyr et al., 2015:S12). Social media can be used to provide health education to adolescents who do not want to visit clinics (Ford et al., 2016:160). Using participatory and interactive methods to create opportunities to engage adolescents in teaching and learning skills to avoid risk behaviour is more effective than traditional methods that did not involve the adolescent learner (Haggerty et al., 2013:8; Haberland & Rogow, 2015:S16).

## **5.5 OPTIMISING ADOLESCENT-NURSE INTERACTION**

This category on 'optimising adolescent-nurse interaction' was developed from the sub-categories 'creating positive adolescent-nurse interaction' and 'building capacity of nurses'. Optimising adolescent-nurse interaction is related to improving the interaction and relationship between nurses and adolescents. This category was

discovered during the initial interviews with both adolescents and nurses and it was confirmed through follow-up interviews with nurses.

The way in which the nurses portray themselves towards adolescents may create opportunities for communication and interaction with adolescents. If adolescents feel respected by nurses, they interact with them. When nurses appear to be not approachable, adolescents will withdraw from nurses (Wood & Jewkes, 2006:113). When adolescents perceive nurses to be judgmental, they avoid interacting with them (Alli et al., 2012:2). For anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity, positive interaction between nurses and adolescents is required. Nurses should thus interact with adolescents in such a way that they perceive them to be open to their needs and problems (Chilinda et al., 2014:1171). The nurses should possess communication skills and portray a positive attitude towards adolescents to enhance a therapeutic relationship that is required to optimize adolescent-nurse interaction (Ramjan, 2004:496).

Interaction occurs amongst people and in relation to each other (Blumer, 1969:8). It depends on how they interpret the circumstances around them and how they construct their actions based on their perceptions. They interpret and construct such actions while responding actively based on meanings acquired (Blumer, 1969:15). The nurses feel comfortable in their healthcare territory while adolescents may not feel the same way. Some adolescents had bad experiences while visiting health facilities, thus they perceive the health environment as intimidating and they dislike visiting and interacting with nurses. However, people are capable of behaving differently and attuning their attitudes to guide their actions (Blumer, 1969:16).

Nurses come from various communities and they are part of those communities where they live and work. Therefore, they also participate in social interaction at home, work and in their communities. They establish themselves in the communities they serve and are capable of influencing adolescents to act differently. Nurses are trusted, respected and resourceful persons in the communities. They should avail themselves to their clients, particularly the adolescents, because some come from poor home environments without adult care and supervision. They can use their influence to encourage their colleagues to treat adolescents with dignity and respect and use their

skills to guide the adolescents to resist peer pressure to become sexually active (WHO, 2012:4).

Most adolescents are sensitive about their sexual health and want to keep all information about it confidential (Sychareun, 2004:162). Nurses who interact with them should therefore have the skills to interact with them in a way that makes them feel free to discuss issues that they may feel embarrassed about (Romero, Middleton, Mueller, Avallino & Hallum-Montes, 2015:493). At no stage should adolescents suspect that private information about them was shared with others (Gilbert, Rickert & Aalsma, 2014:673). Should this happen, they may never again be willing to discuss their problems with nurses or other healthcare staff (Nair, Baltag, Bose, Boschi-Pinto, Lambrechts & Mathai, 2015:291). Therefore, adolescents want nurses to be trustworthy and to always act in their best interest (WHO, 2012: 34). Even though parents may desire to know what is happening with their children, nurses should remember that they promised their adolescent patients that they will only divulge information about them with their permission (Gilbert et al., 2014:676). Instead of discussing information about the adolescents with their parents, the nurses should rather encourage good communication between adolescents and parents.

Male and female adolescents behave differently in accessing the health facilities based on the type of services they want to access (Marcell et al., 2002:39). Male adolescents want to be perceived as strong and they do not want to admit that they also require healthcare services (Pollack, 2006:193). They also tend to be more critical of nurses than female adolescents and thus do not want to interact with them (Marcell et al., 2002:41). They are even more reluctant than female clients to talk about their sexual health (Skoval, Campbell, Madanhire, Mupambireyi, Nyamukapa & Gregson, 2011:9). Nurses should take the responsibility for creating adolescent-friendly interaction with male and female adolescents in order to anticipatorily guide them to resist peer pressure and coercion to sexual activities.

### **5.5.1 Creating positive adolescent-nurse interaction**

Adolescents need to be guided towards taking informed decisions about being sexually active or not, and nurses should interact with them to supply them with the necessary information during anticipatory guidance. Should the situation arise that



adolescents need to decide to have sex or not to have sex, they should be knowledgeable enough to weigh up the pros and cons of the situation and to make informed decisions. As they often do not feel free to discuss sexual matters with their parents, nurses should create opportunities for such discussions (Abel & Fitzgerald, 2006:106).

The nurse participants were aware of the challenges that adolescents have to interact with them and they blamed the settings in clinics for not being conducive for adolescent-nurse interaction. When adolescents have to share the same space with other patients, they refrain from interacting with nurses due to shyness or fear that others can overhear them (WHO, 2012:5). With too many responsibilities, nurses tend not to spend enough time with patients to enable them to feel free to talk to them (Alli et al., 202:4) and when the setting also makes them feel unwelcome, valuable opportunities for interaction are lost (Hoopes, Chandra-Mouli, Steyn, Shilubane & Pleaner, 2015:622).

When clinic hours are extended, more time for interaction between adolescent patients and nurses is created (Synchareun, 2004:163). Adolescents function according to their own schedules and may require clinic services to be open until late at night. This may force nurses to work according to the needs of their adolescent patients when necessary, although it may mean that clinics should be kept open until late at night. Adolescents may also welcome innovative ideas to bring comprehensive health services, tailor-made for their health needs (Romero et al., 2015:489).

When dealing with adolescents, nurses should improvise strategies to keep them interested in health issues and more specifically on sexual matters and ways to resist peer pressure to sexual activities. They require a special way of interaction if one requires their attention during whatever activity is involved. However, if fun and games are engaged in, they are likely to become interested, especially if the health activities are aligned to recreational events to entice them to consistently participate (Motuma, Syre, Egata & Kenay, 2016:5).

Adolescent patients become irritated when they have to spend long periods waiting to interact with nurses at clinics. Görgens-Ekermans and Brand (2012:2282) asserted that South Africa has serious staff shortages caused by nurses leaving the country,

leading to those remaining in practice being burdened by an unmanageable high workload evident by long queues at healthcare facilities. When they interact with their adolescent patients after a long waiting period and they appear to be in a hurry and thus do not spend time with their patients to get to know them well in order to guide them towards resistance of peer pressure regarding risk behaviour, valuable opportunities are lost to guide adolescents (Nair et al., 2015:289). Enabling nurses to balance their workload and to give attention to adolescent health needs is required to increase the quality of health services for adolescents (Alli et al., 2012:5). Endeavours to involve adolescents in their own anticipatory guidance through 'edutainment', which is a "combination of entertainment and education" (Veale, Sacks-Davis, Weaver, Pedrana, Stooove, Hellard, 2015:2) can optimise adolescent-nurse interaction (Milteer & Ginsburg, 2010:e203).

Adolescents do not hesitate to terminate activities that they feel are not provided to them to their satisfaction (Aninanya, Debpuur, Awine, Williams, Hodgson & Howard, 2014:12) and nurses should thus guard against losing momentum when interacting with adolescents (McKee, Rubin, Campos & O'Sullivan, 2011:41). Feedback from adolescents about interaction with nurses should be obtained and future interaction be planned accordingly (Ozer, Adams, Orrell-Valente, Wibbelsman, Lustig, Millstein, Garber & Irwin, 2011:481). Group and individual interaction should be used to ensure that both adolescents who prefer individual sessions and adolescents who prefer group activities are accommodated (Kenya Ministry of Health, 2005:24).

Interaction between nurses and adolescents can take place in clinics and through social media (Francis, Leser, Esmont & Griffith, 2013:165). Adolescents enjoy innovative "ways of communication" (Yonker, Zan, Scirica, Jethwani & Kinane, 2015:9), therefore nurses can investigate and use these in the anticipatory guidance of adolescents towards the resistance of peer pressure (Wong, Merchant & Moreno, 2014:2). Guidance should not only happen in clinics, but in schools and other outreach and recreation facilities as well (Skoval et al., 2011:12). When digital media is used, adolescents can be reached wherever they are (Perry, Kayekjian, Braun, Cantu, Sheoran & Chung, 2012:224).

### **5.5.2 Building the capacity of nurses**

The category on building the capacity of nurses emanated from the following initial codes: 'stereotyping nurses' roles'; 'displaying contradictory attitudes' and 'experiencing shortage of skills'. For the researcher, building the capacity of nurses is related to availing learning processes to empower and skill the nurses to provide quality services in the health environment. Skills building will occur over time.

The adolescent participants felt that nurses communicated with them in a judgmental way and that nurses should be taught how to communicate with adolescents in a youth friendly way. The manner of approach and the language used matter when it comes to communication with others (Godia Olenja, Lavuss, Quinney, Hofman & Van den Broek, 2013:3). Therefore, to be respectful and non-judgmental were important components required of nurses in their interaction with adolescents (Nair et al., 2015:291). The adolescent participants did not appreciate the way the nurses approached and treated them at clinics. At times, the nurses assumed parental roles towards the adolescents and addressed them like their own children. When they did that, their adolescent patients withdrew and opportunities to guide their patients with ways to resist peer pressure to sexual activities were lost (Lince-Deroche, Hargery, Holt & Shochet, 2015:81).

Capacity building of nurses regarding interaction with adolescents is required when the goal of an optimal adolescent-nurse relationship is set. Training should include ways to show respect to adolescents and to interact effectively with them (Schriver, Meagley, Norris, Geary & Stein, 2014:4). Interacting with adolescents in non-intimidating ways when sexual matters are discussed, should be included in capacity building programmes for nurses at clinics (Secor-Turner et al., 2013:S99).

The development of good communication skills can enable nurses to interact with adolescents in non-threatening ways (Alli et al., 2012:5). Interacting in ethical ways to protect confidential information of adolescent patients should be addressed in capacity building (Görgens-Ekermans & Brands, 2012:2282).

A lack of knowledge and skills to interact effectively with adolescent patients can lead to poor quality of care (Holt, Lince, Hargey, Struthers, Nkala, McIntyre, Gray, Mnyani

& Blanchard, 2012:291). It can also affect the relationship between nurses and adolescent patients. Continuous professional development programmes for nurses who work with adolescent patients in clinics should focus on ways to enhance interaction between them and their adolescent patients (Sunnun, Adatara, Opare et al., 2016:212). Open professional relationships between nurses and adolescent patients are required for quality care (Geary et al., 2014:5). Nurses should be trained in the special needs of adolescent patients (Delaney, 2015:155) and also how to show respect for the dignity of their patients (Hoopes et al., 2015:621). Care should be taken not to alienate adolescents from clinics and as a result deprive them from opportunities receive care from nurses (Chilinda et al., 2014:1711).

## **5.6 ENABLING RESPONSIBLE DECISION MAKING**

The category on 'enabling responsible decision making' emerged from two sub-categories, namely 'enhancing self-esteem development' and 'supporting coping strategies', those sub-categories were derived from initial codes focusing on building the character of adolescents. These initial codes came from the adolescents' and nurse participants' in-vivo quotes (refer to Table 4.5). It must be noted that enabling responsible decision making is the last category out of the five categories developed in response to supporting adolescents to resist peer pressure to sexual activity.

Responsible decision making involves a process of making choices based on current circumstances and taking into consideration what the future consequences of those decisions or choices may be. Parents usually make decisions on behalf of their children, but when children reach adolescence they should be enabled to take responsibility for their own decisions. Adolescents may initially require support from adults such as parents, teachers and nurses while they develop the necessary skills regarding responsible decision making. They also need to learn to believe in their ability to make decisions by considering what the consequences of those decisions may be. Confidence in their abilities to determine what behaviour may have dire consequences, has to be developed (Moksnes & Espnes, 2013:6). They should also learn how to keep to their decisions and not to give in to what others expect from them, should it be against their decisions. Peer pressure should be resisted if it may have negative consequences (Dea & Abraham, 2000:45). Confident individuals believe in themselves, no matter what pressure is put on them. They do not need the approval

or pity of their peers. Such adolescents are not easily persuaded to please others or are not easily influenced at the expense of their health and well-being. They rely on themselves and are not dependent on the approval of others (Drolet et al., 2013:542). In this study, the boys indicated that having confidence in themselves helped them to resist peer pressure. According to Moksnes and Espnes (2013:4), adolescents with a strong self-esteem can resist pressure from others to change their behaviour.

The 'self', the 'I' and the 'me' are significant impressions in decision making. These concepts are key to forming the foundation for social attitudes that determine behaviour. They control the individual action and response to self when they have to interpret and act on a situation. The 'I' leads the 'self' to think and decide in reaction to other people. The individual becomes self-aware and has self-control in specific circumstances. In this instance, it has to do with the ability to make responsible decisions. The 'I' and 'me' of the self take centre stage in decision making. In this study, when adolescents decide to resist peer pressure or give in to peer pressure, the 'I' and the 'me' interact with the 'I' representing what the individual wants to do and the 'me' representing the generalised other that the individual or the 'I' is also part of. Adolescents need support for the development of their 'self' and to cultivate the ability of interaction between the 'I' and the 'me' to enable them to make responsible decision and right choices in life (Mead, 1967:174).

When adolescents are empowered with decision-making skills, they become enabled to reject risk behaviour. They are able to make the right choices and to reject negative peer pressure. The 'I' and 'me' interaction guides their reaction toward peer pressure to participate in sexual activity. When they have a high self-esteem, other people's feelings or actions do not matter. The 'I' and 'me' interaction in the process of interacting with the 'self', prepares and empowers the adolescents to develop self-reliance and not to depend on others to control their behaviour for acceptance or belonging to peer groups (Blumer, 1969:63).

Development of the 'self' is key for responsible decision making. When the 'self' is developed, an individual becomes the 'object to self', therefore they perceive themselves and self-critique their actions. In such situations, the individual reviews circumstances and finds ways to handle it, considers how others will react and decides the way to handle it (Blumer, 1969:62). Adolescents need support and guidance to

develop their capability to develop the 'me'. Supporting adolescents to develop the 'me' is not an easy task, and needs inter-sectoral collaboration to empower them. When adolescents have developed the 'me' they act differently and behave differently based on the community values where their 'me' of the self was developed. The self-development is dependent on interaction rules set for interacting with self and others. Adolescents choose groups they admire, based on how their 'me' is shaped by the interaction with the group. If the group is engaged in risk behaviour, it takes the individual's willingness to internalise what the group is doing and believes in and the individual uses the 'me' concept to convince the 'I' to decide what to do or not to do.

Adolescents need anticipatory guidance to be careful of others who might apply negative peer pressure that could make them vulnerable. As such, when they are vulnerable, their 'me' may convince the 'I' to act in a risky manner (Blumer, 1969:63). Adolescents are influenced by their friends with regards to decision making, because they often do things to please their peers. They have silent agreements to do what the group does. According to Blumer (1969:62), individuals are entitled to choose what they want to do and when to do it and disregard what others say or require them to do. Such actions lead to individuals abandoning the group pact and vowing to make choices based on responsible decision making. In this study, it refers to resisting peer pressure and coercion into risk behaviour and to sexual activity.

According to Blumer's statement, "enabling responsible decision making" depends on how an individual interacts with the 'self' to respond to things that matter to them in their life. Human beings can interpret what they experience and attach meaning to their experiences and decide how to react towards their experiences (Blumer, 1969:63). However, in the case of adolescents, support is needed to enable them to practise their decision-making skills. It is important to note that decision making is accompanied by responsibilities and others cannot be blamed for negative outcomes thereof (Blumer, 1969:10).

Initially, children are taught at home how to interact with others, but when they start to interact with others they become exposed to the input from others. Adolescents spend time with their peers who interact with them and who influence their interpersonal skills and thus also their ability to resist pressure from them (Ballard & Syme, 2015:1). In healthy social environments, interaction is promoted and positive social cohesion

between adolescents with the same norms and values develops with positive effect on their interpersonal skills to agree or to disagree with the behaviour of others (Diez Roux & Mair, 2010:131). Environments also have the potential to affect the individual's development either positively or negatively. An individual portrays the impression of how they were brought up (Kaur & Singh, 2013:407). Adolescents thus require an enabling environment at home and at school to learn how to interact with others and how to make decisions in a responsible manner. Should they not develop the skill of responsible decision making and they do not learn how to interact with others in a responsible manner, they become vulnerable to negative peer pressure.

Adolescents need role models of good behaviour and responsible decision-making skills to guide them towards the development of similar skills. Should it not be available, they may resort to their peers who are also not in a position to take responsibility for their behaviour. A group of peers may, without the guidance of older responsible people, determine their own rules with detrimental consequences as it may not be socially acceptable (De Vries et al., 2016:285). The members learn that some behaviour is acceptable by the peer group and that all members need to display it. No questions are asked about whether the behaviour may lead to health risks.

Nurses at clinics can assist adolescent patients to develop skills in responsible decision making and not to rely on peers to tell them what behaviour to display. It should include guidance on development of self-awareness, learning problem-solving skills and working towards good interpersonal relations (NDBE, 2011:15). Skills regarding responsible decision making that have been taught at school, need to be reinforced and new skills need to be taught (Moksnes & Espnes, 2013:2) to enable them to take responsibility for their own behaviour to become responsible adults (Ballard & Syme, 2015:3). Being responsible goes along with having the ability to make responsible decisions (Mukti, 2015:40). Parents, guardians and all other adults with whom adolescents interact should encourage and enable adolescents to learn how to make sound decisions that can enable them to resist peer pressure and coercion to sexual activity (Kerpelman, McElwain, Pittman & Baeder, 2016:119). They should know that when they are hesitant to make their own decisions, their peers may step in and make decisions on their behalf that may include decisions to take part in risk behaviour. During clinic visits, nurses can identify adolescents who need guidance in responsible decision making and make sure that their need regarding the enabling of

responsible decision making gets addressed (Ghoncheh, Kerkhof & Koot, 2014:1). The nurses can address the need themselves or make sure that the adolescent receives help from others (Chilinda et al., 2014:1710). It is important to convince adolescents that they should develop the decision-making skills required to resist peer pressure that is aimed at risk behaviour (Drolet et al., 2013:542).

Nurses can also educate the parents of adolescents to build strong relationships with their adolescent children in order to help them to develop responsible decision-making skills (Kerpelman et al., 2016:105). Not all adolescents grow up with their parents or with parents who can teach them decision-making skills (Rowe et al., 2016:107). In such instances, nurses can compensate for such challenges by being role models to their adolescent patients as far as responsible decision making is concerned (Chilinda et al., 2014:1710; Kennedy et al., 2013:7).

#### **5.6.1 Enhancing self-esteem**

The sub-category on 'enhancing self-esteem development' emerged from consolidating the following initial codes, 'substituting for limited values', 'disregarding own value', 'doubting own self-worth' and 'experiencing negative emotions'. The sub-category on enhancing self-esteem development is related to encouraging adolescents to develop self-confidence to withstand peer pressure and coercion to sexual activity.

Through enhancing the self-esteem of adolescents, they are empowered to become self-confident and self-resilient to withstand the pressures to engage in risk behaviour. Although adolescents differ and mature at a different pace, the development of their personal identity is usually still lagging. Veenstra et al. (2013:408) indicated that adolescents who are experiencing the same emotions tend to befriend each other, start to behave and act in the same manner and may expose each other to peer influences with positive or negative effects (Helfert & Warschburger, 2013:8). Friendships are formed because of affinity (Manango, Ward & Aldana, 2015:20). The more they associate with friends with negative influences on them, the easier they get involved with risk behaviour (Bingenheimer et al., 2015:12). They become like their friends and do not develop their own opinions (Ballard & Syme., 2015:2). Adolescents should guard against an over-dependency on their peers and rather work towards the



development of their own self-esteem to protect themselves from negative influences by peers (Mathys, Burk & Cillessen, 2013:521). They should also develop skills to differentiate between negative and positive influences of peers. Decisions need to be made to associate with peers with positive influences on their self-esteem and to avoid peers with negative influences on their self-esteem (Kabiru, Beguy, Undie, Zulu & Ezeh, 2010:469).

Adolescents with a low self-esteem tend to get into trouble when they try and prove something that they are not (De Vries et al., 2016:284); forced to prove romantic affection from the female side (Hoffman, O'Sullivan, Harrison & Dolezal, 2006:52) to please their peers. Nurses should be vigilant to identify adolescents that have a low self-esteem in order to help them overcome it by building their confidence (Orth & Robins, 2014:386) and helping them to avoid peers who may counteract their attempts to develop their own decision making skills (Cottrell et al., 2003:192; Kajula et al., 2016:1469). Adolescents may honour their peer and friendship connections to the extent that they rely on others to make decisions on their behalf (Veenstra et al., 2013:407) to belong to the group and to please their peers and friends (Drolet et al., 2013:538). Making their own decisions may mean that they are rejected by the peer group (Drolet et al., 2013:548).

Enhancing the self-esteem development of adolescents relies on good interpersonal relationships with parents and other significant adults. When they are humiliated by others, adolescents tend not to develop good relationships with their parents and other significant adults (Weymouth & Buehler, 2016:713). Derogatory remarks from adults may affect their relationship with adolescents (Weymouth & Buehler, 2016:726) and also plant seeds of poor self-image within adolescents (Herres & Kobak, 2015:334). They deserve to be reassured that they are worthy of positive life experiences (O'Dea & Abraham, 2000:55). Anything befalling them is a lesson to strengthen their life experiences.

When adolescents grow up without guidance regarding the development of their own value system due to the absence of parents or due to parents who are poor role models, family members or community representatives can become their role models (Kajula et al., 2016:1469). Sufficient time needs to be spent with adolescents to transmit values to them (Aronowitz & Eche, 2013:283) to enable them to resist

pressure from others to comply with expectations that are against their value system. Even when material goods are offered to convince them to take part in behaviour that is against their value system, they will be able to resist it (Choudry, Ostergren, Ambresin, Kyagaba & Agardh, 2014:2). Although it is the prerogative of parents and guardians to instil values into their adolescent children (Rahman, Rahman, Ismail, Ibrahim, Ali, Salleh & Wan Muda, 2015:7) nurses can also do their part. Support of adolescents to develop a sound value system can be a part of an anticipatory guidance programme to enable adolescents to resist peer pressure and coercion to sexual activity. The nurses can interact directly with their adolescent patients to guide them, or endeavours to assist parents to support their children to develop sound value systems could be included in anticipatory guidance (Mukti, 2015:40).

### **5.6.2 Supporting coping strategies**

The sub-category on supporting coping strategies emerged from the three initial codes, namely 'educating adolescents on preparedness', 'acknowledging responsible sexual behaviour' and 'disclosing accurate health information'.

The adolescent participants defined what peer pressure is in their own terms and they also outlined the support (to develop coping strategies) they would like to receive from the nurses. The nurse participants were cognisant of the adolescents' needs and they were also aware of their parents' limitations. They were prepared to provide assistance and to collaborate with significant role players to support adolescents to develop coping strategies. They also expressed their willingness to engage and educate other role players to address the identified needs of the adolescents.

Educating adolescents on preparedness to resist peer pressure to take part in risk behaviour is the first coping strategy for enabling adolescents to make responsible decisions. It arose after interviewing the adolescents and nurses and gathering data on critical issues that predisposed adolescents to sexual activity, and their parents bringing them to the health facilities for sexual and reproductive health services. Some adolescents did not understand why they had to use contraceptives, while some were encouraged to do so by their boyfriends, who even accompanied them to the health facilities.

The waiting time for consultations and the time during consultations should be optimally used to educate adolescents to resist peer pressure and to make decisions about their sexuality in a responsible manner. It can only be done should the privacy of the adolescents be ensured (Geary et al., 2014:5) and should their needs be addressed in a manner that they find acceptable, such as by making use of social media and digital communication (Petroni, 2011:3). Adolescents prefer to be in control and not to be taught by others how to behave. With accurate information and coping strategies at their disposal, they should be capable of making their own decisions not to get involved in risk behaviour to please others (Rahman et al., 2015:7).

Acknowledgement of the responsible sexual behaviour of adolescents by nurses may enhance their coping strategies. The endeavours of adolescents to practise responsible sexual behaviour should be acknowledged and reinforced to motivate them to continue with it (Ybarra, Bull, Prescott, Korchmaros, Bangsberg & Kiwanuka, 2013:2). The difficulty that they experience to keep up responsible sexual behaviour should be addressed and nurses should arrange opportunities for them to share information with other adolescents who could benefit from it (Kadam & Kumbhar, 2015:180). They can take part in the capacity building of other adolescents (Patton, Sawyer, Santelli, et al., 2015:48). Adolescents often consider nurses to be too old to advise them on responsible behaviour and for that reason may they prefer to be educated by other adolescents (their peers) (Erulkar, Onoka & Phiri, 2005:56).

Nurses should disclose accurate health information to their adolescent patients and their patients should disclose accurate information to the nurses regarding their involvement in risk behaviour. Disclosing the correct health information is important because adolescents engage in many types of risk behaviours. Risk behaviours are many and are interlinked (Boislard et al., 2009:266), one risk behaviour causes another risk behaviour, for example abusing alcohol can lead to addiction, which can lead to having multiple sex partners for transactional sex to pay for alcohol, and then STI and unplanned pregnancy may ensue because unsafe sex is practised (Boislard et al., 2009:265; Jonas et al., 2016:2).

Adolescents must be encouraged to talk to nurses about their sexual health openly in order to be assisted and advised accordingly. When adolescents disclose accurate information, they can be supported to make responsible decisions about their health

(Petroni, 2011:3). It is the duty of the nurses to do a comprehensive assessment to identify the health needs of their adolescent patients to provide tailored health education to them (Schnall, Okoniewski, Tiase, Low, Rodrigues & Kaplan, 2013:6). Ongoing health education with the aim of providing adolescents with encouragement to take responsibility about their own sexual health should be maintained to prevent the consequences of risk behaviour (Ningpuanyeh, 2016:9). Nurses also have the obligation to provide health education to other significant others to enable them to support adolescents with responsible decision making.

Nurses should be available to support and build the capacity of adolescents, their parents and significant others within the communities (Kennedy et al., 2013:10) where adolescents reside. The nurses are tasked to empower adolescents and their parents to improve their connectedness and encourage them to work together (Kemppanainen, Tossavainen & Turunen, 2012:496). Through proper health education, the consequences of risk behaviour can be prevented (Ningpuanyeh, 2016:9).

## **5.7 SUMMARY**

In this chapter, the categories and sub-categories were discussed. In grounded theory research, the categories and sub-categories are described first, which was done in Chapter 4 of this study. Once a description has been completed, the categories and sub-categories should be discussed together with the literature. In the next chapter, the theory that developed out of the description and discussion of the categories and sub-categories will be presented.

## **CHAPTER 6**

### **DESCRIPTION OF THE NURSING THEORY ON ANTICIPATORY GUIDANCE OF ADOLESCENTS TO PEER PRESSURE AND COERCION TO SEXUAL ACTIVITY**

#### **6.1 INTRODUCTION**

In Chapter 4, the research findings were presented in the form of categories and sub-categories that represent the concepts of the nursing theory on anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity. In Chapter 5, the findings were discussed by extant theory and literature to enable the researcher to substantiate the concepts with literature. According to Walker and Avant (1995:167), theory synthesis starts with either one focal concept or a number of concepts. In this study, a number of concepts developed from the data obtained from the nurse and adolescent participants, are used. In Chapter 4, the concepts were described. This chapter summarises the description of the emergent theory that includes the concepts and the associations between the concepts.

In this chapter, the process of theory synthesis is summarised, the theory is presented, the relevance and contribution of the theory are described, recommendations for the application of the theory are suggested and potential areas for further study are discussed.

#### **6.2 THE PROCESS OF THEORY SYNTHESIS**

According to the Merriam Webster Dictionary, a “theory is the analysis of a set of facts in their relation to one another”, while the Collins Dictionary defines a “theory as a system of rules, procedures, and assumptions used to produce a result”. Positivists define a theory as “a statement of relationship between abstract concepts that cover a wide range of empirical observations” (Charmaz, 2014:229), while constructivists view theories as theoretical understanding that is gained through “theorist’s interpretation of the studied phenomenon” (Charmaz, 2014:230). The researcher did a constructivist study and thus focused on an abstract understanding of peer pressure

and coercion of adolescents towards sexual activity and the anticipatory guidance that they need to resist such pressure from peers.

Theories consist of structural components that include concepts, assumptions and statements to indicate the association (in constructivist theory development) or relationships (positivist theory development) between concepts as well as functional components that refer to descriptions of how to use the theory (Gray et al., 2016:139). Concepts are expressed in words to communicate ideas to others. The words that we use to describe concepts are not the concepts, as they are only ways of communicating concepts to others (Walker & Avant, 2011:24). In this study, concepts were derived from categories and sub-categories based on the data that the researcher obtained through interviews with adolescent and nurse participants (refer to Chapter 4). The categories and sub-categories (concepts) were substantiated with quotes from the participants and discussed with extant literature and theory (refer to Chapter 5). Statements link concepts in either a relational manner to indicate a relationship between concepts (indicating correlation or causality) or a non-relational manner that indicates the existence of the concept as described in a theoretical definition (Walker & Avant, 2011:60). Non-relational statements are made when abstract material, such as anticipatory guidance and peer pressure and coercion, are dealt with (Walker & Avant, 2011:62).

There are three ways for developing theories, namely analysis, synthesis and derivation. Analysis is the first approach that was identified. When analysis is used, the whole theory is dissected into smaller components and the relationships between them are scrutinised for better understanding. Analysis helps in defining the relationship of phenomena to each other. It is a way of reviewing existing knowledge about studied phenomena to refine it in order to improve the body of knowledge to correct, update and keep it within the modern times (Walker & Avant, 2011:64).

Theory synthesis is the second approach for developing theories whereby pieces of isolated information are combined to formulate statements. It highlights reliance on observation of information that is not theoretically connected for constructing new concepts, statements and theory. In synthesis, the researcher collects data or interprets data from various sources without referring to a particular theoretical

framework. Data could be sourced from available information and grouped accordingly into required clusters and themes in qualitative research (Walker & Avant, 2011:63).

Derivation is the third approach for developing theories. This approach allows the use of images or correlations for adaptation of concepts, statements or theory to different fields of research study. It could be applied in completely new settings to be explored in order to bring new ideas and change in a different field of expertise. It encourages cross learning and information sharing required for skills transfer amongst experts (Walker & Avant, 2011:63).

The researcher identified synthesis as the approach of choice and preferred to use it as it matched the research study activities that were embarked on for this study.

At the beginning of the study, the researcher discovered that there was no “nursing theory on anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity”. There was limited literature and no theoretical framework on anticipatory guidance for adolescents to resist peer pressure to sexual activity. The study was not based on an existing literature review until data had been collected and analysed. Following data analysis, the concepts emerged in the form of categories and sub-categories (refer to Chapter 4). The concepts were thereafter used to search for relevant literature that was used in Chapter 5 to describe the findings. The extant theory (Symbolic Interactionism) and literature were used to explicate the findings and substantiate the concepts of the emergent theory.

According to Walker and Avant (2011:112), concepts are synthesised when data are collected until theoretical saturation occurs; clusters of data that relate to each other are identified; the clusters are combined and concepts are formed; the concepts are verified through theoretical sampling and coding; extant theory and literature are used to substantiate the concepts (refer to Chapters 3, 4 and 5 of the study); and the concepts are theoretically described (in this study it is done in Chapter 6). Good theoretical definitions contain the defining attributes that refer to the extant theory that is, in the case of this study, symbolic interactionism (Walker & Avant, 2011:109).

Good theoretical concepts should be well-defined and supported through extant literature to make a broader contribution in the research field (Walker & Avant,

2011:114). In this study, symbolic interaction was used; constant comparison was employed to verify concepts that emerged from the study and theoretical sampling was used to confirm the properties of the concepts. The process was also followed using literature control to identify linkages between the findings and existing literature. It was undertaken to explore the emerging concepts for theory development to determine if they get support and appear valid to be trusted in future research.

Statements are important and useful for theory development, when researchers go beyond concept development. Non-relational statements that are applicable to qualitative research are described in the form of definitions of the concepts to portray the characteristics of such concepts. It is also called theoretical definitions (Walker & Avant, 2011:60). The researcher chose statement synthesis as a suitable strategy for constructing statements. According to Walker and Avant (2011:119), the researcher should move between data collection and analysis in order to validate emerging ideas and to refine concepts as new data are collected. Statements are developed as new data are collected (refer to Chapters 3, 4 and 5).

Theory synthesis is a strategy aimed at constructing the theory, in this study a nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity. The end-product should be an integrated system of ideas based on empirical data that in this study refers to the concepts derived from the categories and sub-categories (refer to Chapter 4) and the discussion of it (refer to Chapter 5). The concepts and statements should be organised into a network called a synthesised theory. While concepts are labels for reality and statements indicate links between concepts, theories define and connect a number of concepts to each other in a graphic form (a model) and a linguistic form (the theory) (Walker & Avant, 1995:155). The applicable antecedents (referring to what happened before the concepts and statements) and attributes (characteristics of the concepts and statements) should be included in the theory (Walker & Avant, 1995:167).

### **6.3 PRESENTATION OF THE THEORY**

A detailed description of concepts and statements, the attributes and properties of the concepts as well as the theoretical definitions are outlined. The researcher also describes the structure of the theory and its operationalisation.



### **6.3.1 Purpose of the theory**

The purpose of the theory is to anticipatorily guide adolescents to resist peer pressure and coercion to sexual activity.

### **6.3.2 Philosophical foundation and development of the theory**

The theory has a constructivism foundation guided by symbolic interactionism as a constructivist grounded theory research approach was followed in its development. Adolescents and nurses interpreted peer pressure, coercion, sexual activity and anticipatory guidance to attach meaning to the concepts in line with the principles of symbolic interactionism. Through a comprehensive literature review links were created between concepts to enhance the functionality of the theory.

The theory was constructed through concept, statement and theory synthesis. Empirical data were used to identify concepts, non-relational statements were formulated from an integration of concepts and literature to synthesise the theory. Concepts are labels for reality, statements indicate the link between concepts and theories represent the network of concepts and statements.

### **6.3.3 Assumptions of the theory**

The assumptions of the theory address anticipatory guidance based on principles of symbolic interactionism and the constructivist paradigm.

According to Mulvihill et al. (2005:94), anticipatory guidance entails an interactive process between the nurse and the adolescents sharing specific educational information [sexual reproductive health and adolescent development] with an intention to prepare individuals to cope [adolescents to resist peer pressure] in specific circumstances [during peer sexual coercion]. It encompasses specific roles that each partner [the nurse and the adolescents] in the interactive process should play to achieve outcomes of the anticipatory guidance to resist peer pressure to sexual activity:

- Anticipatory guidance is an empowering process that brings about self-discovery and self-development of adolescents to become self-confident.

- It is an interactive process consisting of positive interaction between the nurse and the adolescents to promote cooperation [between the nurse and adolescents] and empowerment [of adolescents to make informed choices].
- It provides insight to adolescents through bridging the existing knowledge gaps [lack of SRH information] and unmet health needs [access to youth friendly services].
- It develops the chance of changing the attitudes of the nurse [to be non-judgemental] and adolescents [to be receptive of using clinic in order to receive anticipatory guidance].
- It facilitates an open relationship between the nurses and the adolescents to act and interact openly to overcome the barriers of healthy behaviour for adolescents.

In symbolic interactionism, people engage in interactive processes to construct social reality and clarify meanings for themselves (Burbank & Martins, 2009:27). In this instance, the meanings and expected actions for this theory emanated from adolescents' definitions of peer pressure and the nurses outlining their expected support based on their interaction with adolescents and their parents:

- Symbolic meanings are formed by the adolescents for themselves during social interaction (Mead, 1967:9).
- Adolescents interpret and act on situations based on meanings constructed (Blumer, 1969:15) to define things that matters to them wherever they are.
- Peer pressure is defined according to their own experiences and perceptions, they then attach meaning in respect of what others say it is (Blumer, 1969:137).
- They act differently and adjust their attitudes that guide their actions (Blumer, 1969:16).
- Nurses, adolescents and their parents are social beings that act jointly to create their social world through symbolic interaction (Blumer, 1969:4).

The constructivist approach undertakes a natural enquiry for co-construction of a social reality paradigm (Krauss, 2005:761). It involves interaction of interested parties seeking information and those providing the information to co-construct the social reality (Charmaz, 2008:402):

- Social meanings are not forced or preconceived but created interactively.

- Defining social reality is not dependent on a single source but it is co-constructed from multiple sources of information (Ponterotto, 2005:129).
- Exploring the different perspectives of the social reality to understand what it means from their standpoint (Mills et al., 2006b:2) [peer pressure and its manifestation according to adolescent].
- Acknowledging the differences and exploring how to deal with the reality or truth as it emerges (Charmaz, 2006:240).
- The interactive and interpretive processes guide the development of a theory [for anticipatory guidance of adolescents] based on a common understanding between the nurses and adolescents using a constructivist approach.

#### **6.3.4 Context of the theory**

This nursing theory for anticipatory guidance of adolescents fits in the context of the meta-paradigm of nursing, as it impacts on the adolescents' (represents the human-being) improvement of their sexual and reproductive health (represents the health concept), through getting anticipatory guidance (which is the nursing concept) to reduce their vulnerability to peer pressure and coercion where and when they interact with their peers (represent the environment concept). Nurses use their knowledge and skills to provide anticipatory guidance to adolescents to promote their sexual and reproductive health. They provide anticipatory guidance to enable adolescents to resist peer pressure and coercion to sexual activity and thus take responsibility for their own sexual health.

The venues for providing anticipatory guidance should not be limited to healthcare settings. Not all adolescents visit clinics, particularly male adolescents. Therefore, this theory is meant to be implemented in all community settings where adolescents converge or spend most of their time; be it for recreational, schooling or socialising purposes. These venues include schools, recreational centres, sport grounds, community halls and churches. Nurses should not miss opportunities to anticipatorily guide adolescents when they visit clinics for illnesses or when they attend awareness campaigns in the community. All situations where nurses and adolescents meet should be used for anticipatory guidance to resist peer pressure and coercion to sexual activity. Significant adults can be trained as volunteers from respective communities that are committed to help adolescents to steer away from risk behaviour. During the

interaction, anticipatory guidance on specific information related to sexual reproductive health and adolescent development or other unmet health needs can be provided.

### **6.3.5 Concepts of the theory**

The following concepts were used to build the theory with regard to what they refer to in anticipatory guidance. **‘Substituting for parental shortcomings’** refers to a nursing process to enable parents to address challenges to guide adolescents to resist peer pressure and coercion to sexual activity. It includes nursing activities to guide adolescents when their parents are not available or competent to do it. It also enables nurses to put measures in place to address parenting limitations and to enable parents of adolescents to guide their children towards responsible behaviour that includes resistance of peer pressure to become sexually active. **‘Addressing negative peer pressure vulnerability of adolescents’** refers to enabling nurses to identify adolescents’ vulnerability regarding negative peer pressure, to determine what they are dealing with, in order to make an informed decision for responding properly or taking prompt action when helping parents and adolescents to overcome peer pressure. **‘Addressing risk behaviour vulnerability’** refers to nursing activities to enable adolescents to be cognisant of danger and taking appropriate action to minimise the chances of engaging in risk behaviour. **‘Optimising nurse-adolescent interaction’** refers to improving the interaction between nurses and adolescents. **‘Enabling responsible decision making’** refers to the process of helping adolescents to make choices based on the current circumstances and conditions they find themselves in.

#### **6.3.5.1 Concept synthesis**

Concept synthesis is a strategy for developing concepts by acquiring data through observation or other forms of empirical evidence. Like all synthesis, strategies depend on observation or available evidence. The concept synthesis option permits the theorist to use clinical experience to explore phenomena for theory building (Walker & Avant, 2011:107). This process is in line with symbolic interactionism. It is ideal for the generation of new ideas. For theoretical development, concept synthesis is the method of choice of the researcher, because the data collected provided her with new insights

(Walker & Avant, 2011:108). Concepts help to provide labels for things (what peer pressure is according to adolescents) and actions (anticipatory guidance that nurses must provide to help adolescents) around the environment enabling people to experience their environment or community at a given time, place and under specific circumstances (Charmaz, 2014:342). For this theory, concepts are placed within the theoretical context of symbolic interactionism to highlight their explanatory significance (Walker & Avant, 2011:109).

### **6.3.6 Description of the theory concepts**

In this theory, five concepts, namely 'substituting for parental shortcomings'; 'addressing negative peer pressure vulnerability of adolescents'; 'addressing risk behaviour vulnerability'; 'optimising adolescent-nurse interaction' and 'enabling responsible decision making' are used and the related antecedents and attributes are also described. Antecedents are happenings that occur prior to the existence of these concepts (Walker & Avant, 2011:167). Attributes are characteristics that distinguish the concepts used (Walker & Avant, 2011:162). The concepts described below elucidate how they fit into the theory of anticipatory guiding adolescents.

#### **6.3.6.1 *Substituting for parental shortcomings***

In substituting for parental shortcomings, the nurses are expected to avail themselves to take up the 'substitute role' in guiding the adolescents in the absence of parental presence. Nurses are advised to use opportune times to provide comprehensive information, teach and guide adolescents to behave differently (Lawson & Flocke 2009:20) in the event that their parents are incapable of teaching or fulfilling their parenting responsibilities due to unavailability (due to being orphaned, single or parental absenteeism) or lack of parental skills. Parents and their adolescent children often do not communicate openly to share relevant sexual health information to enable adolescents to resist risk behaviour and peer pressure. Parents may use negative messages to discourage their adolescent children instead of openly communicating important issues related to their well-being, health, physical and sexual development. Parents also often leave it to nurses to educate their children as a result of their limited knowledge about adolescent sexual and reproductive health, cultural taboos linked to discussing sex and the stigmatisation of premarital sex. Adolescents wish to receive

health and well-being information from their parents. They also need guidance to respond positively to developmental challenges and how to resist peer pressure that predisposes them to risk behaviour.

In cases where parents cannot attend to their children's needs, nurses should not replace parents but can play a complementary role by anticipatorily guiding adolescents to resist peer pressure that leads them to risk behaviour. In child-headed households, a complete absence of parental guidance necessitates nurses to become substitute parents. When adolescents' needs are not met, they may follow advice from their peers who also need guidance from others. Not all nurses are capable of substituting for parental shortcomings and thus require training to identify these needs and to successfully intervene (Atkinson & Peden-McAlpine, 2014:175).

The **antecedents** of substituting for parental shortcomings refer to poor adolescent-parent communication, limitations on parental knowledge, limited parental guidance and limitations regarding positive parental roles. The **attributes** of substituting for parental shortcomings are acknowledging parental incapacity and enabling effective parenting.

#### ***6.3.6.2 Addressing negative peer pressure vulnerability of adolescents***

Adolescents affected by negative peer pressure tend to engage in risk behaviour. Vulnerability makes them susceptible to peer pressure. Their friends and peers are responsible for influencing them. The peer influence is sometimes positive, which is characterised by good deeds or it can be negative where they are inclined to follow what their negative friends do. Those under positive pressure are less vulnerable and can make informed choices. Adolescents under the influence of negative pressure are ignorant of their own vulnerability. Adolescents' emotional status and their relationships with their parents may influence their susceptibility to vulnerability. Unstable living or home conditions make adolescents vulnerable (Oza et al., 2015:170) of becoming involved in risk behaviour (Ahern et al., 2016:6). The deviant activities may have a detrimental effect on their development to become responsible adults (Rowe et al., 2016:90).

Nurses are expected to provide support to adolescents and their parents in addressing negative peer pressure vulnerability. They require the skills to identify negative peer pressure vulnerability and to help adolescents to avoid it. They need to identify vulnerability earlier and manage it properly to minimise the negative effects of negative peer pressure vulnerability. Nurses have a responsibility to educate adolescents on the dire consequences of negative peer pressure (Reddy et al., 2013:7) and to raise awareness of the possible detrimental consequences. Adolescents must be warned about friends who engage in negative deeds as they may influence them to participate in their negative schemes (Boislard et al., 2009:266). They must be assisted in choosing the right friends. Nurses should also involve parents to address negative peer pressure vulnerability. Without parental support, adolescents become vulnerable to negative influences that predispose them to risk behaviour.

The **antecedents** of addressing negative peer pressure vulnerability of adolescents are related to the vulnerability that adolescents experience, their engagement in risk behaviour due to their vulnerability and the apathy that they portray about sexually transmitted diseases. The **attributes** of addressing negative peer pressure vulnerability of adolescents refer to the identification and management of the negative peer pressure vulnerability of adolescents.

#### ***6.3.6.3 Addressing risk behaviour vulnerability***

Adolescence is associated with risk behaviour (Isiugo-Abanihe et al., 2015:102). It is a developmental stage that is prone to vulnerability. By virtue of being adolescents in a learning stage of their life where they are also establishing their own identity and roles in the society, they are vulnerable. They look to others to endorse them, and thus fall prey to those who are likely to mislead them. Risk behaviour leads to adolescents engaging in activities that may not be good for their health and well-being. They are pressured by friends, peers and adults who exploit them in exchange for material gifts for their sexual pleasure. Without positive approval from others, they feel inferior and could be lured to join negative deeds just to obtain affirmation from their peer group. Adolescents need support from their parents and nurses to develop the self-confidence to resist risk behaviour and to take responsibility for their own actions.

To address adolescent patients' vulnerability to risk behaviour, nurses need to involve their parents in their efforts to help. With support of their parents, adolescents develop self-esteem and become less vulnerable (Rowe et al., 2016:106). Nurses need to establish a collaborative relationship and cooperation when interacting with parents (Wang et al., 2016:236; Malacane & Beckmeyer, 2016:32). Thus, nurses should be part of creating a safe environment for adolescents to minimise their vulnerability. Therefore, implementing programmes to impart knowledge to prevent adolescents to participate in risk behaviour (Abels & Blignaut, 2011:260) and to engage in healthy lifestyles (Hargreaves et al., 2008:118). Such environments are characterised by favourable adolescent–nurse interaction that is inviting with good rapport with adolescent clients (Isiugo-Abanihe et al., 2015:109). A safe space is where adolescents are free to discuss their personal matters with nurses and reassured that they are treated with confidentiality (Geary et al., 2014:5). Adolescents are also offered appropriate training on life skills (Salam et al., 2016:S24) and on health-specific issues such as sexual and reproductive health (Avery & Lazdane, 2010:S64).

Nurses should create adolescent friendly environments on order for these programmes to be successful (Chaisson & Shore, 2014:454). Adolescents meet at schools and places for recreation; this is where nurses, other professional people such as social workers and teachers and even laypeople can manage the programmes. In recreation areas, adolescents feel more comfortable than at school or in clinics. The targeted intervention activities (anticipatory guidance) can be implemented in clinics, schools and other community organisations where adolescents gather.

The concept of addressing risk behaviour vulnerability depends on a safe environment for adolescents to survive within and resist risk behaviour. Creating a safe environment for the promotion of adolescents' healthy sexual and reproductive health is aligned to the environment component of the meta-paradigm of nursing.

**Antecedents** of addressing risk behaviour vulnerability refer to limited knowledge of adolescents about their vulnerability for risk behaviour, challenging adolescent-nurse interactions and poor clinic attendance of adolescents. The **attributes** of addressing risk behaviour vulnerability refer to attempts to build the capacity of adolescents and the creation of conducive environments for adolescent-nurse interaction.



#### **6.3.6.4 *Optimising adolescent-nurse interaction***

Nurses should portray themselves to the adolescents in a positive manner to create communication and interaction opportunities. Adolescents may interact with nurses if they treat them with respect, but they will withdraw if nurses are not approachable (Wood & Jewkes, 2006:113). Adolescents avoid interacting with judgemental nurses (Alli et al. 2012:2). For anticipatory guidance to be successful, there must be positive interaction between nurses and adolescents. Therefore, nurses should portray an open-minded attitude to allow adolescents to come to them with their problems and needs (Chilinda et al., 2014:1171). Nurses are comfortable in clinic settings, while adolescents feel intimidated and therefore dislike visiting clinics because of bad experiences with nurses at certain clinics. However, nurses live and work in these communities and participate in social interaction at home, work and communities. They have relationships with people in the communities they serve, thus they have the potential of influencing adolescents to act differently. Therefore, they are capable of influencing their colleagues to treat adolescents with dignity and respect and use their skills to guide adolescents to resist peer pressure to become sexually active (WHO, 2012:4).

Nurses who interact with adolescents require skills to interact with them to become open to freely discuss personal issues without reservation (Romero et al., 2015:493). Adolescents need assurance that their confidential matters are safe, otherwise they may never again open up to share with nurses or other healthcare staff (Nair et al., 2015:291). Adolescents want nurses to be trustworthy and to always act in their best interest (WHO, 2012:34). Nurses should never divulge adolescents' confidential information, even to their parents unless the adolescents have given permission (Gilbert et al., 2014:676). Adolescents do not utilise the clinics as much as they should because they are not sick (Tangut, Fasil & Desta 2015:27), particularly the male adolescents. Therefore, nurses should take the responsibility to create adolescent-friendly interaction with male and female adolescents in order to anticipatorily guide them to resist peer pressure and coercion to sexual activities.

There are challenges that cause adolescent-nurse interaction to not be conducive. Adolescents also function within their own schedule while nurses have too many responsibilities, thus rendering the clinic setting to make adolescents feel unwelcome,

leading to lost opportunities for interacting with them (Hoopes et al., 2015:622). Adolescents may also welcome innovative ideas that result in comprehensive health services, tailor-made for their health needs (Romero et al., 2015:489). They also enjoy innovative “ways of communication” (Yonker et al., 2015:9), therefore nurses can investigate and use innovative ways of anticipatory guidance towards the resistance of peer pressure (Wong et al., 2014:2).

Nurses should improvise strategies to keep adolescents interested in health issues and more specifically in sexual matters and ways to resist peer pressure to sexual activities. For example, using fun and games to engage adolescents in health activities may attract them to consistently participate (Motuma et al., 2016:5). Such endeavours are known as ‘edutainment’, offering a combination of entertainment and education (Veale et al., 2015:2), and can optimise adolescent-nurse interaction (Milteer & Ginsburg, 2010:e203). Different methods of optimising adolescent-nurse interaction should be involved, for example feedback sessions for planning future interaction (Ozer et al., 2011:481) as well as individual and group discussions for adolescents who prefer such activities (Kenya Ministry of Health, 2005:24). Interaction with adolescents through the use of social media (Francis et al., 2013:165) and digital media to reach them wherever they are (Perry et al., 2012:224), may be another innovative strategy that is attractive to adolescents. In that way, adolescent-nurse interaction may be increased and adolescents may be attracted to use the clinic services.

The emphasis of providing anticipatory guidance to adolescents through optimising adolescent-nurse interaction is aligned to the health and nursing concepts of the meta-paradigm of nursing. The focus of improving the health of adolescents using various strategies of nursing activities to optimise the adolescent-nurse interaction, is key in anticipatory guidance. It is important that the nurses and strategies for implementing nursing activities targeting adolescents should be adolescent-friendly to welcome such efforts aimed at supporting adolescents, for example anticipatory guidance to resist peer pressure.

The **antecedents** related to optimising adolescent-nurse interaction are the perception of adolescents that nurses are judgemental and that they display contradictory attitudes towards them. Adolescents do not want nurses to treat them as

if they are children. The **attributes** of optimising adolescent-nurse interaction are characterised by creating a positive adolescent-nurse interaction in an adolescent-friendly setting with non-judgmental and approachable nurses.

#### **6.3.6.5 *Enabling responsible decision making***

Being able to make responsible decisions is about making the right choices and considering the related consequences. It must be noted that adolescents with a strong self-esteem can resist peer pressure and change their behaviour (Mosksnes & Espnes, 2013:4). Adults often make decisions on behalf of their children, but as they grow older children must be enabled to make their own decisions. Adolescents require support from nurses, parents and significant adults from the community to develop the relevant skills. They must learn to believe in themselves when they make decisions and to stand by what they have decided. It takes confident adolescents not to succumb to pressure from their peers or friends. Male adolescents have shown to be self-confident to resist peer pressure. Adolescents need an enabling environment at home and at school to learn about positive interaction with others and how to make responsible choices. Failing to develop decision-making skills will predispose them to be vulnerable to negative peer pressure.

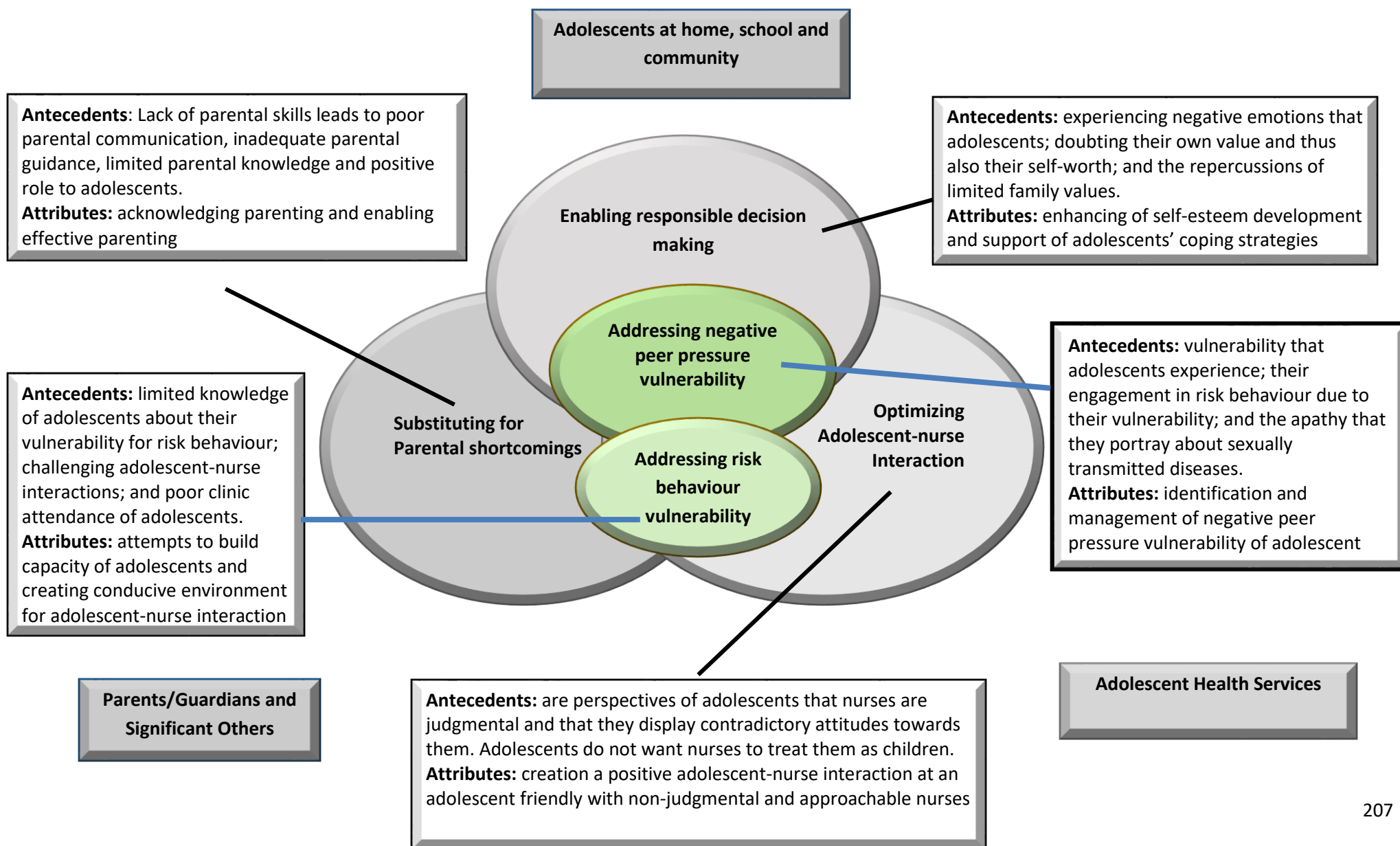
In enabling adolescents to make responsible choices, nurses should assist them by developing their decision-making skills independent of their friends' influence to behave differently. With the guidance of nurses, they may develop self-awareness, learn problem-solving skills and develop good interpersonal skills. Nurses should strengthen the decision-making skills they learn at school (Mosksnes & Espnes, 2013:2) to help them become accountable and to behave responsibly as they grow into becoming responsible adults (Ballard & Syme, 2015:3). When nurses interact with adolescents, they should identify if adolescents have the capability of making responsible decisions (Ghoncheh et al., 2014:1) and if not, then refer them accordingly. Nurses can also help parents to instil values in adolescents by including a sound value system in the anticipatory guidance of adolescents. Both nurses and adolescents should disclose accurate information to enable nurses to provide relevant advice and care based on their specific risk behaviour profile. Over and above all nursing activities, nurses should conduct a comprehensive assessment to identify the adolescent health needs and provide customised health education to them (Schnall et

al., 2013:6). Ongoing health education is required to encourage adolescents to remain responsible about their sexual health to prevent the consequences of risk behaviour to befall them (Ningpuanyeh, 2016:9). Nurses have the task of empowering adolescents and their parents to connect and cooperate with each other (Kemppanainen, Tossavainen & Turunen, 2012:496). They are obligated to provide health education to the adolescents' significant others to enable them to support adolescents in making responsible decisions. They should also support and build the capacity of adolescents, their parents and significant others within the communities (Kennedy et al., 2013:10) where adolescents reside.

In applying the meta-paradigm of nursing to the concept of enabling responsible decision making, the focus is on the concepts of client/human-being and nursing. For nursing, the theory is based on the nurses' responsibility to support adolescents, their parents and significant others to ensure the support for adolescents to make the right choices. Nurses should apply their knowledge and expertise to impart skills to effect change in adolescents with regards to peer pressure. The adolescent clients are at the receiving end to be provided with education and anticipatory guidance to enhance self-development to enable them to make the right choices to avoid the consequences of risk behaviour (Ningpuanyeh, 2016:9).

The **antecedents** of enabling responsible decision making refer to negative emotions that adolescents may experience, situations when they doubt their own value and thus also their self-worth and the repercussions of limited family values. The **attributes** of enabling responsible decision making refer to the enhancing of adolescents' self-esteem and the nurses' support of their coping strategies.

Figure 6.1: Graphic presentation of the concepts for the theory on anticipatory guidance of adolescents to resist peer pressure to sexual activity



### **6.3.7 Statements of the theory**

In this theory, non-relational statements are used to aid in developing the theory for anticipatory guidance of adolescents. Relational statements explain the relationships between concepts and non-relational (emphasising whether the concepts exist or just a definition, they are immeasurable) statements, that are found in theory development. Non-relational statements are used to explain the meanings of concepts in theories (Walker and Avant, 2011:60). Therefore, the theory is discussed in linguistic format based on the concepts grounded in data.

This theory on anticipatory guidance is aligned to the meta-paradigm of nursing and applied all four concepts, namely client/human-being, health, environment and nursing. As defined, the *client* is the adolescents, nurses, parents and significant others; the *health* is the promotion of adolescent sexual reproductive health; the *environment* is the setting where adolescents converge and where they are likely to experience peer pressure and coercion to sexual activity, while *nursing* is the anticipatory guidance provided to adolescents to resist peer pressure to sexual coercion.

The concepts of the theory emerged from data, therefore this theory is grounded in the data derived from the nurses' experience of interacting with parents of the adolescents and the adolescents.

### **6.3.8 Definition of concepts used in the theory**

#### **6.3.8.1 Adolescents**

Young, Furman and Jones (2012:559) defined adolescence as the developmental stage for exploring and experimenting with sex and Lansford et al. (2014:1749) also concurred that it was the stage during which romantic and sexual relationships start. It is a time when the youth are faced by situations that force them to make complex choices that shape their health and well-being (Flicker & Guta, 2008:3). In this theory, it focuses on middle adolescence (14 to 16 years) and late adolescence (17 to 19 years) because they are at different developmental stages. The younger group might have considered engaging in sexual activity or have just started to engage in sexual activity, while the older group might be having sex on a regular basis.

#### **6.3.8.2 Sexual coercion**

It is also known as forced sex, and is defined as being similar to rape, which involves non-consensual sexual activity where penetration forcefully occurs irrespective of the victims' gender. However, it is slightly different from rape where physical violence is used (Miller et al., 2015: 674).

#### **6.3.8.3 Anticipatory guidance**

Yamokoshi et al. (2008:34) explained that anticipatory guidance is an educational idea intended to prepare individuals to be ready to cope with expectations in specific situations. Anticipatory guidance can thus be used to prepare adolescents to cope with peer pressure and coercion to sexual activity. In this theory, anticipatory guidance refers to the anticipated methods that nurses can use to prepare adolescents for the pressure and coercion to sexual activity that they might experience from their peers.

#### **6.3.8.4 Sexual activity**

UNESCO Report (2008:30) defined sexual activity under sexual behaviours where an individual had vaginal or anal sex. Remez (2000:298) previously stated the exclusion of oral sex from the mentioned definition and defined it as a form of sex. In this theory, sexual activity was defined as vaginal, anal and oral sex.

#### **6.3.8.5 Risk behaviour**

According to the Medical Dictionary, risk behaviour is defined as a lifestyle that places an individual at increased risk of suffering a particular condition, illness or injury (medical-dictionary.thefreedictionary.com/high+risk+behaviour). The South African Youth Policy, 10th draft (2012:17), refers to risk behaviour as behaviour linked to a lifestyle choice that is associated with using alcohol and drugs, which leads to other multiple related risks due to peer pressure. These risks may have a negative impact on the health and well-being of adolescents. In this theory risk behaviour refers to the tendency of adolescents to engage in unsafe behavioural activities that predispose their health and well-being to dire consequences.

#### **6.3.8.6 Nursing**

Nursing is “the science and practice of promoting adaptation for the reason of affecting health positively” (Shah, 2015:41). In this theory nursing is related to the anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity.

#### **6.3.8.7 Nurse**

A nurse is an individual prepared and authorised to implement nursing practice activities based on the appropriate scope of nursing practice. They are capable of rendering nursing-related services such as the promotion of health and illness prevention, execute nursing care activities at various settings, provide health education, form part of the healthcare team, supervise and train other at various settings and levels as well as be involved in research (International Council of Nurses, 1987:np). In this theory, a nurse is expected to interact with adolescents at the clinic and outside the clinics and support their parents and significant adults in the community to resist peer pressure to sexual activity.

### **6.3.9 Description of the theory**

This theory is developed for nurses to provide anticipatory guidance of adolescents to resist peer pressure to sexual activity. It is composed of five concepts with associated antecedents and attributes (refer to Figure 6.1). These concepts are ‘substituting for parental shortcomings’; ‘addressing negative peer pressure vulnerability of adolescents’; ‘addressing risk behaviour vulnerability’; ‘optimising adolescent-nurse interaction’ and ‘enabling responsible decision making’.

The antecedents and attributes related to the concepts applied to the meta-paradigm of nursing are described below.

#### **6.3.9.1 Substituting for parental shortcomings**

The **antecedents** of substituting for parental shortcomings refer to poor adolescent-parent communication, limitations on parental knowledge, limited parental guidance and



limitations regarding positive parental roles. The **attributes** of substituting for parental shortcomings are acknowledging parental incapacity and enabling effective parenting.

Aligning this concept to the meta-paradigm of nursing targets the client, who is the parent or significant others or volunteering adults, in order to support them. This is done through acknowledging the parental incapability and enabling them to parent effectively.

#### ***6.3.9.2 Addressing the negative peer pressure vulnerability of adolescents***

The **antecedents** of addressing negative peer pressure vulnerability of adolescents are related to the vulnerability that adolescents experience, their engagement in risk behaviour due to their vulnerability and the apathy that they portray about sexually transmitted diseases. The **attributes** of addressing negative peer pressure vulnerability of adolescents refer to the identification and management of negative peer pressure vulnerability of adolescents.

In order to address the negative peer pressure vulnerability of adolescents, the nursing component of the meta-paradigm becomes key while nurses actively seek to exercise their nursing role through identifying and managing the negative peer pressure vulnerability of adolescents. The nurses should use available strategies and resources to support vulnerable adolescents to resist peer pressure.

#### ***6.3.9.3 Addressing risk behaviour vulnerability***

**Antecedents** of addressing risk behaviour vulnerability refer to limited knowledge of adolescents about their vulnerability to risk behaviour, challenging adolescent-nurse interactions and poor clinic attendance of adolescents. The **attributes** of addressing risk behaviour vulnerability refer to attempts to build the capacity of adolescents and the creation of a conducive environment for adolescent-nurse interaction.

The nursing concept of the meta-paradigm comes into play upon addressing risk behaviour vulnerability as the nurses interact with adolescents to build their capacity to help them to overcome peer pressure. The caring role practised by nurses serves to create a conducive environment for adolescent-nurse interaction to improve poor clinic attendance.

#### **6.3.9.4 *Optimising adolescent-nurse interaction***

The **antecedents** related to optimising adolescent-nurse interaction are perspectives of adolescents that nurses are judgemental and that they display contradictory attitudes towards them. Adolescents do not want nurses to treat them as if they are children. The **attributes** of optimising adolescent-nurse interaction are characterised by creating a positive adolescent-nurse interaction at an adolescent friendly setting with non-judgmental and approachable nurses.

The concept of optimising adolescent-nurse interaction is more relevant to addressing the environment component of the meta-paradigm of nursing. It refers to making the environment adolescent-friendly and building the capacity of nurses to become approachable to adolescents, in order to attract adolescents to utilise the clinics.

#### **6.3.9.5 *Enabling responsible decision making***

The **antecedents** of enabling responsible decision making refer to negative emotions that adolescents may experience, situations when they doubt their own value and thus also their self-worth and the repercussions of limited family values. The **attributes** of enabling responsible decision making refer to the enhancing of self-esteem development of adolescents and the support of their coping strategies by nurses.

The concept of enabling responsible decision making focuses on adolescents becoming relevant and aligned to the client/human component of the meta-paradigm of nursing. Adolescents are helped to make the right choices in various life circumstances through anticipatory guidance from the nurses, whereby their self-esteem is developed and coping strategies supported.

#### **6.3.10 Preparation of nurses to implement the theory**

The implementation of the theory requires trained and adolescent-friendly nurses as well as volunteer adults from the community that are committed to help adolescents to resist peer pressure. It calls for one-on-one interaction between the nurses and adolescents. In instances where nurses are unable to be present, other professional people such as social workers and teachers can manage the programme. The trained significant

community representatives committed from respective communities can guide adolescents to be less vulnerable. Consultation sessions, awareness events and health education opportunities targeting adolescents should be used to engage them for sharing sexual reproductive health, STI prevention and adolescent development information.

#### **6.3.11 Involvement of significant members of communities in the implementation of the theory**

Teachers, social workers, significant adults such as church and community leaders, influential committed people who reside in those communities, representatives from the community and NGOs, guardians, adolescents and their parents can contribute to the successful use of the theory. Anticipatory guidance of adolescents to resist peer pressure and coercion is not the responsibility of nurses only. Nurses should involve community members to support them. Such people should be properly trained by nurses to empower them to serve as responsible role models to adolescents.

#### **6.3.12 Context in which the theory should be implemented**

The nurses are supposed to provide anticipatory guidance to adolescents at all points of contact and in all settings where adolescents converge for fun, schooling, play and recreational purposes. These settings include other venues outside the traditional health venues namely community halls, sports grounds, schools, churches and homes. In the event that anticipatory guidance is conducted at the clinics, it is advised that the clinic environment be reorganised and anticipatory guidance provided in a private dedicated space for adolescents. Nurses are responsible for devising strategies to attract adolescents, more especially male adolescents, to use the clinics. Dedicated time and space for consultation with adolescents should be set aside for adolescents, related to their health needs.

#### **6.3.13 Recipients of anticipatory guidance**

The targeted population to gain from the anticipatory guidance is adolescents (10 to 19 years), however the focus should especially be on adolescents from a younger age (10 to 14 years) so that they grow up empowered with skills to build their self-esteem in order to make responsible decisions to overcome peer pressure.

### **6.3.14 Nursing activities targeting adolescents to provide anticipatory guidance**

The following nursing activities should be used in the anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity.

#### **6.3.14.1 *Substituting for parental shortcomings***

In the event that parents are unable to parent effectively or not available, nurses can step in to act as substitutes. However, substitution does not mean replacing the parents, but rather to complement them. The nurses, as the entry point of accessing the comprehensive health services, can provide the skills parents do not possess for teaching adolescents. Comprehensive assessments need to be conducted to ascertain the extent of parental involvement in their adolescent children's lives and health. Stepping in and devising parenting interventions to provide consistent specific guidance to adolescents to resist peer pressure to sexual activity, should be done when required.

#### ***A: Acknowledging parental incapacity***

This is related to recognising the parents' inability to provide the expected parental guidance. Adolescents need capable parents to provide parental guidance for them to resist risk behaviour. When poor communication between parents and children is acknowledged, it can be assumed that opportunities for adolescents to resist peer pressure and coercion to sexual activity are lost.

The roles that nurses could play are as follows:

- Nurses should be able to identify such parents and help them to improve their parenting strategies.
- Nurses should be observant to identify those parents who could not verbalise their lack of parental skills, because without the relevant knowledge they pose a threat to the upbringing of their children.
- Nurses should comprehensively assess adolescent patients to ascertain to what extent their parents are involved in their development into adulthood.
- Nurses should facilitate the training of parents on effective parenting skills.

- Nurses should support adolescents and parents to improve their connectedness and to cooperate with each other.

### ***B: Enabling effective parenting***

Enabling effective parenting relates to measures to be put in place by nurses to address limitations regarding parenting and to enable parents of adolescents to guide their children towards responsible behaviour that includes resistance of peer pressure to become sexual active.

These measures include the following:

- Nurses should conduct a pre-training assessment and situation analysis to ascertain the extent of the limitation on parenting skills in a community.
- Nurses can enable parents to interact effectively and provide anticipatory guidance to adolescents to resist peer pressure and coercion by their friends.
- Nurses thus have to intervene where parents and adolescent children are, be it at home or at other venues.
- Nurses can work with representatives from communities, and NGOs are also potential sources of support for adolescents and their parents.
- Nurses should train parents to enable them to parent adolescents effectively.
- Nurses should conduct parenting training through well-planned formal programmes of structured sessions over scheduled periods.
- Nurses can arrange workshops when needed to empower parents to interact with their children to guide them regarding responsible sexual behaviour.
- Nurses should also be trained to empower adolescent children to make informed decisions.
- Parenting training can also be done in a less formal way during individual consultations.
- 

#### ***6.3.14.2 Addressing the negative peer pressure vulnerability of adolescents***

Negative peer pressure influences adolescents to engage in risk behaviour that includes early sexual activity. Positive peer pressure involves being motivated to do good things

and being steered away from risk behaviour. It involves being influenced to engage in positive deeds. Vulnerability renders adolescents defenceless to peer pressure and exposes them to become easily influenced by others. Addressing negative peer pressure vulnerability can be done through individual or group interventions. It requires a multi-disciplinary approach to prevent occurrence and the impact of negative peer pressure. Nurses and community healthcare workers can be involved in addressing negative peer pressure vulnerability of adolescents within their communities. Collaboration with other community members, including the parents of adolescents, is required to render support to adolescents to resist negative peer pressure. An important endeavour is to help adolescents to become aware of their vulnerability to negative peer pressure.

### ***A: Identifying negative peer pressure vulnerability***

Nurses should be able to identify their adolescent patients' vulnerability regarding negative peer pressure vulnerability. Health education aimed at their empowerment to be aware of their vulnerability should be part of anticipatory guidance. When adolescents are aware of their vulnerability, they can be taught how to overcome it.

Nurses can assist by implementing the following:

- Providing adolescents with correct health information and proper guidance to safeguard their well-being and interest.
- Educating adolescents about the dire consequences of negative peer pressure and raising their awareness of the detrimental consequences thereof.
- Alerting adolescent patients about the circumstances that could cause peer pressure vulnerability.
- Nurses should use the opportunities to do comprehensive screening to identify the direct and indirect causes of vulnerability to peer pressure.
- Conducting interviews to identify peer pressure vulnerability of adolescents in private venues.
- Nurses should be sensitive to signs of vulnerability in order to promptly help adolescents to resist peer pressure.
- Nurses should also be vigilant to the possible lack of knowledge regarding the transmission of sexually transmitted diseases.

## ***B: Managing negative peer pressure vulnerability***

Adolescents are exposed to risk behaviour due to their adventurous attitude linked to their developmental stage. Therefore, they need support to be less vulnerable to peer pressure in order to resist risk behaviour. Parents must be advised not to use punitive measures to manage adolescents, because it will repel them to confide in their parents. It is imperative to share alternative ways to manage their vulnerability, so as to enable parents to care for and communicate effectively with their children. Parents need knowledge and skills, they need to know their children's whereabouts and the ability to guide them effectively. It should be noted that the health facilities are not the only places where adolescents can be reached for guidance on how to manage pressure from their peers to take part in risk behaviour. Not all nurses are capable of assisting parents and their adolescent children to reduce adolescent vulnerability.

Nurses can manage negative peer pressure vulnerability in the following ways:

- Providing anticipatory guidance while conducting the adolescent health assessment regarding peer pressure vulnerability.
- Nurses should start with building relationships with adolescent patients that will ensure that they visit the clinic on a regular basis for health promotion, illness prevention and treatment of minor ailments.
- The healthcare services should be youth friendly to optimise service utilisation and to increase accessibility of health services to adolescents to alleviate their vulnerability.
- Nurses can implement targeted intervention activities (anticipatory guidance) in clinics, schools and other community organisations where adolescents gather, to assist adolescents to reduce their vulnerability.
- Nurses should educate parents to exercise constant parental monitoring and maintain good interpersonal relationships with their adolescent children. It enables parents to track and know their children's whereabouts and also discourages adolescents from engaging in risk behaviour to get the approval of their peers.
- Nurses should offer programmes at clinics focused on the illness prevention and health promotion of adolescents instead of waiting for adolescents to become sick to consult the clinics.
- Nurses should not wait for adolescents to come to the health facilities, but services can be taken to schools and venues where adolescents congregate. Anticipatory guidance cannot be targeted for implementation at health facilities only.

- Nurses should create adolescent friendly environments for these programmes to be successful. Adolescents find these spaces to be conducive for them to express themselves and it thus creates ideal venues for them to receive guidance on how to manage their vulnerability regarding negative peer pressure.
- Nurses and significant adults can empower adolescents to reject peer pressure and educate them to make informed choices.
- Nurses should facilitate training of the parents of adolescents and community representatives to increase the number of people available to assist adolescents to develop their self-esteem and confidence.
- Nurses should develop and implement formal anticipatory guidance programmes to reduce adolescents' vulnerability towards peer pressure and risk behaviour.
- Nurses should engage parents to assist the adolescents to overcome peer pressure, because they might know unique circumstances that affect their adolescent children.

#### **6.3.14.3 Addressing risk behaviour vulnerability**

Addressing risk behaviour vulnerability focuses on dealing with vulnerability that leads to risk behaviour. Risk behaviours that adolescents may encounter encompass taking part in irresponsible sexual relationships, illicit drug use and abusing alcohol. Pressure to engage in risk behaviour is also exerted by adults, particularly older men who exploit adolescents for sexual favours. These older men use expensive gifts in exchange for sexual favours. Adolescents from poor families are more vulnerable to such exploitation. Adolescents who have a strong self-esteem are less vulnerable to risk behaviour and thus do not need peer approval of their behaviour. However, they require support from trusted adults, such as their parents and nurses at clinics, to help them to develop the courage to resist risk behaviour and to take responsibility for their own actions. Therefore, nurses are needed to provide guidance to reduce their vulnerability to risk behaviour. Supportive parents and adolescent-friendly nurses create enabling, friendly environments that support adolescents to reduce their risk behaviour vulnerability. Parents and adolescent children need to have a trusting relationship and good communication to enable adolescents to resist risk behaviour. Parents need to be involved in activities aimed at addressing the risk behaviour vulnerability of their adolescent children. Community organisations are also important partners to get involved in projects to address adolescents' vulnerability towards risk behaviour.



### ***A: Attempts to build the capacity of adolescents***

Building the capacity of adolescents involves a process of increasing knowledge of adolescents on adolescent-related challenges and teaching them about strategies to cope with them. Strategies to cope include resisting risk behaviour such as being sexually active to please others. Adolescents prefer interactive participatory learning where they are actively involved. They also need dedicated learning spaces in clinics and in other community resources where they can interact with other adolescents to develop their interpersonal skills. In cases where they share spaces with adults in clinics, they feel uncomfortable and they shy away from interacting with nurses or visiting the clinics.

Nurses can build the capacity of adolescents in the following ways:

- Nurses can anticipatorily guide adolescents by providing education and training regarding challenging situations that predispose them to risk behaviour.
- Nurses can also organise educational sessions in spaces where adolescents converge or they spend most of their time.
- Nurses can conduct on-the-spot teaching at health facilities and formal structured programmes at organised venues in the community to build the capacity of adolescents.
- They should involve adolescents in the planning of learning opportunities so that they take ownership of their own capacity building.
- Nurses should conduct a pre-assessment activity to determine the adolescents' existing knowledge and readiness to learn to ensure that their training is pitched at the correct level of teaching.
- They should offer age-appropriate training with opportunities for experiential learning for adolescent and disseminate it over a period of time.
- They can provide on-the-spot training in clinics when adolescents require knowledge and skills to manage specific challenges.
- Nurses can create learning spaces in other settings where adolescents socialise, such as schools or in churches where they can learn from other adolescents and from adults who have been trained to facilitate the capacity building of adolescents.
- Nurses can facilitate meetings for capacity building on scheduled dates and times when adults do not make use of the buildings. In instances where it is not possible to

create spaces in clinics, schools and churches can be used where only adolescents attend.

### ***B: Creating conducive environments for adolescent-nurse interaction***

Creating conducive environments for adolescent-nurse interaction is related to establishing an environment in clinics that makes adolescents feel comfortable, and developing alternative strategies to attract adolescents to use the clinics. Adolescents often do not use health facilities, because they perceive nurses as being judgmental when they conduct sexual health screening. For nurses to reach out to adolescents, the environment at the clinic should be conducive and welcoming. Nurses are expected to treat adolescents with dignity and respect. The nurses and adolescent participants appreciated venues at clinics where adolescents could meet without supervision from adults. Adolescent patients do not like venues where they mix with adults or spaces where they can be overheard during consultation. Nurses can use different creative platforms that are attention-grabbing to attract those adolescents who are not interested in using clinics. Clinic management should provide relevant training for nurses to create conducive environments for adolescent–nurse interaction.

Nurses can contribute to creating conducive environments for adolescent-nurse interaction in the following ways:

- Nurses should have a friendly approach and extend invitations to adolescents to visit the health facilities at times that suit them to increase clinic utilisation.
- Training can be done on health-related issues such as life skills and on health specific issues such as sexual and reproductive health.
- Posters and digital media should be used to create a health-oriented environment in clinics.
- Education sessions can be done in the form of edutainment to make health education interesting and to attract adolescents to the clinic.
- They can use social media to provide health education to adolescents who do not want to visit clinics.
- Nurses can use participatory and interactive methods to create opportunities to engage adolescents in teaching and learning skills to avoid risk behaviour.

#### **6.3.14.4 Optimising adolescent-nurse interaction**

Optimising adolescent-nurse interaction relates to improving the interaction and relationship between nurses and adolescents. The way in which nurses portray themselves towards adolescents may create opportunities for communication and interaction with adolescents. Adolescents may interact with nurses when they feel respected. However, when nurses appear to be not approachable, adolescents withdraw from them. Positive interaction between nurses and adolescents is required for the anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity to take place. They can use their influence to encourage their nursing colleagues to treat adolescents with dignity and respect and to use their skills to guide adolescent patients to resist peer pressure to become sexually active. Nurses should thus interact with adolescents in such a way that they perceive them to be open to their needs and problems.

##### ***A: Creating positive adolescent-nurse interaction at an adolescent friendly setting***

Adolescents need guidance towards making informed decisions on becoming sexually active. They need to be knowledgeable to know the pros and cons of the situation and make informed decisions before they decide whether to have sex or not to have sex. Nurses should create opportunities to discuss sexual matters, as adolescents may not feel free to discuss such issues with their parents. The clinic set-up is often not conducive for interaction with nurses, thus adolescents refrain from interacting with nurses out of shyness or fear that they may be overheard. Nurses may also appear to be too busy and are thus perceived to not have time to anticipatorily guide adolescents regarding sexual matters. Sometimes the clinic setting makes adolescents feel unwelcome, thus a valuable opportunity to interact is lost. They also function according to their own schedule; therefore, nurses should be innovative in order to accommodate them. Adolescents need a special way of interaction to keep them interested.

Nurses can contribute to creating positive adolescent-nurse interaction at an adolescent friendly setting in the following ways:

- Nurses should interact with adolescents to provide them with the necessary information during anticipatory guidance.

- They should extend clinic hours to allow more time for interaction between adolescents and nurses.
- Nurses should provide comprehensive health services, tailor-made for adolescents' health needs.
- Nurses should improvise strategies to keep adolescents interested in health issues and more specifically in sexual matters and ways to resist peer pressure to sexual activities. Such innovation involves aligning recreational events to entice them and includes fun and games to make adolescents interested in participating in health activities.
- Endeavours to involve adolescents in their own anticipatory guidance through edutainment, which is a 'combination of entertainment and education'.
- Nurses should obtain and use feedback from adolescents for planning any future interaction with them.
- Group and individual interaction should be used to ensure that adolescents who prefer individual sessions and adolescents who prefer group activities are accommodated.
- Nurses can also use innovative ways of communication, like social media, to interact with adolescents for anticipatory guidance purposes. The use of digital media means to reach adolescents where ever they are.
- Nurses should not only focus on providing guidance in clinics, but also in schools and other outreach and recreation facilities.

### ***B: Building capacity of non-judgmental and approachable nurses***

Building the capacity of nurses is related to making learning opportunities available to provide skills and to empower the nurses to provide quality services in the health environment. A skill-building process is a long-term exercise. The adolescents are unhappy with services when they are addressed in a judgmental manner. Therefore, nurses are required who can create adolescent-friendly environments in clinics as a prerequisite for anticipatory guidance regarding ways to resist peer pressure and coercion to sexual activity.

The building of capacity of non-judgmental and approachable nurses can be achieved in the following ways:

- The training of nurses to do anticipatory guidance of adolescents should include ways to show respect to adolescents and to interact effectively with them.
- Capacity building training programmes of nurses should include ways of interacting with adolescents in non-intimidating ways for discussing sexual matters.
- Nurses should be trained to provide them with good communication skills to enable them to interact with adolescents in non-threatening ways.
- Nurses should interact with adolescents in ethical ways to protect confidential information of adolescent patient.
- Nurses should be trained in the special needs of adolescent patients to be able to treat them with dignity and respect.

#### **6.3.14.5 *Enabling responsible decision making***

Responsible decision making involves a process of making choices based on current circumstances and considering what the future consequences of these decisions may be. Adolescents need to be enabled to make informed choices and not to rely on parents or friends to make decisions on their behalf. However, they might need support from adults such as their parents, teachers and nurses to help them to develop the relevant skills in decision making. They need to be empowered to believe in themselves and to become accountable for their actions. They should be enabled to keep to their decisions and not to relent to peer pressure. Confident adolescents do not need peer approval because they believe in themselves. Being empowered enables adolescents to reject risk behaviour because they are able to make responsible decisions. Adolescents need anticipatory guidance to be cognisant of other people that lure them into negative peer pressure vulnerability. Adolescents thus require an enabling environment at home and in school to learn how to interact with others and how to make decisions in a responsible manner. Children who do not learn to interact with others responsibly, become predisposed to vulnerability. Good behaviour and responsible decision making requires role models of good behaviour and skills in decision making. In the absence of such, adolescents resort to the peer influence of ill-informed adolescents without the guidance of an older responsible person. Such groups develop their own rules with negative consequences that may not be socially acceptable. However, adolescents should be convinced to develop decision-making skills essential for resisting peer pressure that is linked to risk behaviour. Nurses at clinics can assist adolescent patients to develop skills

in responsible decision making that rely on positive self-awareness, skills to solve problems and ways to work towards good interpersonal relations.

### ***A: Enhancing of self-esteem development of adolescents***

The enhancing of self-esteem development is an important aspect in the anticipatory guidance of adolescents. Adolescents should believe in themselves and their own abilities to resist peer pressure and coercion to sexual activity. Skills are required to differentiate between negative and positive peer pressure. Therefore, adolescents should sustain a consistent association with peers that have a positive influence on them and avoid those that have a negative influence on their self-esteem. Having good interpersonal relationships with significant adults enhances the development of the self-esteem.

Nurses can contribute to the enhancement of the self-esteem development of adolescents in the following ways:

- Nurses should be vigilant to identify adolescents that have a low self-esteem in order to help them overcome it by building their confidence.
- They should help adolescents to avoid peers who may counteract their attempts to develop their own decision-making skills.
- Nurses should spend enough time with adolescents to transmit values to enable them to resist peer pressure.
- Nurses can also partake in instilling values to adolescents as part of anticipatory guidance to enable adolescents to resist peer pressure.
- Nurses can interact directly with their adolescent patients to guide them in their endeavours to assist parents to support their children in the development of sound value systems, which could be included in anticipatory guidance.

### ***B: Supporting coping strategies***

Supporting coping strategies is being cognisant of what is happening and a willingness to support the shortcomings. Adolescents must disclose the correct information in order to be supported accordingly. Disclosing the correct health information is important because adolescents engage in many types of risk behaviours. Risk behaviours are many and interlinked. One risk behaviour can lead to another, for example abusing

alcohol causes addiction which can lead to having multiple sex partners for transactional sex to pay for alcohol, and then STIs and unplanned pregnancies may ensue if unsafe sex is practised. Adolescents prefer to be in control and dislike being instructed by others on what to do. They must also be encouraged to talk to nurses about their sexual health openly in order to be assisted and advised accordingly. By being equipped with accurate information and coping strategies, they should be capable of making their own decisions on not to be involved in risk behaviour. However, adolescents prefer to be educated on responsible behaviour by other adolescents, particularly their peers. The nurses should be willing to engage and educate other role-players to address the identified needs of the adolescents. They are tasked with empowering adolescents and their parents to improve their connectedness and encourage them to work together. Nurses should use consultation time optimally to educate adolescents to make decisions concerning their sexuality in a responsible manner. Consultation should be done in privacy to ensure that the sexual health needs of adolescents are met and addressed properly.

Nurses can contribute to the support of coping strategies of adolescents in the following ways:

- Nurses should educate adolescents on being prepared to resist peer pressure to partake in risk behaviour as a step towards responsible decision making.
- Nurses should acknowledge and reinforce the motivation for responsible sexual behaviour of adolescents, which may enhance their coping strategy.
- They should arrange opportunities to share information with adolescents who need it.
- Nurses should disclose accurate health information to their adolescent patients and their patients should disclose accurate information regarding their involvement in risk behaviour.
- Nurses should be available to support and build the capacity of adolescents, their parents and significant others within the communities where adolescents reside.

### **6.3.15 Network of concepts and statements that form the theory**

The concepts of the theory and the nursing activities to operationalise the concepts do not exist in isolation. They form a network and each concept needs to be viewed in relation to the others (refer to Figure 6.2).

*Substituting for parental shortcomings* enable nurses to anticipatorily guide adolescents to become aware of negative peer pressure and risk behaviour vulnerability. In the absence of parents, substitutes may play a role in the support of adolescents to resist peer pressure to sexual activity. Risk behaviour is addressed and responsible decision making is supported. In substituting for parental shortcomings, nurses intervene with adolescents in such a way that the nurse-adolescent interaction is enhanced in order to anticipatorily guide adolescents to make responsible decisions in order to resist peer pressure and coercion to sexual activity.

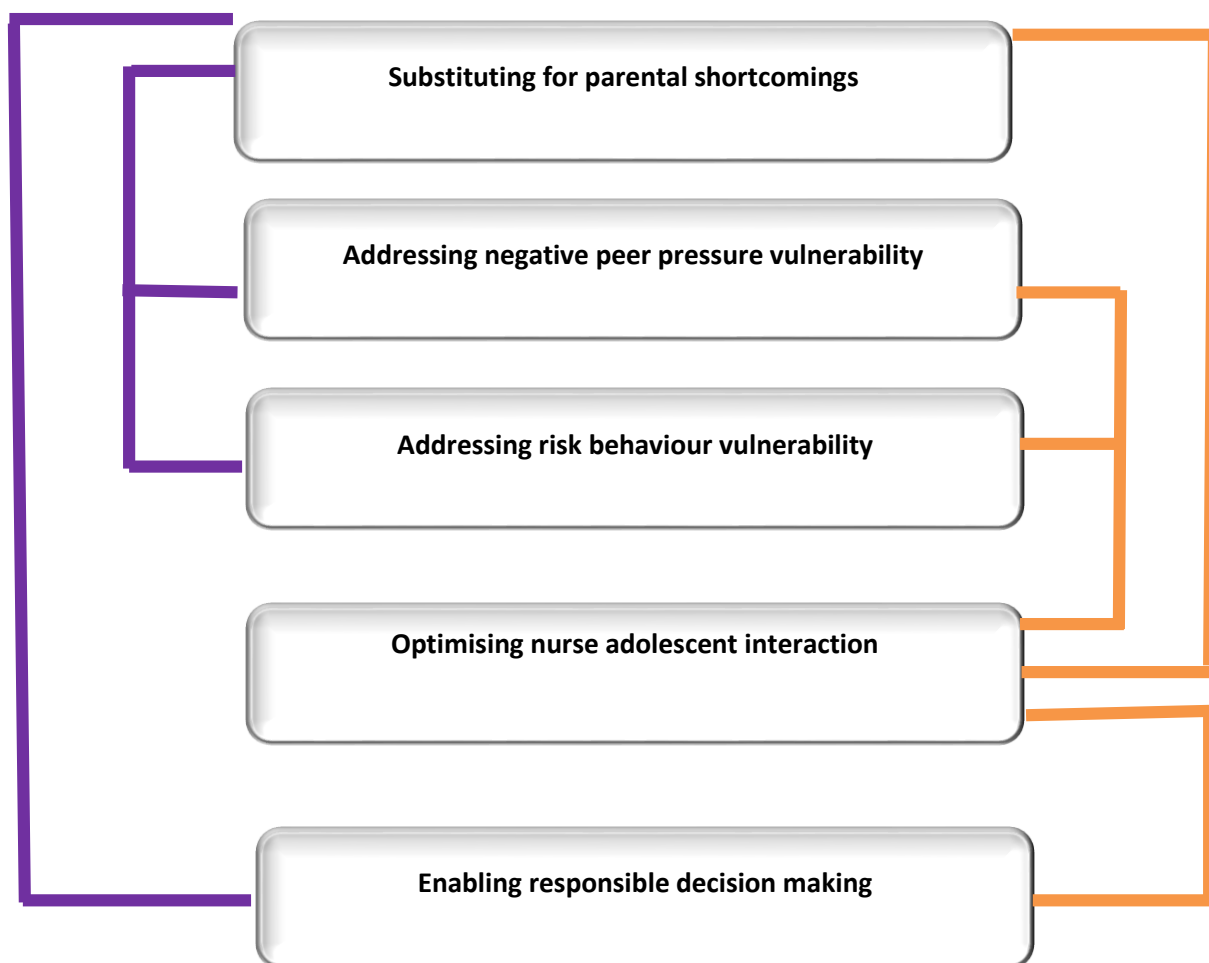
*By addressing negative peer pressure vulnerability of adolescents* during anticipatory guidance and by identifying the vulnerability and managing it, nurses may act as substitutes for parental shortcomings and assist adolescents to take responsibility for their own sexual health. Addressing negative peer pressure and risk behaviour vulnerability are closely linked and positive results of the one may lead to a similar outcome in the other situation.

*Addressing risk behaviour vulnerability of adolescents* during anticipatory guidance can be an activity that is executed as part of endeavours to substitute for parental shortcomings. In instances where negative peer pressure and risk behaviour impact on the well-being of the adolescents, it is of utmost importance. The capacity building of the adolescent can be linked to 'addressing negative peer pressure vulnerability' and 'addressing risk behaviour vulnerability of adolescents.

*Optimising nurse-adolescent interaction* is a requirement for the operationalisation of the other concepts related to supporting and caring for adolescents. Without a positive nurse-adolescent relationship, substituting for parental shortcomings, addressing negative peer pressure vulnerability, addressing risk behaviour vulnerability and enabling responsible decision making, cannot take place.

*Enabling responsible decision making* through the anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity may help adolescents to become less vulnerable to risk behaviour and peer pressure that may lead to risk behaviour.





**Figure 6.2 Interrelationship of concepts in the theory for ‘anticipatory guidance of adolescents to resist peer pressure to sexual activity’**

### **6.3.16 Venues for the use of the theory**

The theory on anticipatory guidance may be used during consultation sessions with adolescents during their visits to healthcare facilities. It can also be used outside healthcare facilities where adolescents regularly meet, such as at schools and recreation facilities.

### **6.3.17 Requirements for the optimal use of the theory**

Nurses in different clinical settings should be able to use the theory to empower adolescents to resist peer pressure and coercion to sexual activity. The context of the theory is well described and nurses who work in a similar context should find the theory applicable to their practice. It is important that the theory be implemented in an

adolescent-friendly environment. Schools, recreation facilities and community centres where adolescents socialise are venues that can be considered for the implementation of the theory.

Adolescent-friendly, knowledgeable nurses who opt to take care of adolescents should implement and use the theory. They should consider anticipatory guidance as more important than managing problems. The prevention of sexually related problems should be more important than taking care of patients once the problems have occurred. Venues that adolescents view as 'safe' to be who they are, need to be used. Adolescents do not want to use the same facilities as older people as they may encounter their own parents or the neighbours and friends of their parents at these facilities. Anticipatory guidance should be rendered at times that the adolescents consider to be best. Such time slots may not be during the day time and the nurses should thus be willing to implement the theory at times the adolescents prefer. The nurses will require the support from their supervisors and the facility management, as adolescent-friendly environments need to be established in and outside the healthcare facility.

#### **6.4 RELEVANCE AND CONTRIBUTION OF THE THEORY TO THE KNOWLEDGE BASE**

Constructivist grounded theory research was conducted to develop the 'nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity'. The meta-paradigm of nursing and the principles of symbolic interactionism were applied.

**Credibility:** The extent to which the study can be considered trustworthy was factored in by recognising the standards of rigour (Chiovitti 2003 :430). The study was conducted to explore the social phenomena of interest (anticipatory guidance and peer pressure/coercion to sexual activity). Sufficient data were collected to substantiate the concepts and their associated antecedents and attributes. During the research, the emergent categories (that developed into concepts) and relationships between categories were justified and matched through constant comparison and a systematic review of existing literature. The categories were discussed with extant theory and literature. The researcher thus claims that the concepts emerged from the participants'

interviews and cover responses from both groups of participants, namely nurses and adolescents.

**Originality:** The theory consists of fresh ideas that emerged as a result of exploring participants' perceptions regarding peer pressure and coercion to sexual activity as well as anticipatory guidance. A discussion of the emergent concepts compared with existing literature was done after the categories emerged from the data to ensure that "fresh conceptual understandings" (Charmaz, 2006:182) were reflected in the concepts. The researcher used sensitising concepts from the conceptual framework presented in Chapter 1 of the thesis, not for the purpose of directing the data collection and analysis, but to ensure that the theory would fit into the meta-paradigm of nursing.

**Resonance:** The researcher posed appropriate and sensible questions to the participants to capture their perceptions in full. It was evident in the codes and concepts that emerged at a later stage. The researcher captured the meanings of the concepts as they were defined by adolescent and nurse participants. The comparisons between individual participants' responses were drawn and analysed accordingly.

**Usefulness:** The theory appears to be a user-friendly and convenient tool that can be used by nurses working in any public clinic setting within the communities to support adolescents to resist peer pressure and coercion related to sexual activity. The theory consists of guidelines on how it should be used.

Validity, trustworthiness and rigour are equally important in constructivist grounded theory studies as in other qualitative research to ensure credibility that the study has credibility, dependability, transferability and confirmability (Rolfe, 2006:305). If a study possess these qualities and meet the criteria for trustworthiness the findings can be trusted and used in other settings, however this study followed the Charmaz criteria for ensuring stringent rigour. To ascertain the quality of the grounded theory methodology; social reality should be constructed by many players who are involved knowledgeable in the field of that speciality. These knowledgeable researchers as obliged to report their findings without any anticipation of results but only in the true form as it emerged from deliberations of the participants (Gioia, Corley & Hamilton, 2012:18).

## **6.5 POTENTIAL AREA FOR FURTHER STUDY**

It is recommended that the theory be implemented and evaluated in a variety of public health clinic settings as well as venues outside traditional health settings for its relevance and the impact that it may have on the empowerment of adolescents to resist peer pressure and coercion to sexual activity.

## **6.6 CONCLUSION**

The 'nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity' is based on adolescents' experiences as well as perceptions of nurses regarding the anticipatory guidance of adolescents. The relevance and contribution of the theory were highlighted. Further research to evaluate the theory is recommended.

## **6.7 SUMMARY**

In this chapter, the process of theory development was described in detail.

The emergent nursing theory was pronounced, the concepts, assumptions and the associations between the concepts were highlighted to communicate the statements made to enable the development of the nursing theory on anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity. The researcher defined the antecedents and attributes for each of the concepts that were used in the nursing theory. The nursing activities that could be implemented to provide anticipatory guidance were explained. The relevance and contribution of this theory would benefit adolescents and enable them to make informed choices. It is envisaged to be applicable in all settings where adolescents meet for school, fun and play.

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## **Z**

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**ADDENDUM A**  
**PROBING GUIDE FOR THE INTERVIEWS**

## **ADDENDUM A**

### **GUIDE WITH PROBES FOR ADOLESCENT PARTICIPANTS**

The probes below follow the key question that seeks to determine “how does peer pressure and coercion to sexual activity manifest among adolescents and how do adolescents experience it? The probes are not asked in a specific order and not all the probes are used during a single interview.

#### **Initial probes**

1. Tell me what you understand about the words “peer pressure” and “coercion”.
2. How did you experience peer pressure and coercion in your life?
3. When did you experience peer pressure and coercion in your life?
4. How did peer pressure and coercion happen when you experienced it?
5. Who was involved when you were pressured and coerced?
6. What was your reaction when you experienced peer pressure and coercion?
7. What is the cause of peer pressure and coercion among adolescents?
8. How does peer pressure and coercion lead to sexual activities?
9. Do some adolescents find it easier than others to resist peer pressure and coercion?
10. How can one resist peer pressure and coercion?
11. What skills does one need to resist peer pressure and coercion?

#### **Intermediate probes**

1. Tell me about what you have learnt about peer pressure and coercion.
2. Who taught or made you aware about peer pressure and coercion?
3. How were you taught about peer pressure and coercion?
4. What did the lessons on peer pressure and coercion entail?
5. What changes occurred in your life following peer pressure and coercion?
6. Can you elaborate on lessons you learned about peer pressure and coercion that changed your life, and how did that change your life?
7. Who can help adolescent to resist peer pressure and coercion?

#### **Ending probes**

1. What do you think adolescents should do to resist peer pressure?
2. How did your experience help you to resist another episode of peer pressure and coercion?
3. Do you think that nurses can help adolescents to resist peer pressure and coercion?
4. Do you think that nurses could assist adolescents to resist peer pressure and coercion?
5. How should nurses support adolescents to resist peer pressure and coercion?
6. What suggestion can you give to nurses to assist adolescents?
7. What should be the things nurses consider if they want to assist the adolescents?
8. How can nurses support adolescents to resist peer pressure and coercion?

### **GUIDE WITH PROBES FOR NURSES**



These questions follow the key question that seeks to explore “how should nurses use anticipatory guidance to assist adolescents to resist peer pressure and coercion to sexual activity”. The probes are not asked in a specific order and not all the probes are used during a single interview.

### **Initial probes**

1. Have you ever worked with adolescents who are under peer pressure to take part in sex?
2. Do adolescents talk to you about the pressure from friends to have sex?
3. Do you think that many adolescents are under pressure from their friends to have sex?
4. Do you think that they need help from nurses to resist peer pressure and coercion to sex?
5. Do you prefer that they talk to their parents?
6. Are you willing to help them if they prefer to talk to you?
7. What could be done better to improve confidence of adolescents on nurses?
8. Given the current status and relationship the adolescents and nurses have; how will nurses communicate the proposed planned activity to support adolescents.
9. How would you describe the adolescents in need of help to resist peer pressure and coercion?

### **Intermediate probes**

1. Tell me about what you understand about anticipatory guidance.
2. Could you share your experiences of working with youth and their behaviour where peer pressure and coercion is concerned?
3. Do you think that nurses should intervene when adolescents are under pressure from friends to have sex?
4. What should nurses do to help them adolescents who are under pressure to have sex?

### **Ending probes**

1. What ideas do you have that could be included in anticipatory guidance of adolescents to resist peer pressure and coercion to sex?
2. How are you going to support adolescents to resist peer pressure and coercion?
3. What should be contained in the anticipatory guidance for adolescents to resist peer pressure and coercion?

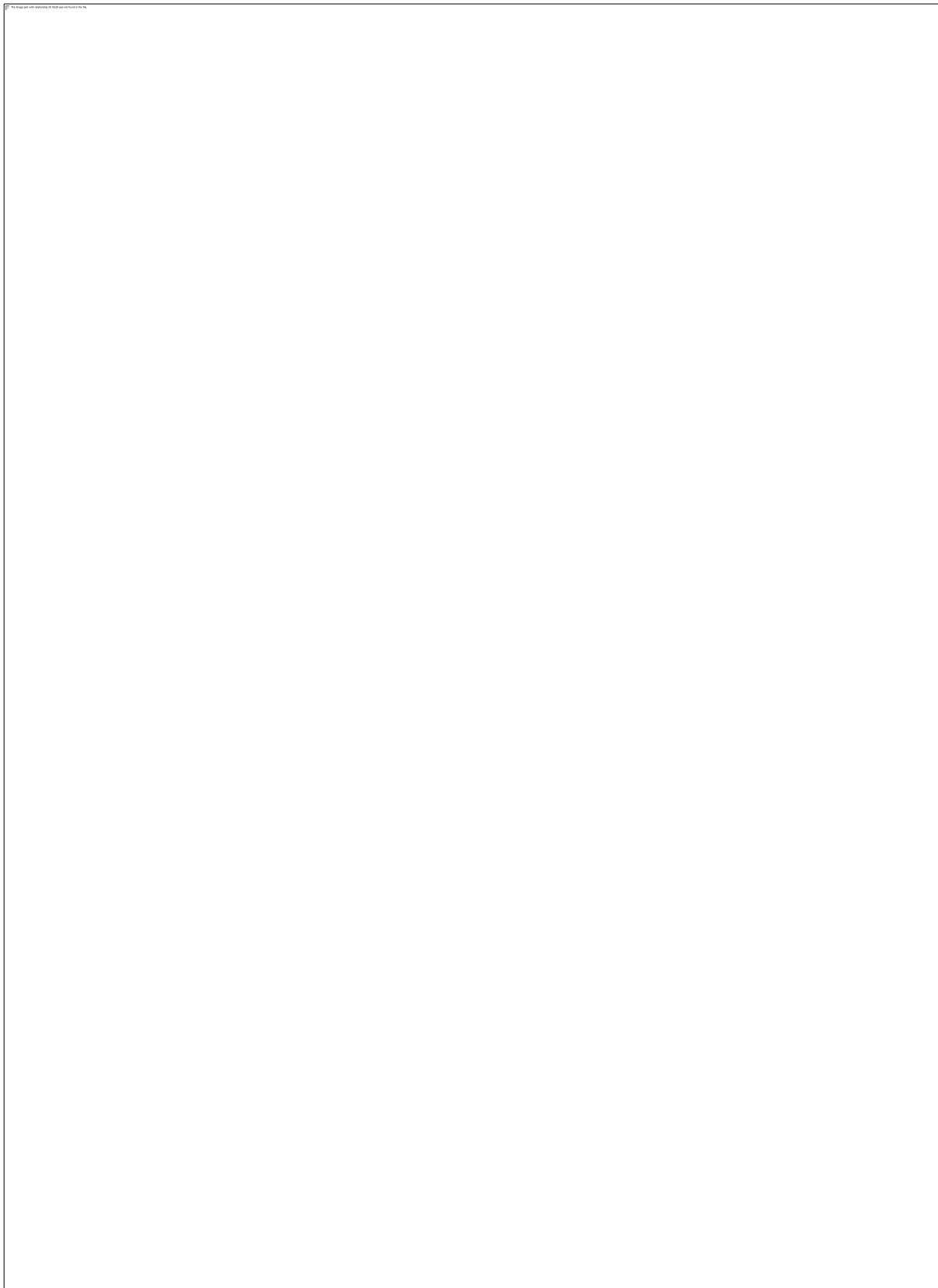
**ADDENDUM A1**  
**APPROVAL FROM THE UNIVERSITY OF PRETORIA ETHICS**  
**COMMITTEE**

**ORIGINAL LETTER FROM THE UNIVERSITY ETHICS COMMITTEE WILL BE ATTACHED**

**ADDENDUM B**  
**RESEARCH ETHICS CLEARANCE CERTIFICATE FROM THE**  
**GAUTENG PROVINCIAL DEPARTMENT OF HEALTH FOR**  
**CONDUCTING THE RESEARCH STUDY**

## **ADDENDUM B**

**APPROVAL FROM GAUTENG DEPT OF HEALTH: ETHICS COMMITTEE**



**ADDENDUM B1**  
**LETTERS TO REQUEST PERMISSION TO CONDUCT THE**  
**RESEARCH STUDY**

**GAUTENG PROVINCIAL DoH**

**CITY OF TSHWANE**

**TSHWANE DISTRICT HEALTH SERVICES**

**ADDENDUM B 1: Letter of Obtaining Permission –Gauteng Provincial Department of Health-Research Unit**

Caesar Unit 304,  
966 12<sup>th</sup> Avenue,  
Wonderboom South,  
0084.  
Tel: 082 927 3346

Date: \_\_\_\_\_

Gauteng Department of Health  
Research Ethics Unit  
The Fields Building  
Corner Hilda and Burnette Street  
**PRETORIA**  
0001

Dear Dr Manei Letebele

**Re: Approval to conduct a Study for PhD purposes**

I am a nurse and PhD candidate at the University of Pretoria. I hereby wish to submit this research proposal for Provincial Ethical Review and Approval to conduct a study entitled: **“A Nursing Practice Model for Anticipatory Guidance of Adolescents to Resist Peer Pressure and Coercion to Sexual Activity”**. This proposed study has already been granted approval by the University Research Ethics Committee. I need the Gauteng Department of Health approval to proceed with data collection.

The aim of this study is to develop a nursing practice model to provide anticipatory guidance to adolescents to enable them to resist peer pressure and coercion to sexual activity.

The data collection involving adolescents and nurses is planned to be done at selected primary healthcare clinics in the Tshwane District in Gauteng Province, South Africa from February to May 2014 in line with the proposed study plan to execute and finalise the research report by Nov 2014.

I hope that the permission approval will be granted so that necessary research can be done to make a contribution to the fight against the consequences of coerced adolescents' sexual activities.

Regards,

\_\_\_\_\_  
Yours Faithfully  
Mrs E.O Mashia  
Principal Researcher



## LETTER OF PERMISSION TO CONDUCT A RESEARCH STUDY

University of Pretoria  
Department of Nursing Science  
PO Box 677  
PRETORIA  
0001

The District Health Management: Primary Healthcare Services  
Tshwane District Health  
Private Bag X  
**PRETORIA**  
0001

Dear Sir/Madam

**Re: Approval to conduct a Study for PhD purposes REF: Student Number - 98299035**

I am a 2012 PhD Candidate at the University of Pretoria. I hereby wish to submit this research proposal for Ethical Review and Approval to conduct a study entitled: **“Towards a Nurse Practice Model to reduce adolescent sexual coercion”**.

The aim of this study is to develop a nursing practice model to provide anticipatory guidance to adolescents to enable them to resist peer pressure and coercion relating to sexual activity in Tshwane District, Gauteng Province, South Africa.

The research objectives are to:

- Explore and describe peer pressure and coercion from the adolescents' perspective;
- Explore and describe the manifestation of peer pressure and coercion
- Explore and describe how peer pressure and coercion lead to adolescent sexual activity
- Develop a nurse practice model on anticipatory guidance for adolescents to resist peer coercion.

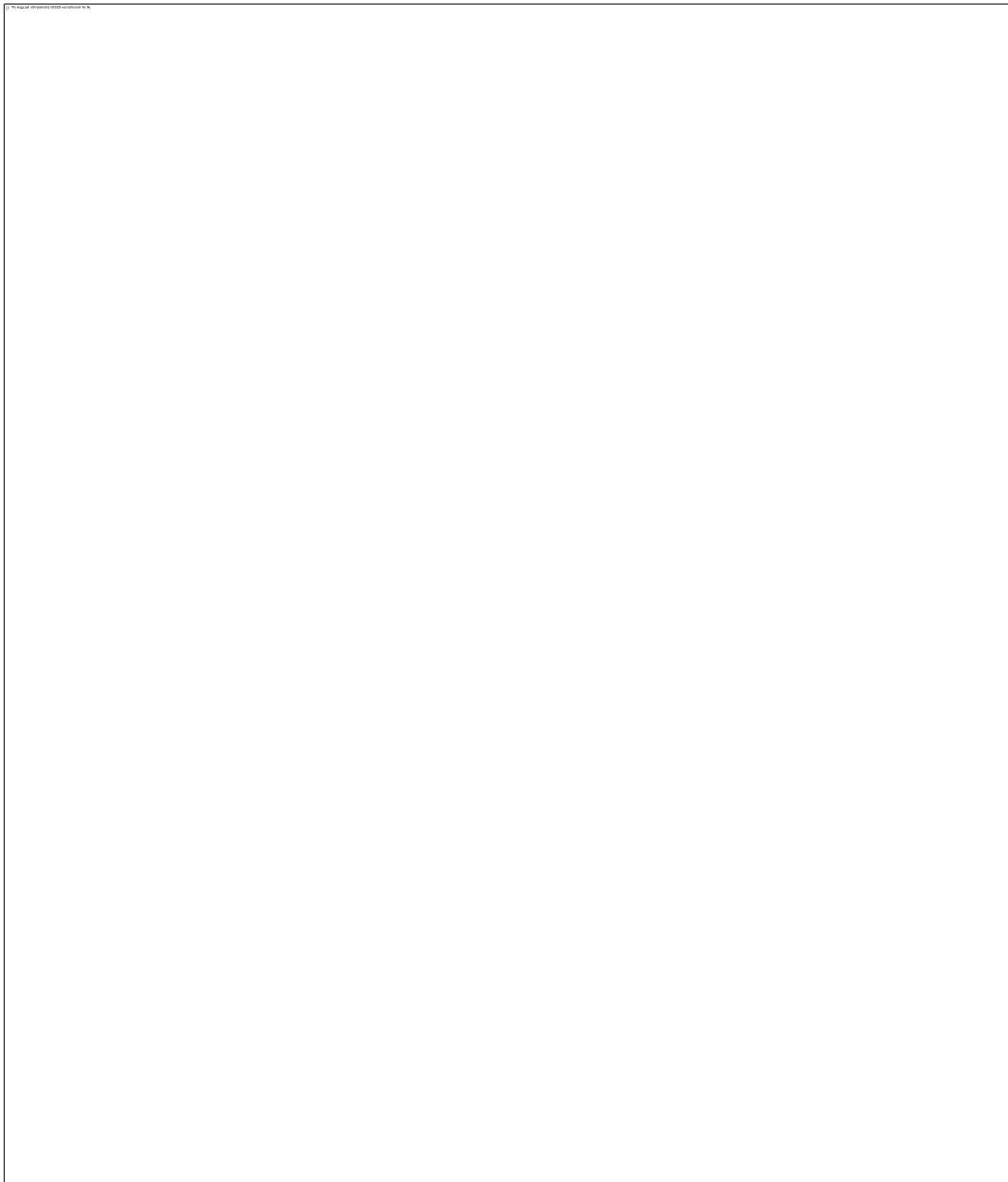
The proposed study will take place at identified and select public health facilities in Tshwane District with Gauteng Province, South Africa. The proposed study is scheduled to take place during September to December 2013 in line with the proposed study plan to execute and finalise a research study before end the of year 2014.

Yours Faithfully  
Mrs E.O Mashia  
Principal Researcher

## CoT LETTER TO REQUEST PERMISSION

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**ADDENDUM B2**  
**APPROVAL LETTER FROM DISTRICT HEALTH SERVICES- GPDoH**  
**TO CONDUCT THE RESEARCH STUDY (Ms Moreane Letter)**



**ADDENDUM B3**  
**APPROVAL LETTER FROM CITY OF TSHWANE TO CONDUCT THE**  
**RESEARCH STUDY (Dr Elfreda)**

**ADDENDUM C: APPROVAL FROM CoT CLINIC TO CONDUCT THE**  
**STUDY**



**ADDENDUM D**  
**PARTICIPANT INFORMATION LEAFLET AND CONSENT FOR**  
**NURSES AND OTHER EXPERTS IN YOUTH DEVELOPMENT AND**  
**ADOLESCENT REPRODUCTIVE HEALTHCARE**

## **ADDENDUM D: Participant information leaflet – nurses and other experts in youth development and adolescents' reproductive healthcare**

**Title of the Study:** “A NURSE THEORY FOR ANTICIPATORY GUIDANCE OF ADOLESCENTS TO RESIST PEER COERCION TO SEXUAL ACTIVITY”

**Dear Participant,**

### **1. INTRODUCTION**

You are invited to participate in a research study. This brochure will assist with giving you the relevant information to help you decide to participate in this particular research study. It is important to understand what the research study entails before you can make a decision to participate. Should this brochure fail to provide all the information you need to know, feel free to ask the researcher.

### **2. THE NATURE AND PURPOSE OF THIS STUDY**

Adolescents experience pressure from friends to take part in sex. They often do not know the sex partners well and do not know their HIV status. Condoms are not always used and adolescent pregnancies and HIV infections are often the result of such sexual activity. The aim of this study is to construct a nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity. You as a health professional is a very important source of information on youth development and adolescents' reproductive care and are thus approached to take part in this study.

### **3. EXPLANATION OF PROCEDURES TO BE FOLLOWED**

This study involves intensive interviews regarding the peer pressure and coercion to sexual activities that adolescents experience and the ways in which health professionals and very specific nurses can assist them to resist the pressure and coercion. I will ask you some questions on your perspective about how adolescents can be prepared for anticipated peer pressure and coercion so that they can have the knowledge and skills to resist it.

### **4. RISK AND DISCOMFORT INVOLVED**

There are no risks in participating in the study as only interviews about your perspectives



regarding the guidance of adolescents to resist peer pressure and coercion to sexual activity will be done. The interview will take about 45 minutes of your time.

## **5. POSSIBLE BENEFITS OF THIS STUDY**

Although you will not benefit directly from the study, the results of the study will enable us to improve healthcare to adolescents in future. At the end of the study I will provide you with a copy of the findings.

## **6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?**

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason. Your withdrawal will not affect you in any way.

## **7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?**

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria and the Gauteng Department of Health Research Committee. Copies of the approval letters are available if you wish to have one.

## **8. INFORMATION AND CONTACT PERSON**

The contact person for the study is Mrs Olga Mashia. If you have any questions about the study please contact her at cell 082 927 3346. Alternatively, you may contact my supervisor Prof Neltjie van Wyk at cell 082 776 1649.

## **9. COMPENSATION**

Your participation is voluntary. No compensation will be given for your participation.

## **10. CONFIDENTIALITY**

All information that you give will be kept strictly confidential. Once we have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you or your clinic or your health department.

## CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way. I have received a signed copy of this informed consent agreement.

Participant's name ..... (Please print)

Participant's signature: ..... Date.....

Investigator's name ..... (Please print)

Investigator's signature ..... Date.....

Witness's Name ..... (Please print)

Witness's signature ..... Date.....

**ADDENDUM E**  
**PARTICIPANT INFORMATION LEAFLET- PARENTS OF**  
**ADOLESCENTS YOUNGER THAN 18 YEARS**

## **ADDENDUM E: Participant information leaflet – parents of adolescents younger than 18 years**

Title of the Study: “A NURSE PRACTICE THEORY FOR ANTICIPATORY GUIDANCE OF ADOLESCENTS TO RESIST PEER COERCION TO SEXUAL ACTIVITY”

Dear Participant,

### **INTRODUCTION**

Your child is invited to participate in a research study. This brochure will assist with giving you the relevant information to help you decide to allow your child to participate in this particular research study. It is important to understand what the research study entails before you can make a decision to let your child participate. Should this brochure fail to provide all the information you need to know, feel free to ask the researcher.

### **THE NATURE AND PURPOSE OF THIS STUDY**

Adolescents experience pressure from friends to take part in sex. The aim of this study is to develop a way to construct a nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity. Your child who is an adolescent might be aware of such behaviour and can help health professionals to develop a way to assist adolescents to resist such pressure from friends. Your child is a very important source of information and is thus approached to take part in this study. No questions will be asked about whether he or she is sexually active.

### **EXPLANATION OF PROCEDURES TO BE FOLLOWED**

This study involves intensive interviews regarding the peer pressure and coercion to sexual activities that adolescents experience. I will ask your child some questions on how peer pressure and coercion to sexual activity manifests.

### **RISK AND DISCOMFORT INVOLVED**

There are no risks in participating in the study as only interviews about your child's experiences about the manifestation of peer pressure and coercion to sexual activity will be done. The interview will take about 30 minutes of his/her time.

## POSSIBLE BENEFITS OF THIS STUDY

Although your child will not benefit directly from the study, the results of the study will enable

us to improve healthcare to adolescents in future. At the end of the study I will provide your child with a copy of the findings.

## WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your child's participation in this study is entirely voluntary. You can refuse to let him/her participate or have him/her stop at any time during the interview without giving any reason. Your withdrawal of your child will not affect you and him/her in any way.

## HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria and the Gauteng Department of Health Research Committee. Copies of the approval letters are available if you wish to have one.

## INFORMATION AND CONTACT PERSON

The contact person for the study is Mrs Olga Mashia. If you have any questions about the study please contact her at cell 082 927 3346. Alternatively, you may contact my supervisor Prof Neltjie van Wyk at cell 082 776 1649.

## COMPENSATION

Your child's participation is voluntary. No compensation will be given for the participation.

## CONFIDENTIALITY

All information that you will give will be kept strictly confidential. Once we have analysed the information no one will be able to identify him/her. Research reports and articles in scientific journals will not include any information that may identify him/her.

## CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to allow my child to take part in this study has told me about nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am allowing my child to participate willingly. I have had time to ask questions and have no objection that he/she participates in the study. I understand that there is no penalty should I wish to let my child discontinue with the study and his/her withdrawal will not affect him/her in any way.

I have received a signed copy of this informed consent agreement.

Participant's name ..... (Please print)

Participant's signature: ..... Date.....

Investigator's name .....(Please print)

Investigator's signature ..... Date.....

Witness's Name ..... (Please print)

Witness's signature ..... Date.....

## VERBAL INFORMED CONSENT

--

I, the undersigned, have read and have fully explained the participant information leaflet, which explains the nature, process, risks, discomforts and benefits of the study to the person whom I have asked to allow his/her child to participate in the study.

The person indicates that s/he understands that the results of the study, including personal details regarding the interview will be anonymously processed into a research report. The participant indicates that s/he has had time to ask questions and has no objection to allow her/his child to participate in the interview. S/he understands that there is no penalty should his/her child wish to discontinue with the study and the withdrawal will not affect her/him in any way. I hereby certify that the client has agreed to allow his/her child to participate in this study.

Participant's Name: ..... Please print)

Person seeking consent:..... (Please print)

Signature: .....Date.....

Witness's name:..... (Please print)

Signature:..... Date.....

**ADDENDUM E(1)**  
**CONSENT FOR PARENTS CHILDREN UNDER 18 YEARS TO**  
**PARTICIPATE IN THIS STUDY**



**ADDENDUM E (2) CONSENT FOR PARENTS CHILDREN UNDER 18 YEARS TO PARTICIPATE IN THIS STUDY**

I confirm that the person asking my permission to allow my child to take part in this study has told me about nature, process, risks, discomforts and benefits of the study. I have also received, read (or had information read to me) and understood the above written information (Information Leaflet and Informed Consent) regarding the study.

I am aware that the results of the study, including personal details, or names will not be made known to anybody or written on research reports. I am allowing my child to participate willingly.

I have had time to ask questions and have no problem or don't refuse that he/she participates in the study. I understand that there is no punishment should I wish to let my child stop taking part in the study and his/her pulling out of the study will not affect him/her in any way.

I have received a signed copy of this informed consent agreement.

Participant's name: ..... (Please print)

Participant's signature: ..... Date.....

Investigator's name: ..... (Please print)

Investigator's signature: ..... Date.....

Witness's Name: ..... (Please print)

Witness's signature: ..... Date.....

## VERBAL INFORMED CONSENT

I, the undersigned, have read and have fully explained the participant information leaflet, which explains the nature, process, risks, discomforts and benefits of the study to the person whom I have asked to allow his/her child to participate in the study.

The person indicates that s/he understands that the results of the study, including personal details regarding the interview will be anonymously processed into a research report. The participant indicates that s/he has had time to ask questions and has no problem to allow her/his child to participate in the interview. S/he understands that there is no punishment should his/her child wish to discontinue with the study and pulling out of the study will not affect her/him in any way. I hereby certify that the client has agreed to allow his/her child to take part in this study.

Participant's name: ..... (Please print)

Participant's signature: ..... Date.....

Investigator's name: ..... (Please print)

Investigator's signature: ..... Date.....

Witness's Name: ..... (Please print)

Witness's signature: ..... Date.....

**ADDENDUM F**  
**PARTICIPANT INFORMATION LEAFLET- ADOLESCENTS 18 YEARS**  
**AND OLDER**

## **ADDENDUM F: Participant information leaflet – adolescents 18 years and older**

**Title of the Study:** “A NURSE PRACTICE THEORY FOR ANTICIPATORY GUIDANCE OF ADOLESCENTS TO RESIST PEER COERCION TO SEXUAL ACTIVITY”

**Dear Participant,**

### **1. INTRODUCTION**

You are invited to participate in a research study. This brochure will assist with giving you the relevant information to help you decide to participate in this particular research study. It is important to understand what the research study entails before you can make a decision to participate. Should this brochure fail to provide all the information you need to know, feel free to ask the researcher.

### **2. THE NATURE AND PURPOSE OF THIS STUDY**

Adolescents experience pressure from friends to take part in sex. They often do not know the sex partners well and do not know their HIV status. Condoms are not always used and adolescent pregnancies and HIV infections are often the result of such sexual activity. The aim of this study is to construct a nursing practice theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity. You as an adolescent who might have experienced peer pressure and coercion or might be aware of such behaviour can help health professionals to develop a way to assist adolescents to resist such behaviour from friends. You are a very important source of information and are thus approached to take part in this study. No questions will be asked about your sexuality or whether you are sexually active or not.

### **3. EXPLANATION OF PROCEDURES TO BE FOLLOWED**

This study involves intensive interviews regarding the peer pressure and coercion to sexual activities that adolescents experience. I will ask you some questions on how peer pressure and coercion to sexual activity manifests.

### **4. RISK AND DISCOMFORT INVOLVED**

There are no risks in participating in the study as only interviews about your experiences about the manifestation of peer pressure and coercion to sexual activity will be done. The interview will take about 30 minutes of your time.

## **5. POSSIBLE BENEFITS OF THIS STUDY**

Although you will not benefit directly from the study, the results of the study will enable us to improve healthcare to adolescents in future. At the end of the study I will provide you with a copy of the findings.

## **6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?**

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason. Your withdrawal will not affect you in any way.

## **7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?**

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria and the Gauteng Department of Health Research Committee. Copies of the approval letters are available if you wish to have one.

## **8. INFORMATION AND CONTACT PERSON**

The contact person for the study is Mrs Olga Mashia. If you have any questions about the study please contact her at cell 082 927/3346 or 072 831 1255. Alternatively, you may contact my supervisor Prof Neltjie van Wyk at cell 082 776 1649.

## **9. COMPENSATION**

Your participation is voluntary. No compensation will be given for your participation.

## **10. CONFIDENTIALITY**

All information that you give will be kept strictly confidential. Once we have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you.

## CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way.

I have received a signed copy of this informed consent agreement.

Participant's name ..... (Please print)

Participant's signature: ..... Date.....

Investigator's name: ..... (Please print)

Investigator's signature:..... Date.....

Witness's Name: ..... (Please print)

Witness's signature: ..... Date.....

## VERBAL INFORMED CONSENT

I, the undersigned, have read and have fully explained the participant information leaflet, which explains the nature, process, risks, discomforts and benefits of the study to the participant whom I have asked to participate in the study.

The participant indicates that s/he understands that the results of the study, including personal details regarding the interview will be anonymously processed into a research report. The participant indicates that s/he has had time to ask questions and has no objection to participate in the interview. S/he understands that there is no penalty should s/he wish to discontinue with the study and his/her withdrawal will not affect her/him in any way. I hereby certify that the client has agreed to participate in this study.

Participant's name ..... (Please print)

Participant's signature: ..... Date.....

Investigator's name: ..... (Please print)

Investigator's signature: .....Date.....

Witness's Name: ..... (Please print)

Witness's signature: ..... Date.....

**ADDENDUM G**  
**PARTICIPANTS' INFORMATION LEAFLET**





## **Annexure G (1): Participants' Information Leaflet**

**Dear Participant younger than 18 years,**

### **1. INTRODUCTION**

I wish to know if you would like to volunteer to be part of a research study in which you will get the opportunity to discuss with me; how young people like you get pressurised by friends to have sex. According to what I have read in books and research journals it does happen and through this study, I want to get more information from you so that I can plan in cooperation with you and nurses from the clinics and other centres how to help young people who do not want to engage in sex because of the pressure that their friends put on them to act against their will.

This leaflet will assist with giving you the relevant information to help you decide to participate in this particular research study. It is important to understand what the research study is all about before you can make a decision to take part. Should this leaflet fail to provide all the information you need to know, feel free to ask the researcher or the supervisor. Their contact cell phone numbers are written on this leaflet on number 8 below.

### **2. THE NATURE AND PURPOSE OF THIS STUDY**

Adolescents experience pressure from friends to take part in sex. The aim of this study is to get more information from adolescents to help young people who do not want to have sex against their will because of the pressure that their friends put on them. You might be aware of such behaviour and can help health professionals to develop a way to assist other adolescents to resist such pressure from friends. Therefore, you are a very important source of information and are the reason you are requested to take part in this study. No questions will be asked about your sexual life or whether you are sexually active or not. If you feel uncomfortable with any of the questions you need not answer it, and if you become upset by the questions a trained person will be available to talk to you.

### **3. EXPLANATION OF PROCEDURES TO BE FOLLOWED**

This study involves intensive interviews regarding the peer pressure and coercion to sexual activities that adolescents experience. About 10 adolescents are going to take part in this study. It will take place in a quiet and private venue in the clinic. No-one will hear us and in my research report I will not include any information that will identify you. What you will tell me will not be communicated to the clinic staff or any other person except through my research report. I will ask you some questions on how peer pressure and coercion to sexual activity manifests.

### **4. RISK AND DISCOMFORT INVOLVED**

There are no risks in participating in the study as only interviews about your experiences about the manifestation of peer pressure and coercion to sexual activity will be done. The interview will take about 30 minutes of your time.

### **5. POSSIBLE BENEFITS OF THIS STUDY**

Although you will not benefit directly from the study, the results of the study will enable us to improve healthcare to adolescents in future. At the end of the study I will provide you with a copy of the report.

### **6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?**

Your participation in this study is not forced. If you do not want to take part any more you may decide at any time during the study, not to carry on. No-one will force you to carry on. No-one will be cross or upset with you if you do not want to take part, and you will still receive the healthcare services you need from the clinic. You don't have to give me your answer now, take your time and read the rest of this form before you decide.

### **7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?**

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria and the Gauteng Department of Health Research Committee. Copies of the approval letters are

available if you wish to have one and show it to your parents.

## **8. INFORMATION AND CONTACT PERSON**

The contact person for the study is Mrs Olga Mashia. If you have any questions about the study please contact her at cell 082 927 3346. Alternatively, you may contact my supervisor Prof Neltjie van Wyk at cell 082 776 1649.

## **9. COMPENSATION**

Your participation is not forced. No compensation will be given for the participation.

## **10. CONFIDENTIALITY**

All information that you give will be kept strictly confidential. Once we have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you.

**ADDENDUM GG1**  
**LINE BY LINE CODING (ADOLESCENTS)**

## RESEARCH TOPIC: A NURSING THEORY FOR ANTICIPATORY GUIDANCE OF ADOLESCENTS TO RESIST PEER PRESSURE AND COERCION TO SEXUAL ACTIVITY

### The aim of this study is twofold:

Firstly, to determine how peer pressure and coercion to sexual activity are experienced by male and female adolescents in an urban area in Gauteng, a province in South Africa and

Secondly, to develop a nursing theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity.

### The research objectives are to:

1. Explore and describe peer pressure and coercion to sexual activity from the adolescents' perspective;

### Research Question 1: What are the experiences of adolescents with regard to peer pressure and coercion to sexual activity?

Initial Coding	Participant Quotations	Revised Focused Code: Imposing force on peers to act involuntary
1. Being forced to do things to belong to a friendship circle	<p><b>A: Researcher: Tell me what you understand about the words “peer pressure” and “coercion”.</b></p> <p>Participant: Peer pressure so that you can still <u>be together</u> with them.( AP #1)</p>	<p><b>Memo:</b> According to the adolescents they claim that peer pressure is when their other adolescents force their friends to do things so that they remain together in the friendship. AP# 1 attested to that by saying “Peer pressure is <u>when your friends force you to do things</u> so that you can still <u>be together</u> with them”.</p>

<p><b>2. Being forced by friends to do something one does not want to do</b></p>	<p><b>B: Researcher: What is peer pressure? Say it in your own words.</b></p> <p>Participant: Peer pressure ... “njengoba ushilo” meaning “like you said”.</p> <p><b>Researcher☹: What is peer pressure? In your own words (interjected) Say it in English.</b></p> <p>Participant: is like a friend or many friends <u>forcing you to do something</u> you don’t want to do (AP # 2)</p>	<p>AP# 8 added to that statement by saying “<u>sometimes when you get forced to do things you don’t want to do by your friends</u>”. AP#8 &amp; AP#9 also concurred with AP#1 that in peer pressure there is an element of being forced to do things one doesn’t want to do. Both participants put it the same way without mincing words that” <u>peer pressure means that sometimes when you get forced to do things you don’t want to do by your friends</u>”.</p> <p>AP#8 also remarked that in peer pressure adolescents influence other to do things even if they don’t want to do it.</p> <p>Whereas AP# 3 indicated that peer pressure is when friends push for others to do something they don’t</p>
<p><b>3. Being pushed to do unwanted things/ deeds</b></p>	<p><b>C: Researcher: Tell me what you understand about the words “peer pressure”.</b></p> <p>Participant: The word “peer pressure”. I understand that</p>	

	<p><u>when someone push you to do something that you don't want.</u> Maybe make you feel bad when you don't want and force you to do what you don't like, is that what I understand about peer pressure. (AP #3)</p>	<p>want. Also mentioned that there is a guilt feeling if as friends one doesn't want to do as imposed.</p> <p>AP#6 brought a different twist of insight to the interview that in peer pressure there is a hint of impressing others. <u>"Peer pressure is something that you do just to like impress other people"</u> (AP #6).</p>
<p><b>4. Being forced by friends to engage in unwanted deeds</b></p>	<p><b>D: Researcher: Tell me what you understand about the word peer pressure</b></p> <p>Participant: I think actually <u>it means that sometimes when you get forced to do things you don't want to do by your friends.</u> (AP# 8)</p>	<p>Imposing actions involves adolescents leading their peers to go to the clubs, taverns, dating, drinking alcohol, doing stuff and smoking drugs.</p> <p>When asked what doing stuff meant it was said it involved drinking alcohol, sex and drugs and AP# 8 clarified what stuff is and said it is <u>"Like smoking, drinking, drugs and having sex"</u>.</p>
<p><b>5. Being forced to do some things.</b></p>	<p><b>E. Researcher: Tell me about what you understand by the word peer pressure. What is</b></p>	



<p><b>6. Being forced to do unwanted things/ deeds</b></p>	<p><b>peer pressure in your own words:</b></p> <p>Participant:” Peer pressure (Translation- <u>Is something that other people forces you to do... like smoking drugs )...</u></p> <p>Translation: <u>they force you to do things you don’t want to do</u>) (AP #9)</p>	<p>Most of the adolescents in this study say in peer pressure there a person or persons who force their peers to carry out unwanted deeds and they spell out that there is force used and the other party does not want to do as required by peers. This person or persons is someone the adolescent know or a friend. Evidence is in the statement from AP# 3 “<u>when someone push you to do something that you don’t want</u>” and AP#1 “is <u>when your friends force you to do things</u></p> <p>Overall it can be summed up that in peer pressure the following elements are present namely pushing and forcing others to do something they don’t want to do, influencing, persuading, pleasing and impressing others to be in the friendship circle.</p>
<p><b>7. Doing something to impress others</b></p>	<p><b>F: Researcher: Firstly I would like you to tell me about peer pressure, what you understand about the words “peer pressure”?</b></p> <p>Participant: For me personally I think that peer pressure <u>is something that you do just to like impress other people</u> (AP# 6)</p>	

<p><b>8. Being persuaded to do unwanted things</b></p>	<p><b>Researcher: Tell me what you understand about the word peer pressure</b></p> <p>Participant: ... Actually they will tell you that maybe sometimes you have to go to the tavern or you have to go out dating and <u>doing all the stuff</u>; and you don't want to do them and <u>they will always persuade you to such things even though you don't want to do such things.</u>(AP#8)</p>	
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Initial Coding	Participant Quote	Revised Focused Code 2: Compelling adolescent to conform to peer expectations
a). Dating but not ready for sex b). Putting pressure on a friend to have sex	<b>Researcher: What was that you forced her to do?</b> Participant: Me and my other friend... she said she was dating but <u>afraid to have sex</u> with her boyfriend. <u>We forced her to have sex.</u> (AP #1)	<b>Memo:</b> The participant shared different compelling experiences of peer pressure in their life.  AP#1 with her other friends imposed an act to their anxious friend to have sex with her boyfriend. The forced adolescent was dating but afraid to have sex. She mentioned that she orchestrated that their scared friend have sex with her boyfriend. "She said she was dating but <u>afraid to have sex with her boyfriend. We forced her to have sex.</u> (AP #1)."
c). Doing bad deeds to prove allegiance	<b>Researcher: Hmm, some of the things are illegal! Which are those?</b> Participant: Some <u>may be say go and steal that thing from that person, go beat that person to show that you are one of us</u> and in turn it might make you face jail time or land you in trouble . (AP#6)	AP#6 shared her experience where she was subjected to stealing and beating a person to prove belonging to the peer group. She reported examples of illegal activities her peer set to be done " <u>Some may be say go and steal that thing from that person, go beat that person to show that you are one of us.</u> She was aware of her actions and consequences because she mentioned that it could " <u>in turn it might make you face jail time or land you in trouble</u> ".
d). Being forced to date a girl	<b>Researcher: what was happening?</b> Participant: <u>It was those guys forcing a guy to date a girl.</u> (AP #8)	AP#8 witnessed adolescent boys forcing another adolescent boy to date a girl. He said " <u>It was those guys forcing a guy to date a girl</u> ". He also mentioned that peer pressure is associated with doing stuff which he explained as " <u>Like smoking, drinking, drugs and having sex.</u> "
e). Doing bad deeds	<b>Researcher: When you say "stuff" what stuff are you referring to?</b> Participant: Like <u>smoking, drinking, drugs and having sex.</u> (AP #8)	Adolescent boys are forced to act in a certain way or do certain actions or deeds as mentioned above by their peers. This is how adolescent boys experience peer pressure.
Initial Codes	Participant Quotes	Revised Focused Code 3: Idolising material possessions as indicators of peer status

<b>1. Material belongings determine how peers view others</b>	<b>Researcher: Tell me what you understand about the words “peer pressure”.</b> Participant: Okay, peer pressure is... eh let me just say; <u>when you have friends and they have what you don't have then is like you don't have things they have; then you start pressurising yourself.</u> (AP # 4)	<b>Memo:</b> Upon being asked what peer pressure meant to her, AP#4 likened peer pressure what happens to somebody when their friends possess things they don't have and whatever you have they don't have and one start putting pressure on themselves. To AP#4 peer pressure is about having and owning certain things and what your friends have and you don't have as she put it. Quote: “ <u>when you have friends and they have what you don't have then is like you don't have things they have; then you start pressurising yourself</u> (AP # 4).”  AP#5 stated the almost similar answer as AP#4 that peer pressure is about someone having something you don't have and you desperately want it. She said jealousy make adolescents be affected by peer pressure. Quote: sometimes other people... jealous. Like <u>someone have a thing that you really don't have and you really want it</u> (AP #5).  In response to a question about what causes peer pressure AP#3 indicated that families are not socioeconomically equal. Some adolescents wear same type of clothes whereas those from rich families wear expensive ones. She said “ <u>we are teenagers in our own home we are not equal and some people are rich, some are poor.</u> When we are wearing; <u>we are not wearing the same clothes; some are wearing expensive clothes</u> ”. Those from poor families feel pressurised to get expensive clothes as well and thus find boyfriends, particularly the sugar daddies. They start dating sugar daddies in order to get expensive clothes like their friends. The sugar daddies then buy things
<b>2. Possessing things that others don't have makes others jealous</b>	<b>Researcher: So except the family problems that causes other people to pressure other people, what are the other causes of peer pressure? Other things that make adolescents apply peer pressure, what are they?</b> Participant: sometimes other people... jealous. Like <u>someone have a<sup>2</sup> thing that you really don't have and you really want it</u> (AP #5)	
<b>3. Possessing different economic status</b> <b>4. Wearing different clothes based on value</b> <b>5. Seeking sugar daddies to provide for material needs</b> <b>6. Dating older men in exchange of material goods</b>	<b>Researcher: What do you think causes peer pressure among adolescents?</b> Participant: That causes peer pressure is because as <u>we are teenagers in our own home we are not equal and some people are rich, some are poor.</u> When we are wearing; <u>we are not wearing the same clothes; some are wearing expensive clothes.</u> So we are	

<sup>2</sup> AP#4 and AP#5 come from extreme setting but they had the same idea on what causes peer pressure. One comes from a township in a semi-urban setting and the other one from a rural province but the life orientation lessons they learnt gave them a similar insight as far as they could remember.

	<p>getting pressurised by starting to found our boyfriends to buy; sugar daddies... We start <u>dating sugar daddies so that we can have those things, expensive clothes that our friends have.</u> (AP #3)</p>	<p>and expensive clothes for adolescents. Quote: “We start <u>dating sugar daddies so that we can have those things, expensive clothes that our friends have.</u> (AP #3)”.</p>
<p><b>7. Wearing expensive clothes to be attractive</b></p> <p><b>8. Dating older men in exchange of material goods</b></p>	<p><b>Researcher: And then the other thing that you mentioned earlier, you said sometimes people group themselves according to their richness, their beauty. Do you think the issue of clothes and material things have an influence on peer pressure and how so?</b></p> <p>Participant:....if you are beautiful and if <u>you wear expensive clothes you attract men</u> and then you attract certain jobs and then as we young girls we'll do anything to reach that level; <u>ending up dating sugar daddies doing all these kind of stuff in order to fit in.</u> (AP #6)</p>	<p>AP#6 was asked to describe the relationship between clothes, material things and peer pressure as it manifested in peer pressure. She mentioned that adolescents wear expensive clothes to be attractive for men and certain jobs. That is illustrated in this quote “<u>if you wear expensive clothes you attract men</u> and then you attract certain jobs” . Adolescents are daring when they are desperate to reach certain levels. They go to an extend of dating sugar daddies and do anything to fit in. “<u>ending up dating sugar daddies doing all these kind of stuff in order to fit in</u> (AP #6).”</p>

Initial Codes	Participant Quotes	Revised Focused Code 4: Suffering negative effects of peer pressure
<b>a). Considering peer pressure as a bad thing</b> <b>b). Becoming pregnant in a young age</b>	<b>Researcher: Okay. Eh... Tell me what you have learned about peer pressure?</b> Participant: Eh... I have learnt many things about the peer pressure because peer <u>pressure is about bad thing</u> because you <sup>3</sup> <u>become pregnant</u> in a young <sup>4</sup> <u>age</u> . (AP # 3)	<b>Memo:</b> AP#3 said she learnt many things about peer pressure. She said peer pressure is a bad thing and it could lead to pregnancy at an early age. “Peer <u>pressure is about bad thing</u> because you become <u>pregnant in a young age</u> (AP # 3)”.  When AP#4 was asked how peer pressure lead adolescents to sexual activity and how it happens? She confirmed that peer pressure lead to sexual activity because an adolescent become more sexually active under peer pressure situations. “ You <u>become more sexually active</u> (AP# 4)”  In exploring what the content of the life orientation lessons of peer pressure contained; it was established that adolescents were taught about not smoking or not doing something bad as well as not being the company of bad people. “She said we must <u>not smoke or do something bad; don’t walk with peoples who are</u>
<b>c). Confirming that peer pressure leads to sexual activity</b>	<b>Researcher: Okay... how does peer pressure lead to sexual activities? Do you know?</b> Participant: Yes, it leads.... <b>Researcher: How does it happen?</b> Participant: <u>You become more sexually active</u> <sup>6,7</sup> . (AP# 4)	
<b>d). Advising adolescents to avoid risk behaviours like smoking and other bad things.</b>	<b>Researcher: Yah, what was included when she taught you?</b> Participant: She said we must not smoke <u>or do something bad</u> ; don’t walk with peoples who are not good. (AP #2)	

<sup>3</sup> Becoming pregnancy at an early age is teen pregnancy that follows unprotected sex and that is a risk behaviour that predisposes adolescents to STI and HIV

<sup>4</sup> Teenage pregnancy has many other complications like premature birth of low birth weight neonates and pre-eclampsia.

<sup>6</sup> Sexual activity amongst adolescents is often unplanned thus protection is not used

<sup>7</sup> Being more sexually active is a risk and likelihood of unplanned pregnancy is high.

e). Dating could lead to impregnating girls f). Behaving bad in the community	<p><b>Researcher: I know you said you might not finish your education, what else?</b></p> <p>Participant: <u>You can impregnate a girl or eh... do anything that is bad in the community.</u> (AP#2)</p>	<p><b>not good</b> (AP #2).” They were advised against risk behaviours like smoking and other bad things.</p>
g). Emphasising consequences of peer pressure h). becoming a drug addict or have an unplanned pregnancy e	<p><b>Researcher: From those lessons which ones do you remember? Or what did lesson on peer pressure? What were the various topics you discussed?</b></p> <p>Participant: Topics discussed were <u>consequences of a person’s actions</u>. Peer pressure has many end results. <u>One could end up being a drug addict or pregnant.</u> (AP #7)</p>	<p>Following up with a question to explore what else could go wrong if people are dating as the participant indicated over and above not finishing school; AP #2 echoed that adolescent boys could impregnate the adolescent girl or behave bad in the community. : <u>You can <sup>5</sup>impregnate a girl or eh... do anything that is bad in the community.</u> (AP#2)</p> <p>The response regarding lessons learnt about peer pressure from life orientation at course; AP#7 highlighted that they learnt about consequences of a persons’ actions and the end results thereof. He further mentioned that one may end up becoming a drug addict or pregnant. His response was “Topics discussed were <b>consequences of a person’s actions</b>. Peer pressure has many end results. <u>One could end up being a drug addict or pregnant.</u> (AP #7)”.</p>

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<sup>5</sup> AP#2 and AP#3 is a boy and girl from township and village attending at a public school and their responses are similar.

Initial Codes	Participants' Quotes	Revised Focused Code 5: Influencing others to perpetuate peer pressure
1. Influencing each other across gender 2. Thinking peer pressure is a way of life for adolescent 3. Using peer pressure for popularity and to outshine others	<b>Researcher: So because the information is going to be utilised by people who are English speaking; as much as we can, we need to utilise English but wherever you feel you need to express yourself in African language you can and I will translate in English (participant agreed to follow suggestion).</b> So you say "Peer pressure is a certain age group found at high school, <u>they like influencing each other among their male or female grouping. They like to think what they do in their groups is a way of life used by adolescents. And then they use it for popularity; they want to prove that they are popular than others and they like to be seen (AP #7)</u>	<p>MEMO: The participant expressed himself in his mother tongue and researcher had to translate the response from AP#7 on peer pressure. He said it emanates from a group of adolescents who influence each other thinking whatever they do in the process is a way of life. This what he said "<u>they like influencing each other among their male or female grouping. They like to think what they do in their groups is a way of life</u>". These group of adolescents flourish on popularity, brag about it and want to be seen as popular figures wherever they are. <u>They use it for popularity; they want to prove that they are popular than others and they like to be seen (AP #7).</u>"</p> <p>AP#2 did not waste time in his response to describe what causes peer pressure; he said people who think they are better than others and wants to influence other people are the ones. Quoted saying" Because they <u>think they are the best. They want to influence other people (AP # 2)</u>".</p> <p>AP# 6 said low self-esteem and low self-image is the cause of peer pressure. The desire to fit in, to be perfect and to be well known to other make adolescent be pressured no matter what. She said "low self-esteem, uhm ...<u>low self-image causes peer pressure. Just that thing wanting to fit in, wanting to be perfect and wanting like to be known (AP# 6).</u>"</p> <p>AP#8 mentioned that adolescents who think they are better than the other adolescents want them to follow and do what they</p>
4. Thinking they are better than others 5. Influencing others to perpetuate peer pressure deeds	<b>Researcher: And what do you think causes other people to pressure other people?</b> Participant: Because they <u>think they are the best. They want to influence other people (AP # 2)</u>	
6. Influencing factors of peer pressure are low self-esteem and low self-image 7. Wanting to fit in 8. Seeking perfection 9. Seeking popularity	<b>Researcher: Okay, what do you think is a cause of peer pressure? What causes it?</b> Participant: I think uhm... is low self-esteem, uhm ... <u>low self-image causes peer pressure. Just that thing wanting to fit in, wanting to be perfect and wanting like to be known (AP# 6).</u>	
10. Seeing oneself as better than others	<b>Researcher: Oh ...Okay... what causes people to apply peer pressure to other adolescents?</b>	



<b>11. Being a self-proclaimed leader</b>	Participant: The reason I think is because sometimes you see <u>what they are doing as better<sup>8</sup> than the other; you want others to follow you and to do what you are doing.</u> (AP #8)	instruct them to do. He said “you see what they are doing as better than the other; you want others to follow you and to do what you are doing (AP #8)”.
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<sup>8</sup> AP# 8 had the similar thought that adolescents who think they are better than other thus want other adolescents to follow them or they influence them.

2. Explore and describe the manifestation of peer pressure and coercion to sexual activity;

Initial Coding	Participant Quotations	Revised Focused Code 6: Being degraded by peers
<p>1. Ill-treatment executed by those following traditional practices</p> <p>2. Discriminating those who are not following traditional practices; Ill-treatment and threats are common</p> <p>3. Being degraded by those who practice traditional circumcision</p>	<p><b>Researcher: How did you experience peer pressure as a person?</b></p> <p>Participant: Translation “I experienced it at high school from some of my friends,... eh like in class and other classes. There were guys; this thing starts from most of those who practice traditional <u>circumcision</u>. It starts at that stage. <u>They went there for circumcision in the mountains, so they think they are men...</u> you see. And then if you’ve never been there that is when most of the people, <u>they start like treating you and threatening you because you’ve never been there</u>” (AP # 7)</p>	<p>AP#7 personal experience of peer pressure happened while he was at high school. There were some adolescent boys who practiced traditional circumcision who perceived themselves as men “(<u>this thing starts from most of those who practice traditional circumcision ...They went there for circumcision in the mountains, so they think they are men AP#7)</u>” because they underwent the circumcision rituals. These adolescent boys treated and threatened those who never went for traditional circumcision. He mentioned that “<u>they start like treating you and threatening you because you’ve never been there</u> (AP # 7)”.</p>
<p>7. Being forced by others to do unwanted activities</p> <p>8. Resisting but later relenting to peer pressure</p> <p>9. Being called derogatory names</p>	<p><b>Researcher: (Probing question) what was happening?</b></p> <p>Participant: It was <u>those guys forcing a guy to date a girl. He refused but at the end they were always teasing him, calling him names.</u> (AP #8)</p>	<p>For AP#8 his experience of peer pressure happening in his watch was when he witnessed adolescent boys forcing another adolescent boy to date a girl. When the boy refused to do what he was forced to do; he was teased and called names. Quote “It was <u>those guys forcing a guy to date a girl. He refused but at the end they were always teasing him, calling him names</u> (AP #8)”</p>
<p>10. Having fearless attitudes</p> <p>11. Being complacent about treating girls</p> <p>12. Taking girls for granted and preying on them sexually</p>	<p><b>Researcher: Let us deviate to find out if any of this peer pressure exerted by friends lead to sexual activity among boys and girls at school, does it happen?</b></p> <p>Participants: well it does....It does...like these guys, some of them they tell themselves (“Translation –<b>meaning they think they are tougher than anybody</b>”) So <u>they think that they can treat anyone and threaten them.</u> Like every</p>	<p>When the researcher explored how peer pressure to sexual activity manifested among girls and boys at school, AP#7 responded that some adolescent boys had an attitude and were prone to treat and threaten anyone at school. Quote” It was <u>those guys forcing a guy to date a girl. He refused but at the end they were always teasing him, calling him names</u> (AP #7)”. They also took for granted that girls will fall for them and do as they want. AP#7 remarked that all these boys wanted from girls was sex. “Like every girl they fall for,</p>

	<p>girl they fall for, <u>they think that girls will fall for, will do the thing they want. What they want from the girl is just sex. (AP #7)</u></p>	<p><u>they think that girls will fall for, will do the thing they want. What they want from the girl is just sex (AP #7)</u>"</p> <p>This behaviour portrayed by the adolescent boys in schools is utter bullying tactics.</p>
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Initial Codes	Participants Quotes	Revised Focus Code 7: Approving pressure from friends
<b>1. Citing friends as perpetrators in peer pressure activities.</b> <b>2. Perpetrating deeds of pressure with friends</b>	<b>Researcher: Have any close friend experience peer pressure? How did it happen if it did?</b> <i>Brief silence, looked like she did not understand. Waited a bit.</i> Participant: <u>Yes, with my friend<sup>9</sup>s. I was involved, I did it.</u> (AP #1)	<b>Memo:</b> In her response to the question on how did her close friend experience peer pressure; AP#1 replied that she and her friends were involved in the peer pressure incidence. They perpetrated the deed. She said “: <u>Yes, with my friends. I was involved, I did it.</u> (AP #1)”.  When AP#3 was asked to give her account of peer pressure experience she mentioned that she had many friends who liked going to clubs, or going to night clubs and coming home at night. Her friends invited her to go out with them. Her statement was as follows” I was <u>having many friends</u> that like to <u>go to the club, go and come at night everyday so</u> always <u>they want me to go with them</u> (AP #3)”. For this participant association with clubbing adolescent friends who went out at night and these friends extended an invitation for her to come along to the club at night irrespective of the age and timing.
<b>3. Associating with friends clubbing and enjoying night life</b> <b>4. Getting invited to join and tag along with friends</b>	<b>Researcher: Did it happen to you or did it happen to somebody while you were watching?</b> Participant: It has happened to me while I was in Grade 6. My...I was <u>having many friends</u> that like to <u>go to the club, go and come at night everyday so</u> always <u>they want me to go with them.</u> (AP #3)	

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<sup>9</sup> AP#3 mentioned friends. “Friends” was referring to peers her same age. A probing question to establish age and peer status was asked.

Initial Codes	Participants' Quotes	Revised Focused Code 8: Influencing peers to approve own behaviour
<p>1. Wanting others to go through the same bad experiences like them</p> <p>2. Influencing others so that they have the same experience</p>	<p><b>Researcher: What is the cause of peer pressure and coercion among adolescents? What causes adolescents to force, to apply peer pressure to their friends? What causes that?</b></p> <p>I think it is because maybe we want to fall... we want to <u>get in problems together</u>; many of us not so that I <u>cannot have a problem alone</u>. (AP #1)</p>	<p><b>Memo:</b> AP#1 stated the reason for other adolescents to apply peer pressure to their friends is that they want them to have problems like they did. In brief they want to be alike in terms of running into problems. Those who encountered a certain problem, they want to their friends to have the similar exposure. Thus AP#1 said <u>"we want to get in problems together; many of us not so that I cannot have a problem alone."</u></p> <p>AP#9 concurred with the statement posited by AP#1. Adolescents who want their friends to do same things like they do. They dislike friends who are acting differently or contrary to what is expected as friends in their friendship circle. They use their influence to their friends to do as they want. Thus <u>"they want you to do the same thing. They don't want you to be different than them. They want you to be like them and do things they do. (AP #9)"</u></p>
<p>3. Being Influenced by friends to do unwanted actions</p> <p>4. Influencing peers to do same activities</p> <p>5. Giving marching orders to peers</p> <p>6. Influencing peers to do what they do</p>	<p><b>Researcher: In your opinion what causes peer pressure?</b></p> <p>Participant: <u>Having difficult friends who want you to do what they want so that you all do the same thing. They want you to do the same thing. They don't want you to be different than them. They want you to be like them and do things they do. (AP #9)</u></p>	

Initial Codes	Participants' Quotes	Revised Focused Code 9: Relenting to peer pressure to gain peer approval
1. Observing older people doing inappropriate actions to impress others.	<p><b>Researcher: How did you experience peer pressure in your life?</b></p> <p>Participant: I have seen many things, boys and girls doing such things. <u>Seeing older people smoking or doing something unnecessary and have to impress ... (a bit frustrated for lack of better word to express himself).</u> (AP #2).</p>	<p><b>Memo:</b> When AP#2 was asked as how he experienced peer pressure; he indicated that he saw boys and girls doing things and he referred them as “such things” and “somethings that were unnecessary”. One action he mentioned was smoking of older people. (<i>There was limitation in self-expression thus sometimes led to lack of appropriate words to use</i>). These things he saw did not expect older people to do them. When it happened they were doing these deeds to impress others. He said “<u>Seeing older people smoking or doing something unnecessary and have to impress</u>” AP#2)”.  This is a clear instance of relenting to peer pressure for the fact that you do it for others not yourself. “Doing it to please” or “giving in to what is wanted by others”.</p>
2. Being romantically involved with older men 3. Doing without thinking and judging right 4. Doing things for money 5. Being romantically involved with older men	<p><b>Something is happening; we want to know if young people experience coercion and who is coercing them to do stuff. Have you seen that?</b></p> <p>Participant: No, I have not seen such things but according to my understanding it comes to young girls; they think impulsively. <u>Like they do things... they do things for money. They end up falling in love with older guys like having sugar daddies which is a wrong thing.</u> I think that serves as coercion but you won't realise it because like she is accepting. (AP #8)</p>	<p>AP#8 denied having personal experience of peer pressure but mentioned that from what he understands is that; it is girls who affected by peer pressure or coercion. He mentioned that girls do things impulsively for the sake of money. He said in the process they become romantically involved with older men, i.e. sugar daddies. He criticised the girls' love relationships with sugar daddies as wrong. He viewed as coercion and reported that it is subtle coercion because the girls accept what is happening in the love relationship with older men. “<u>They end up falling in love with older guys like having sugar daddies which is a wrong thing.</u> I think that serves as coercion but you won't realise it because like she is accepting (AP #8)”.</p>
6. Defining immoral behaviour	<p><b>Researcher: Okay, you say young people copy older people doing all these wrong things (7:35) thinking it is a way of life. The issue of sexual activity how does it manifest there. How does it come into play?</b></p>	<p>AP#7 was asked how perceiving doing wrong things seen as a way of life relate to manifestation of peer pressure to sexual activity? He said the behaviour that adolescent girls portray at entertainment parties is seen</p>

	<p>Participant: Well like... I don't know how to answer this one but what I have seen , eh...may be let's say few months back like at entertainment parties; there is always those <u>chicks that are dancing, like undressing and other stuff; I think that causes sexual activity.</u> (AP #7)</p>	<p>as causing sexual activity. Why, because the girls undress and dance; that is perceived as sexual hints. "At entertainment parties; there is always those <u>chicks that are dancing, like undressing and other stuff; I think that causes sexual activity</u> (AP #7)".</p>
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## ANNEXURE GG2

### CONCEPTUAL AND SELECTIVE CODING (NURSES)

ANNEXURE GG 2: Developing Categories using In-Vivo Codes: A Nursing Theory for anticipatory guidance of adolescents to resist peer pressure and coercion to sexual activity			
Quote	Initial Codes	Focused Codes/ Sub-categories	Categories
<p>"I think that is a good setting for all the other young students they are in a comfortable setting. They are in a class...that is where they speak mostly of all funny encounters that they have gone through with their friends. ...is the best place to get them to talk to them; using the Life Orientation subject... nurses can come and address them at some point. Not necessarily to address but to converse with them because they are in a comfortable setting (NP1)".</p> <p>"For one hour. Once a week, if we say then we cannot afford one a week; it can be one a month ... For the duration of a lesson that is 45 minutes...I have an experience that once you introduce yourself well to the adolescents they ... eh...they analyse you when you start working with them. Then when they get used to you then it is a very nice place to work at with the adolescent (TP 5)".</p> <p>"If like; there were people... health people found all over and they always or may be visit schools every month not every quarter. They should share vital information and give guidance to school children. I think it would be better for young people being informed about potential risks and consequences.(AP 7)</p> <p>"By being there providing services for them most of the time. I think of the time that we need to render primary healthcare services. We need to be there most the time so that they can get used to us; not go there once and being away for a long time (TP 3)".</p> <p>"We sat down with our Area Manager. We planned and agreed that we need to open the clinic after hours and during the weekend; Monday to Friday we close at 6pm and Saturday until 1pm, still we don't get them...the service hours were extended to accommodate adolescents in school and farm working people but still the adolescents don't come...Very few adolescents attend at the clinic. It shows that we need to go to them (TP3)".</p>	Creating adolescent – nurse interaction prospects	Creating positive adolescent – nurse interaction	<b>Optimising nurse-adolescent interaction</b>
<p>"If nurses they really wanna help us; it will help to go out to the community. Maybe ... They will really have to do kind of extracurricular activities like going to the playing field. That is where they will find lots of us (AP8)".</p> <p>"...young people they like recreational things, where you can form a group... But if you can say to them we are going to have a meeting where you can come so that we can talk. They are not going to come but then you say come we are going to have fun day, there is going to be music...the youth will come because those are things they love... you are going to say in this fun filled environment and "happening environment" let us talk about what is it you think is it about peer pressure, ... You will be able to interact ... (NP2)".</p> <p>"Follow the change means follow the language and so that you are able to speak to them and even know that they do; what they have changed, for example they are always seated in-front of TVs and they are always busy with the "WhatsApp" and you name them. You must know that and involve that in your talk (TP 5)".</p> <p>"...having the chill room...specific for young people in the clinic settings. When they do for adults it should be separated; adults here and adolescents there,... So I think if they can do that and another thing is facilities like playing stations, library and so on for knowledge and entertainment (NP 6)".</p>	Providing alternative strategies to attract adolescents		



<p>“...like Mabana Centres where there is a lot of life skills training and a lot of dealing with issues in a real way and this where now I think we can overcome negative peer pressure because now it was ...the activities were meant to entertain and educate at the same time (TP2)”.</p>			
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**Table 4.4: In-vivo quotes for optimising nurse-adolescent interaction (Continued)**

<p>"Some other nurses must learn how to talk to people well; like they don't have to take advantage. Some they take advantage because they are nurses. Even when you go to the hospital and clinics... for one to get help it is very difficult. Sometimes you will hear people talking while seated... this nurse is not okay ...talk to that nurse because am scared of approaching her because of the way she is." (AP 5)</p> <p>"Those interviewed already had some good relationship with the adolescents...just training everybody to be youth friendly;... most nurses when they are in contact with an adolescent they don't de-role and they become a parent that is where they become hostile... they are thinking now of the own children ... coming here looking for contraceptives...that is when the relationship get soured (NP7)".</p> <p>"I think what nurses should improve it's the attitude... how you welcome one to your home and they are going to be free to talk to you...if nurses can change their attitude toward adolescents and take them as clients and respect them as they come along; not treating them according to their age... The more you respect them the more the more you gain respect from them and then that is when you will gain respect; they will talk to you (NP 2)".</p> <p>"I think what nurses should improve it's the attitude... how you welcome one to your home and they are going to be free to talk to you...if nurses can change their attitude toward adolescents and take them as clients and respect them as they come along; not treating them according to their age... The more you respect them the more the more you gain respect from them and then that is when you will gain respect; they will talk to you (NP 2)".</p> <p>"Some other nurses must learn how to talk to people well; like they don't have to take advantage. Some they take advantage because they are nurses. Even when you go to the hospital and clinics... for one to get help it is very difficult. Sometimes you will hear people talking while seated... this nurse is not okay ...talk to that nurse because am scared of approaching her because of the way she is." (AP 5)</p> <p>"they chose a young somebody who can be at the level of the adolescents than somebody who will not judge them and then take them as their mother tell them that their child does not even do that. Why are you doing that? Why are you sexually active? ...whereas they don't even know what their children are doing outside? I think if they get somebody they can open up to that can help them a lot (NP2)".</p> <p>"They have to change their mind-set; yah we have to change the mind-set of the older nurses by workshopping them and in-service training so that they can have new information. We need to try to update them (TP3)</p> <p>"If we had enough nurses, some of them should be trained to work with adolescents because I don't think the integrated approach is working well in our country...I understand the nurse cannot leave a sick person and attend to the adolescent who is not sick. So more nurses need to be trained that is the first thing, and then secondly nurses that are not trained need to be sensitised to understand the adolescent program." (TP4)</p> <p>"The bottom-line is the shortage of nurses. If that one is not addressed I don't see how we can train nurses but we are not going to be able to handle the workload...if we had enough nurses we should be starting from the curriculum...a nurse that specialises in youth and adolescent health issues. So that... their work is solely to address adolescent and youth issues at a clinic level. (TP4)".</p> <p>"...the beginning one needs to be very honest with it, if working with young people is not my passion... through training you can really help young people and the nurses understand what is happening in the country terms of youth risk behaviour and then obviously the need to prevent this (TP1)".</p> <p>"Yes... people who apply for nursing or who want to be nurses should have passion for that job because if you don't and you are just doing it that's where you start becoming judgmental...So I think maybe as schools and institutions they should interview people before they do certain careers cos at the end the person can get mad at patients because they are stuck in the wrong career (AP 6)".</p>	<p>Stereotyping nurses' roles</p> <p>Displaying contradictory attitudes</p> <p>Experiencing shortage of skills</p>	<p>Building capacity of nurses</p> <p>Building capacity of nurses</p>	<p>Optimising nurse-adolescent interaction</p>
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**Table 4.4: In-vivo quotes for optimising nurse-adolescent interaction**

### **ANNEXURE GG 3**

#### **EARLY MEMO dated 17/12/2015 revised on 13/1/2016**

The following open data memos were prepared in response to the question on **how can nurses support adolescents to resist peer pressure and coercion to sexual activity**. Nine transcripts from nurse participants were reviewed against the existing memo written on 23 Dec 2015. The following account outlined what is going on in the data gathered from the nurse participants and what the nurses are saying about peer pressure and coercion to sexual activity. These nurses related their experiences as they are exposed to adolescents in their daily work at the primary healthcare facilities around Tshwane.

Below are researcher's questions and the responses from the nurse participants.

#### **MEMO 1: Getting pressure to become sexually active**

**Researcher: Okay, do you think many adolescents are under pressure from their friends to have sex?**

In response to this question, the data showed that nurses believed that adolescents are under pressure although it is not all of them. Data revealed that adolescents are pushed or motivated by different reasons that made them to be pressured to participate in sexual activity. According to nursing participant adolescents were acknowledging that they **relenting to peer pressure** due to the same reasons identified by nurse participants.

NP# 1 expressed her thoughts that not all the adolescents were under pressure of participating in sexual activity because of their friends but external influences like **watching pornography** influencing adolescents. The nurse participant referred to adolescents **having the mentality of sexual activity** from **observing pornographic material**. She meant that even when friends were not influencing them but **watching pornography** had a bad effect on adolescents. Pornography is sexually laden material. She had a perception that adolescents considered **participating in sexual activity** as **"being cool"**. She also added that another driving factor was for participating in sexual activity was **dating older guys** to be seen as **"being cool"**. On

the other hand, older guys were **having an upper hand of forcing adolescents to partake** in sexual activity in the pretext of **proving love to their partners**. It is evident that adolescents find themselves in a difficult position of **participating in sexual activity** for **proving love to somebody** or even **participating in sexual activity** for **being cool**.

Data revealed that adolescents are participating in sexual activity is sometimes a consequence out of **dating older guys** and sometimes they are **doing it** for mysterious intentions of **being cool to their friends** and for **proving love to their older guys**.

In this memo, the researcher outlined the reaction of the first nurse participant (NP#1) that was interviewed. The quote below described her perception of adolescents' experience to sexual peer pressure and coercion to sexual activity and how it resulted.

***Nurse Participant #1: "Not all of them. Some of them it is just their mentality from porn observation and some from friends. They think there is something cool about it and that is why they partake in it, or sometimes after they have dated an older guy which they think is cooler (participant thinking of the correct word to use) another case of sexual coercion because the older guy forces them to partake in sexual activity to prove whether or not they love the person."***

The same question was asked to Nurse Participant #2 but this time it was adapted to explore the influence of friends on peer pressure to their fellow adolescents. NP #2 indicated that not all adolescents spoke openly about **getting pressure from their friends**. However, from the conversation between nurses and adolescents during the clinic consultation the nurse was picking up cues from the adolescent client who was **yearning to have a baby**. The adolescent was **yearning to have something her**

**friends were having**<sup>10</sup>, “having a baby”. **Yearning to have something** owned by others is envy. The nurse expressed that the adolescent was somehow **envying her friends** who had babies. Therefore, data is telling us that adolescents are having a tendency of **envying others** and then **exposing themselves to risky situations**. The adolescent’s reaction left the nurse in awe because the adolescent was too young to be **having a baby**.

Below is the question and quote that was in response to the abovementioned explanation.

***Researcher: 2009, okay. And from your experience do adolescents talk to you about the pressure that their friends apply on them to have sex? When they consult do they ever talk about it?***

***Nurse Participant NP #2: Some they do and some don’t because adolescents some are open and some are not . Some they do tell; there is this other client (data translated to English) who once said she wants a baby because all the friends have babies. So she feels that she must get a baby. By then she was 19 years old. I was thinking she is only 19 and still at school and on the side she wants a baby. She envies her friends who have babies and all that.***

In response to the question seeking to explore if friends were **pressuring other adolescents/ peers to participate in sexual activity**. NP #3 from her experience while working at the health facility, she discovered that adolescents were **avoiding falling pregnant** at all cost but they were **willing to have sex**. She expressed that

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<sup>10</sup> AP # 3, AP #4 and AP #5 also mentioned that sometimes adolescent bully others or pressured themselves because of wanting to have things other adolescents possessed.

they were showing no fear of **having sexual activity with their boyfriends or friends**.

According to data collected from the nurse, for adolescents having sex is not a “**big deal**”<sup>11</sup>. The issue of friends **putting pressure on their peers** was not the main challenge because adolescents had no fear but were **showing willingness to have sex with the friends**.

The researcher guessed that **showing willingness to have sex** could be equated to **being ready to participate in sexual activity**. When an individual is willing and ready to do something there is no force involved there. However, from the deliberation already highlighted in this memo, NP #1 indicated that adolescents are sometimes **doing things for being cool to their friends or for proving love**. For every adolescent action, there is a motivation why it is happening.

The quote below outlined the question and nurse participant response for the data reflected.

**Researcher: Is it their friends that pressurise them or their boyfriends that forces them to participate in sex?**

***Nurse Participant #3: What I have noticed neh... is that most of the youth, they don't want to fall pregnant. It is the one thing they want to avoid but they are not that afraid to continue with the actual activity whether it is with a boyfriend or friends. It really does not matter. The main thing is that they don't want to fall pregnant whilst doing it. For them sex is not a big deal but the falling pregnancy is the part that they are really trying to avoid.***

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<sup>11</sup> Explore the meaning of “**big deal**” for having sex from other nurses.

When a follow up question was asked regarding identifying adolescents who were pressured by their friends to partake in sexual activity; this was the response from the Nurse Participant #3:

***Nurse Participant #3: “Family planning, Uhm...Most of them they had the health education part of it. When questions arise as to why Family Planning; Why do you want to know family planning? What do you know about peer pressure? Uhm... and then that is where you get that the impression that this person is actually is not her decision per se do it but she is doing it because ... she wants to participate in sexual interaction.”***

Out of the data collected above, it became evident that adolescents are **opting to use family planning services** because they are having a push or **being pushed to participate in sexual activity**. NP #3 indicated that she got an impression that adolescents are **being influenced by others to come for family planning** services. She further explained that she detected that the adolescents were not willingly **taking a decision to use family planning services** but they were doing it anyway. She mentioned that she realised that even for adolescents **participating in sexual interaction was not their personal decision to do so**.

On the flip side data also revealed that adolescents don't think about issues the way other people viewed them. The nurse participant implied that adolescents have their own way of perceiving situations and interpreting them. According to NP #4 adolescents seem not to be having peer pressure in their vocabulary. What adults is defining and interpreting as peer pressure they are viewing that as **“a way of belonging”**. While they are acting in the spirit of belonging and doing the same things they are not **realising that they have the right of refusing doing something they don't want to do**. NP#4 emphasised that adolescents appreciated **doing the same thing for belonging to their peer group**.

The nurse participant highlighted that peer pressure could be positive and negative; it depended on the situation and what the people concerned were up to. There is a need for exploring the positive implication of peer pressure from other nurses. Upon getting the exact meaning and interpretation of positive peer pressure from other nurses; the researcher would be in the position developing the relevant anticipatory guidance for supporting support adolescents to resist peer pressure and coercion.

The reaction below is related to NP #4 response as explained.

**Researcher: And then did the adolescents talk to you about peer pressure from their friends to have sex?**

***Nurse Participant NP #4: Sometimes if you say it is peer pressure; they don't think it is peer pressure. For them they always say it is a way of belonging. They feel that belonging they need to have friends to belong and do the same things together unaware that they have a right to say "NO" I cannot do that. Sometimes peer pressure can be seen as a positive thing where there is common understanding and more or less on doing the same things. Otherwise it can be seen as a positive thing or it can be vice versa.***

Data revealed that adolescents were **denying being sexually active** and **alleging their friends were sexually active**. NP #5 deduced from the conversations she had with adolescents that they were **experiencing pressure of doing what their friends were doing**. It is evident from previous nurse participants' responses that adolescents were having a tendency of **doing what their friends are doing for belonging to a peer group**. However, the nurse participant indicated that some adolescents confessed **being ready to become sexually active**. The nurse participant was amazed by the adolescents' reaction that their parents were **accepting that they were ready for becoming sexually active**. The nurse participant indicated that in her interaction with adolescents she indicated that the adolescents' parents might be anxious about adolescents getting pregnant. The adolescents countered that their parents were **accepting that they are now ready to become sexually active**. NP #



5 indicated that adolescents were **alleging their parents knew they were old enough to becoming sexually active** therefore adolescents were not worried about anything but concerned about **preparing to do what their friends are doing**.

NP #4 acknowledged that adolescents are **having sex for various reasons** however she mentioned that friends is one reason **motivating them to becoming sexually active or having boyfriends**. She also stated that they are having sexual activity with their boyfriends for getting incentives.

***Nurse Participant #4: Well eh...I can say yes because there are various reasons they have to have sex. One of them is that maybe if their friends are sexually active and have boyfriends or maybe they will have some incentive from these boyfriends. Therefore, the other ones maybe compelled to do that. Sometimes also some of the bullying that happens in various communities. You find that some of them because they want to conform to the groups not because they want to do all those things. There are various reasons why young people are ...(participant just lost a proper word)...yah.***

***Nurse Participant NP #5: The common thing is that when they come here you will ask them questions, some of them will say “no, I am not sexually active but my friends are, now from that you can see it is peer pressure that is making them to do it. Then some of them will say “I have just seen it is the time” when you ask them “if you can get pregnant what will you do to answer your parents because your parents are scared”. They will just say “No my parents know I am old now”.***

NP #6 had a different twist in her response about friends having an influence on their peers on becoming sexually active. She has experience of working in District School Health Services therefore she encountered situations where parents were the ones **pressuring their adolescent children to become sexually active**. The adolescents

in primary school reported that their mothers were **pushing them to copy their peers who were having babies and getting the South African Social Security Agency (SASSA) Child Support Grant**. She indicated that adolescents started **envying those who were having things they don't have** and resorted to doing what their parents are suggesting. The issue of **envying what others have been the driving factor for peer pressure** is not showing in this memo for the first time. NP #6 mentioned the clothes, fashion and fancy things which other adolescents were possessing were the source of envy.

The nurse participant also mentioned older men as another group that **forcing adolescents to become sexually active**. The older men were mentioned for their involvement with students to add on what their parents cannot provide. NP #6 went at length to talk about the food and sweet things that required cash to be purchased. She revealed that despite the Department of Basic Education **providing the feeding scheme at schools**; adolescents were not interested in that type of food but they were **looking for other types of foodstuff**. Therefore, the older men were **providing the purchasing power** at a cost of adolescents **becoming sexually active**. That is where the relationship of adolescents and older men is surfacing due to the power play.

The older men are possessing purchasing power to lure the adolescents. The adolescents are helpless to resist **being forced to participate in sexual activity** because they are **yearning to possess material things that their peers have**. NP#6 mentioned that another group vulnerable to becoming sexually active is orphans. The researcher did not probe further about the issue but it came up somewhere in the other interviews that they need help and support to resist peer pressure to sexual coercion.

***Nurse Participant NP #6: Yah... most you get in schools especially in primary schools you do get them; and then you do get them in high schools. Most of the kids who are under pressure; when going further to find out why, the reasons... they will tell you "my mommy when I ask for money", she will tell me "don't you see your friends***

*they are getting SASSA” this is the money for the child grant and so... just decide from there because she sees that those ones are having everything, especially the attire. Nowadays they are on fashion and fancy things; they want phones; they want tablets. Another group is a group of young people who are forced by older men... like they are students. Yes, the department is giving food ... support of food in school in the form of meals, but you know they get bored of this feeding scheme and then they just want to explore you know. Young people like sweet things...(researcher interjected and added junk food) yes ... junk food and whatever. And then the other type is those learners who are orphans...neh.*

When interviewing Nurse Participant #7, a follow up question regarding vulnerable children was factored in. The researcher wanted to know from NP#7 whether it was easy detecting vulnerable children under pressure to participate in sexual activity. NP #7 defined the vulnerable group of children.

She specifically delineated that vulnerable children were children **not having parents**, those **not staying with their parents**; those whose parents have died as well as those who were **staying with relatives having a poor relationship**. She emphasised that those parents who were always busy **not spending time with their adolescent children**. It meant these parents were **not making time to be with their adolescent children**. It showed how spending quality time with adolescents was impacting on them thus **making them vulnerable to risks** around them. NP #7 also included adolescents from dysfunctional families as another group of vulnerable children. Dysfunctional families meant families that are **not functioning well as a social unit**.

*Nurse Participant NP #7: Yah... Not necessarily being able to identify but my experience is that those that are vulnerable for example those that (06:05) do not have parents; they are not staying with their parents; those that are orphans both parents have died; eh... those that maybe staying with relatives and the*

***relationship between themselves and relatives is not good. Those that parents are actually busy, they do not have time to spend some time with their children to spend quality time. I found those being more vulnerable. Uhm... So I will say those in dysfunctional families.***

NP # 7 also agreed that adolescents were **getting pressure from their friends** to participate in sexual activity. She learnt from adolescent children in her neighbourhood that adolescent girls were **pressuring boys to sleep with them**. Sleeping with somebody is a subtle way for referring to sexual activity. She highlighted that it was commonly known that adolescent boys were the ones that were alleged to be forcing adolescent girls to participate in sex. She raised that there were some other forms of pressuring others to participate in taking drugs like alcohol and dagga. NP #7 explained that upon taking alcohol at taverns individuals have a tendency of losing control of thinking properly and getting pressured to having sex is possible. She hinted that when adolescents are under the influence of alcohol and without self-control over their bodies they might end up getting pressured to having sex.

***Nurse Participant #7: They do. I remember sometimes when my children were growing up I called some adolescents around the community where I was staying (07:34) to talk to them (participant laughingly chuckled) and it was interesting to learn that; they told me that some girls pressurise the boys to sleep with them. Culturally we know that it is the other way around and the other thing was not necessarily pressure of having sex but pressure of taking a drug which could be alcohol, can be any other drug, may be dagga or marijuana. What happened or sometimes even alcohol; so after they have taken alcohol they have no control and they don't think properly and get pressurised and these can happen at taverns sometimes or any place where they are drinking as adolescents and they end up finding themselves having sex...you know...because they were pressured and had no control over their bodies during that time. Uhhh...***

NP #8 added to what NP #7 said by **confirming that adolescents are getting pressured to have sex** though they do not disclose their incidences. She shared her discovery of the game played by adolescents while under the influence of alcohol that lead to adolescent boys **having sex with multiple partners**. NP #8 experience link to NP #7 discussion that where adolescent is **drinking alcohol sexual activity would happen**. In this case adolescents were **bunking school** and **engaging in alcohol binging** at some home without adult supervision. The adolescent boys would be **competing for a top spot** of the last man standing after having se sex with multiple girls. They would go around **having sex with all the girls** in the room **without using condoms**. These adolescents were not **recognising the risks** they were **putting themselves in**.

*Nurse Participant NP #8: Yah, I think so, even if they did not disclose to me because as you go around we visit youth at schools, we found out funny name of the game they are having in groups. You find that the youth is absent from school as a group they drink liquor in one of their friends' home because parents are not there. Afterwards they just have sex, one partner changes all the girls and they like to see who the last man is standing. They are not using condoms. You will find that it is a group of four boys and four girls, so these boys will rotate amongst the girls to see who is going to last longer having sex with those girls. So they are not looking at the risk they are putting themselves in.*

NP #9 also agreed that adolescents are under pressure from their friends to what they do. However, in the East Lynne community adolescents were **putting pressure on others for different things than sexual activity**<sup>12</sup>. The nurse participant confirmed

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<sup>12</sup> There was a relationship between what AP #10 and NP # 9 mentioned regarding peer pressure to sexual activity. At East Lynne peer pressure to sexual activity was not an issue. Adolescents understood sexual activity and they came to the clinic prepared to seek contraception before they engage in sexual activity.

that adolescents were **having consensual sex** than being pressured by their friends to participate in sexual activity. NP # 9 mentioned that adolescents are **getting pressured for not doing what their friends wanted** at school, if they were **not conforming** there was **name calling**. Some adolescents who were not participating in some activities were **feeling like they were not part of the peer group** or they were **considering them boring**.

***Nurse Participant: Yah...something like that. They feel like they are not part of the in group or they are boring or they ... (did hand gestures)***

***Nurse Participant NP #9: I think it is more peer pressure of friends at school. If you are not doing it you are not in or you are marked as... ( participant lost the term used according to adolescent lingo at East Lynne) What do they call it? (Participant thinking aloud)***

The researcher wanted to know if nurse participant has ever worked with adolescents under pressure to participate in sexual activity. NP#9 responded that she never came across adolescents that were **being pressurised to participate in sexual activity**. She reckoned that adolescents **consulting at the clinic for family planning services** understood sexual participation and they were **engaging in consensual sex**.

***Nurse Participant #9: Uhm... not that I have come across, the youngsters that come for family planning understand sexual participation and from what I have discussed with them it is consensual sex.***

## **MEMO 2: Helping adolescents to resist peer pressure**

The researcher further explored if the nurses thought that adolescents needed help from nurses to resist peer pressure and coercion to sex? The subsequent responses came from all the nurse participants responding to the same question regarding help from nurses.

The very first nurse participant had a perception that adolescents were **having a mentality that nurses were monsters**. She expressed that adolescents were **not giving any constructive criticism about nurse**. She thought adolescents were **not going to ask for nurses' help** though she was convinced that adolescents would get help if they needed help from nurses. NP #1 guaranteed that adolescents could be helped if they need help.

***“Nurse Participant #1: For as long as everybody has that mentality that nurses are monsters they cannot give you any constructive criticism, I don’t think they will ask for help; but they could do with some help.”***

Data revealed that nurses have certain perceptions that are worth exploring further to fill out the knowledge gap before developing anticipatory guidance to help adolescents. There were **glaring concepts during that interview** were “monster mentality” and “constructive criticism”.

NP #2 believed that **knowing about sexuality and contraceptives** is important for adolescents. She commented that adolescents should avoid **getting wrong information from the street**. Adolescents are encouraged on **having right information from nurses** rather than **getting wrong information from the street**. Researcher guessed information from the street meant that it is from unreliable sources. NP #2 emphasised that adolescents need **verifying the unprofessionally acquired information from the street**. **Getting correct information** help adolescents in **knowing what to and the consequences of their actions**.

***Nurse Participant #2: Especially on sexual issues where they need to know that they are sexually active and for contraceptives. They want to know about it because they can get information from the street and it is not right for them to get information from the street. They can come to the nurses and whatever they heard from outside is not the same thing that the professional person is telling them.***

***This is how things are done and this is the repercussion of me doing that.***

Explore the concept of “**getting information from the street**” from other nurse what it means in their own understanding.

NP #3 was also asked how she thought she should intervene to help adolescents under pressure to have sex. She remarked that nurses could intervene by **equipping adolescents with health information**. She believed that **referring adolescents to other professionals** like Social Workers and Psychologist could be another form of intervention. She raised her concern that people from Black communities were **not utilising Social Worker and Psychologist services**. She hinted that some adolescents were **going to benefit from the other professional services** rendered in **helping them to deal with their issues**. She pointed out that adolescents were **not dealing with certain things in their lives** thus **resorting to their peers** in whatever they do. She remarked that adolescents are **finding comfort in their peer groups** because they are **getting a sense of belonging**. NP #3 mentioned that adolescents are also comfortable in **talking to their peers about anything** they cannot discuss with their parents. She further identified that when adolescents are **having trouble of reaching out to their parents** they resort to **seeking advice from their peers**. She hinted that adolescents were aware that they were **not getting the right advice from their peers**. NP #3 suggested that the adolescents that were **having issues pushing them to resort to peers** needed to be referred for **discussing such issues accordingly**. She also stated that other adolescents are **rebellious by turning to their peers** when they are **having issues with their parents** or making them behave in the opposing way.

**Researcher: Do you think nurses should intervene when adolescents are under pressure from their friends to have sex?**

***Nurse Participant # 3: Oh... intervene. Okay we can intervene, I think we can equip them with information that we have as far as***



*health is concerned but in other cases I think they can also be referred to talk to other teams like there are Social Workers, Psychologist. I think especially us Black people we don't utilise these services. We don't. Others they can be saved in terms of being referred because the peer pressure sometimes adolescents they do certain things because they have other things that they are not dealing with, they find comfort in their peers like they belong, they talk about anything . That is if a am an adolescent and I have trouble reaching out to my mother or my dad or parents both combined, I am going to my peers, they are the ones I am going to seek advice from and obviously I am not going to get the right advise, then such adolescent can be referred to like discuss the whatever is pushing them to do such things. Like being rebellious kind of. Some just do it but they are rebelling they just turn to their peers. I think they are rebelling.*

NP #4 concurred with the previously interviewed nurse participants that adolescents needed nurses' help to resist peer pressure and coercion to sexual activity. She also mentioned that other health professional care providers are capable in **providing help to adolescents**. She emphasised that healthcare workers and nurses **working with adolescents** should be **having an understanding of adolescents' issues** to assist them. **Having an understanding of issues** affecting adolescents before **offering help** to them is important.

***Nurse Participant #4: I think they need help not only from nurses, all the healthcare providers because the healthcare providers also who are providing them with health services including the nurses. Yes, they do need assistance but also even the healthcare workers and nurses need to understand the issues that affect young people before they can be able to get help.***

A follow up question was asked to explore what NP #4 meant about understanding youth/adolescent issues. NP#4 highlighted that the nursing training curriculum was **excluding the content on adolescent and youth**. She indicated that there were numerous training programmes about **building the capacity of nurses** to enable them to manage adolescents' issues. She further highlighted that nurses needed **training to update their skills and building their confidence enabling them to deal with adolescents**. She pointed out that even the healthcare providers need to be knowledgeable in **dealing with adolescents' issues positively**.

*Nurse Participant: Unfortunately yes, if you can go back to the nursing curriculum; it does not have the component of adolescent and youth but also now on that, there are several training programmes that capacitate nurses so that they can be able to respond positively on issues of young people but also they need to be updated on adolescent issues so that they have confidence on how to deal with adolescents. Therefore, based on that, on the other side the healthcare provider also need help to be capacitated to understand the issues of young people so that they can be able to deal with issues of young people.*

The researcher further explored how the nurses should be supported and who should take first step to help nurses to understand adolescents' issues? NP#4 responded that a need analysis should be done to ascertain if nurses **working with adolescents** understood the adolescents' issues. NP #4 indicated that **determining the nurses' experience and expertise in dealing with adolescents' issues** was needed. She mentioned that those nurses **having the experience** could be asked to help to come up with a re-orientation programme for **helping other nurses in building their confidence** to work with adolescents.

*Nurse Participant: It can be in various forms from the institution where the need analysis should be done to find out; are these nurses working with adolescents? Do they understand*

*adolescents' issues of the young people? Have they been trained or have experience and expertise on how to deal issues of adolescents? And therefore, as individuals who are exposed and who have experience we can come up with a re-orientation programme so that they gain confidence of what they are doing and also be able to do what is best for the young people.*

There was a suggestion to ascertain if nurses needed a re-orientation programme to help them gain confidence to address adolescents' issues.

The researcher continued asking NP#5 if nurses were in a position of **helping adolescents to resist pressure** from their friends to resist peer pressure. NP#5 also concurred with the previous nurse participants that were interviewed in this study. She agreed that **giving the adolescents health talks** on peer pressure and **discouraging them to become sexually active** could help adolescents.

*Nurse Participant #5: Yes, we can just try and give health talks about peer pressure and not to be sexually active. You can just make health talks to the adolescents and maybe we can help.*

The response from the School Health Nurse was that through the programme nurses were **conducting dialogue sessions** where adolescents were speaking out. These sessions were an **enabling platform for adolescents to speak out**. For those who were afraid of **confronting nurses during sessions**; they were given contact details for **booking appointments with the school health nurse** for helping them. NP #6 mentioned that the school health nurses are promoting privacy and are encouraging adolescents to use SMSing option to Life Orientation Teachers.

*Nurse Participant #6: You know ... with the sessions where we included the Psychologist , we were telling them to speak out and then that is where the platform they used to come to the clinic because we have given them the contact because in schools some of them are afraid to come to you (referring to the school nurse)*

***specifically. We gave them the address, everything to book, to SMS the Life Orientation Teacher so that they can come for privacy.***

The nurse participant was expected to respond to the question on adolescents need for help from the nurses to resist peer pressure. NP#6 concurred with the previous nurse participants that adolescents do need nurses' help. She also mentioned that adolescents do not only need nurses' help but they also need it from the community. However, she was complaining that **lacking parental care** was **exposing adolescents to unwanted situations**. She responded that the parents needed education on methods or ways of **dealing with their kids**. The nurse participant confessed that sometimes nurses were **having shortfalls of dealing with adolescents** at the clinics. Having shortfalls, the researcher guessed it meant **having shortcomings**. She was complaining that nurses had a problem of **seeing the adolescents coming to the clinic as their children** instead of clients. NP#6 indicated that the approach which the nurses are using for **interacting with adolescents** is a problem. The nurses were reported to be **criticising, shouting and trying to mentor adolescents** instead of **dealing with the presenting problem**.

***Nurse Participant #6: Yes , they do. They do need help from us and also from the ground... us we can help because we are doing that. We are trying but the serious problem that I am seeing is the parents. Parental guidance. A lot of parents need education on how to deal with their kids. On our side as nurses sometimes we also have downfalls with the kids because when they reach the clinic. You see that child as your child and you don't treat her for the problem. You start by criticising, shouting, trying to mentor while they have a problem on the table . Another problem. (researcher interjected asking if nurses need some education).***

Following up to the previous participant's response regarding the need for nurses to be educated to understand adolescent issues; NP# 6 concurred that nurses needed **training on youth friendly services**. She emphasised that adolescents were **having a problem of sharing the waiting area** and **mixing with adult clients**. It was

reported that adolescents were **disliking being in the same space with their neighbours** when visiting the clinic. That mentioned reason is the main one the adolescents were **avoiding coming to the clinic** or a reason they were **choosing backstreet abortion**. The adolescents are not in favour of **being in the same bench with adults at the clinic** while waiting for nurses' help, even worse when they are pregnant. NP #6 stated that adolescents were **choosing not going to the clinic or doing abortion** instead of being in the same place with their neighbours.

***Nurse Participant #6: Yah, they need training on Youth Friendly Services. We need to be youth friendly somewhere, somehow... Another problem with young people, they say mixing with adults in the clinic, it is a problem. They will tell you that they are there in the same bench with my neighbour and in the afternoon, why some of them they don't go to the clinic or they do abortion. Those that are pregnant they do backstreet abortion because they know when they go to the clinic the neighbour is also pregnant and you know, sharing with the adults is another problem for them.***

In responding to the same question as above NP# 7 responded that adolescents needed nurses' help. She retorted that **growing up comes with confusing bodily changes**. She warned that in the absence of **explaining to adolescents about the experienced bodily and hormonal changes**, adolescents would do anything for **earning a feeling of belonging to a peer group**.

NP#7 highlighted that during the puberty time, adolescents are **having a shaky relationship with their parents**. This period was envisaged to be the time where adolescents are **relying more on their friends**. She reckoned it was a dangerous time in the adolescent's life because they were **learning about a lot of things** of which some were incorrect. She reiterated that the presence of parents during this time is needed for **correcting any myth** otherwise the adolescent might be **ending up in trouble**.

*Nurse Participant #7: They do. We all know that when we grew...eh...the changes that happen in our body confuses us. If there is no one who can explain to you about what is happening in your body about the hormonal changes that takes place can actually make you do things because you want to have a feeling of belonging. Unfortunately, that is the time during puberty where the relationship between parents and their children get shaky because the behaviour of adolescents and the adolescents end up relying on their friends outside. And that which is a very dangerous time because the adolescent will learn a lot of things; sometimes those things are not correct. If the parent or guardian is not there to correct those myths that they are getting, that is where they end up in trouble.*

NP#7 further hinted that adolescents needed help coming from their homes. The adolescents need good relationships and communication with their residing families. She advised viewing adolescents in totality when **dealing with them**. **She encouraged enabling adolescents to consult their parents or guardians** when they have problems. She attested that when children have a good foundation and relationship with their parents it was enabling them to speak freely with adults. She also gave an example **citing having an open relationship with her children**. Children approaching their guardians or parent having freedom to say whatever they have is **creating an opportunity for correcting things they say**. NP#7 reported that things like **bullying could lead adolescents to trouble** because adolescents act somehow when they are bullied or treated somehow.

*Continued NP #7: So they do need help from... I mean the English people say charity begins at home. They need to have a good relationship or a good communication from the homes where they are staying, with people they are staying with. Eh... building that relationship will not only look at sex and sexuality issues or peer pressure but it will look at them as a totality because the adolescent*

*will be free to go to their parents or guardian with any other problem that they have. I see it with my grandchildren here at home. I have built that relationship to make them free to talk to me. Yah... they come and say anything to me. They are free to say anything to me and I correct those things. Yah. So even things like bullying you know ... it can lead them to trouble because the adolescent can also start to act the way the other children are treating them and so on.*

The researcher probed further to explore how nurses should provide the required help. NP#8 gave confirming response. She reiterated that **educating adolescents** and **telling them of ways** used by other peers to make them feel inferior. She emphasised **boosting confidence of adolescents** for **surviving being pressurised**. NP#8 alluded that lacking confidence make adolescents become pressurised because of wanting to fit in to the peer group.

*Nurse Participant #8: I think if you can educate them and even tell them ways that other peers are using to make them feel that they are inferior <sup>13</sup>to boost their confidence and whatever. These youths can survive not being pressurised because mostly it is due to lack of confidence and they want to fit in the group.*

NP#9 also concurred with other nurse participants that adolescents needed support from nurses. She said adolescents feared **coming to the clinic** because of judgmental nurses. Those nurses were **ridiculing adolescents telling them they were too young for family planning or sex**.

She mentioned that adolescents needed help from somebody who has a common ground with them. She meant a nurse who had an understanding of adolescents, whom adolescents were **feeling comfortable around** him or her and they could

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<sup>13</sup> Incidence matches one mentioned by AP #7

openly speak to them. She mentioned that adolescents could be well off with that type of nurse because they are a new generation and adolescents are **thinking differently from the nurses** due to different morals and values. NP #9 believed having a younger nurse was going to be better because adolescents and nurses were thinking differently.

***Nurse Participant #9: I actually think so because the young girls have a fear of coming to the clinic because they are scared to be judged by the nurses. They are being told they are too young for family planning or too young for sex. I think we need someone to have common ground with them; that understands them knowing they will be comfortable with them at the clinic. Someone who can speak openly about anything.***

***Nurse Participant: You have norms and values, you know you have this young generation what they think and what the nurse think might differ***

***Researcher: You say having a young nurse to work with or deal with adolescent will help? Nurse Participant: Yes***

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