

**THE ROLE OF ANTENATAL SERVICES IN SUPPORTING TEENAGE PREGNANT
GIRLS IN LERIBE DISTRICT OF LESOTHO.**

By

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DEDICATION

This study is dedicated to my two precious sons, Koloti and Mpheka and my wife, Mphaphathi Ntjabane. Their unconditional love, support, patience and encouragement have contributed immensely to my success. They were my source of energy and strength during the study period. May the Almighty God shower them with blessings.

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DECLARATION

I declare that the study titled "THE ROLE OF ANTENATAL SERVICES IN SUPPORTING TEENAGE PREGNANT GIRLS IN LERIBE DISTRICT OF LESOTHO" is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

A handwritten signature in blue ink, appearing to read 'Seema Elliot Ntjabane', is written over a horizontal line.

Seema Elliot Ntjabane

Date: 6th September 2013

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THE ROLE OF ANTENATAL SERVICES IN SUPPORTING TEENAGE PREGNANT GIRLS IN LERIBE DISTRICT OF LESOTHO.

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ABSTRACT

A qualitative, descriptive, contextual study design was used to describe the role of antenatal services in supporting teenage pregnant girls in Leribe district of Lesotho.

The study population consisted of all teenage pregnant girls between 13-19 years of age. Non-probability convenient sampling technique was used to identify potential participants. Data was collected by means of tape-recorded in-depth individual, semi-structured interviews and analysed using Tesch's descriptive method of qualitative data analysis (Creswell 2009:186).

The findings of this study revealed that teenage pregnant girls require comprehensive antenatal services that are sensitive to the needs related to their age. Strategies in which antenatal services can be strengthened to support teenage pregnant girls better were described.

KEY CONCEPTS:

Antenatal services; teenage girls; pregnancy; qualitative research; semi-structured interviews; themes and sub-themes; literature control; role; support systems.

ABBREVIATIONS

AIDS	-	Acquired Immunodeficiency Syndrome
ANC	-	Antenatal care
CDC	-	Centres for Disease Control and Prevention
DHMT	-	District Health Management Team
DHS	-	District Health System
DOH	-	Department of Health
EGPAF	-	Elizabeth Glaser Paediatric AIDS Foundation
EPI	-	Expanded Programme on Immunisation
FANC	-	Focused Antenatal Care
HIV	-	Human Immunodeficiency Virus
JHPIEGO	-	John Hopkins's Programme for International Education in Gynaecology and Obstetrics
LDHS	-	Lesotho Demographic and Health Survey
MDGs	-	Millennium Development Goals
MOH	-	Ministry of Health
NGO	-	Non-Governmental Organisation
PHC	-	Primary Health Care
STIs	-	Sexually Transmitted Infections
TAP	-	Teenage Pregnancy
UNFPA	-	United Nations Population Fund
UNISA	-	University of South Africa
US	-	United States
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health Organisation

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Antenatal care refers to care before birth, and includes education, counselling, screening and treatment to monitor and promote the well-being of the mother and foetus (WHO, 2003). It is generally thought to be an effective method of improving pregnancy outcomes (Hollow, Oakley, Kurinczuk, Brocklehurst & Gray 2011:2). It is therefore, the priority of the Ministry of Health in Lesotho to provide antenatal and counselling services to teenage girls during pregnancy and delivery because these services will improve their health and probability of survival (LDHS 2009:103). In 1998, the Ministry of Health through National Adolescent and Development Program influenced the establishment of antenatal clinics at Adolescent Health Corners, also called teenage corners, which focus specifically on pregnant teenagers (Phafoli, Van Aswegen & Alberts 2007:17a). Teenage pregnant girls are viewed as an important group, which can benefit from effective and supportive antenatal services.

In terms of global coverage, antenatal care (ANC) is largely described as a success story. The available literature shows that 71% of women worldwide receive some form of ANC; in industrialised countries, more than 95% of pregnant women have access to ANC. The research conducted in Nigeria by Dairo and Owoyokun (2010:4) indicates that antenatal care utilisation of 65% in developing countries is low when compared to that of the developed countries which is 97%. Skilled attendance at delivery is 53% in developing countries while it is 99% in the developed countries and postpartum care utilisation is 30% compared to 90% in the developed countries. On the other hand, Lincetto, Mothebesoane-Anoh, Gomez, and Munjanja (2006:51) view antenatal care coverage as a success story in Africa particularly as over two-thirds of pregnant women (69%) have at least one antenatal visit. However, to achieve the full life-saving potential that antenatal care (ANC) promises for women and babies, four visits providing

essential evidence-based interventions, a package often called focused antenatal care, are required. Good antenatal care links the woman and her family with the formal health system and increases her chances of using skilled attendant (doctor or nurse) at birth.

According to LDHS (2009:104), 89.2% of women in Leribe district of Lesotho received antenatal services from a skilled health care provider. During the year 2011, a total of 6384 antenatal clients were seen in Leribe district, out of which 1058 were girls less than 20 years of age (Antenatal register 2011). In the entire country of Lesotho, 92% of pregnant girls less than 20 years of age received antenatal services from the skilled health care provider (LDHS 2009:104). However, the specific role of antenatal services in supporting teenage pregnant girls in Leribe district of Lesotho has not been rigorously evaluated. Programmes that can improve antenatal services for teenage pregnant girls in Leribe and teenage pregnant girls' experiences with regard to recent antenatal services have also not been evaluated.

This study, therefore, investigated the role of antenatal services in supporting teenage pregnant girls in Leribe district of Lesotho. A descriptive, contextual study design using a qualitative approach was employed to collect information from teenage pregnant girls.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Teenage pregnancy is a serious public health challenge in the African community and most children born to teenage girls have very few chances in life due to the poverty they are born into. Therefore, it is important to encourage teenage girls not to have children before they are financially able to support themselves (Chigona & Chetty 2008:278). It is estimated that in low and middle income countries, 10% of all teenage girls become mothers before they are 16, with highest levels being in sub-Saharan Africa, South-Central and South-Eastern Asia (WHO Factsheet 2008:14). The available literature shows that the risks of death following pregnancy are twice as high for girls between 13 and 19 years than for women between the ages of 20 and 24. The maternal mortality

rate can be up to five times higher for teenage girls aged between 10 and 14 than for women of about 20 years of age (Braine 2009:410).

In many developing countries, teenage pregnancy is associated with poor health and social exclusion. Therefore, timely access to appropriate care and support can help to avoid poor outcomes and maximise teenage pregnant girls' chances of a positive transition to motherhood (DOH 2009:4). Pregnant teenagers are less likely than older mothers to access antenatal care early, and are less likely to keep appointments due to a range of interlocking factors such as not realising she is pregnant, taking time to come to terms with pregnancy, not being able to afford transport, and actively seeking to conceal the pregnancy (DOH 2009:9). Teenage pregnant girls are a third less likely than older mothers to breastfeed. They are also at increased risk of inadequate diet during pregnancy. These teenage pregnant girls are also three times more likely than older mothers to develop postnatal depression (DOH 2009:9).

The Leribe district of Lesotho, where the researcher currently works is not an exception to the above situation. Leribe is one of the ten districts of Lesotho and lies in the northern part of the country and has a total population of 293, 369, which makes it the second largest district in Lesotho (Bureau of Statistics 2010:3). This demographic profile offers a sizable number of teenage pregnant girls in this district.

1.3 STATEMENT OF THE RESEARCH PROBLEM

Little is known about the role of antenatal services in supporting teenage pregnant girls in Leribe district of Lesotho. Antenatal services are provided all over the district, the schedules and content are the same. However, adherence to these services varies in both attendance rates and the time of the first visit among teenage pregnant girls. The researcher at his work area of Leribe district in Lesotho noticed that pregnancy rate especially among teenage girls of less than 20 years of age was high. Therefore, before health services or support services can be planned and implemented for teenage

pregnant girls, it is essential that an in-depth study be conducted to understand the unique role of antenatal services in support of teenage girls during their pregnancy.

Lesotho Planned Parenthood Association (2010:9-10) indicates that even though there is high sexual activity among teenagers in Lesotho, contraceptive prevalence among teenagers of both sexes for any method is 16.3% (Lesotho Planned Parenthood Association, 2010). Condom use during first sexual encounter is 10% among teenage boys and 6% for teenage girls with only 11% of teenage girls reporting to be currently using condoms (Lesotho Planned Parenthood Association, 2010). Consequently, low rates of contraceptive and condom use have resulted in high rate of pregnancy among teenagers in Lesotho. These behaviour patterns are associated with challenges such as early and unwanted pregnancy, unsafe abortion, sexually transmitted infections (STIs) and HIV infection (Lesotho Planned Parenthood Association 2010:9-10). Antenatal services provide an opportunity to teach teenage pregnant girls how to recognise and respond to signs of obstetric complications as they may have little knowledge and experience in reproductive health (Alemayehu, Haidar & Habte 2010:121).

It is against this background that the current study was conducted to make a contribution to the understanding of the role of antenatal services in supporting teenage pregnant girls in Leribe district of Lesotho. Knowledge obtained from the findings of this study can be implemented to improve health services specific to the antenatal care of teenage pregnant girls. The study therefore purports to describe the role of antenatal services in supporting teenage pregnant girls.

1.4 AIM OF THE STUDY

1.4.1 Research Purpose

The purpose of this study was to describe the role of antenatal services in supporting teenage pregnant girls in Leribe district of Lesotho.

1.4.2 Research Objectives

1. To describe the role of antenatal services in supporting teenage pregnant girls.
2. To identify programmes that can improve antenatal services for teenage pregnant girls.

1.4.3 Research Questions

1. What is the role of antenatal services in supporting teenage pregnant girls?
2. What are the programmes that can improve antenatal services for teenage pregnant girls?

1.5 SIGNIFICANCE OF THE STUDY

There is no recorded research found that had been conducted in Leribe district of Lesotho on the role of antenatal services in supporting teenage pregnant girls. Therefore, the findings of this study will assist the District Health Management Team (DHMT) of Leribe to strengthen the body of knowledge for health workers in this important area of public health. It is anticipated that data collected in this study will also be valuable for planning innovative antenatal and support services for teenage pregnant girls. It was also empirical to carry the study to know more about the role of antenatal services in support of teenage pregnant girls as this would assist in improving planning for the antenatal services programmes. The importance of attending antenatal services by teenage pregnant girls can never be overemphasized. It reduces the risk of maternal mortality, accessing antenatal care late and the development of postnatal depression. However, there are more benefits of attending antenatal clinics such as ensuring the receipt of appropriate care and support that can help to prevent poor health outcomes.

1.6 ETHICAL CONSIDERATIONS

Ethical protection of participants was maintained throughout this study. Before the study begun, ethical clearance was obtained from the higher Degrees, Research and Ethics Committee of the Department of Health Studies at the University of South Africa (UNISA) (Annexure A). Institutional consent and site permissions were obtained from the Ministry of Health of Lesotho after communicating through a formal letter from UNISA (Annexure C). Informed consent and assent were obtained from the participants.

1.7 DEFINITIONS OF TERMS

In facilitating meaningful dialogue about issues related to the role of antenatal services in supporting teenage pregnant girls, key terms were defined including ‘antenatal services’, ‘teenage girls’, and ‘pregnancy’. For example, some people use the terms such as “teenage girl” and “teenage mother” interchangeably, especially in day-to-day conversation. This use of conceptually different words occurs with little clarifications. Therefore, it is important to clarify what the terms “antenatal services”, “teenage girls”, and “pregnancy” relate to and to operationalize their use within the current study.

1.7.1 Antenatal services

The term ‘Antenatal services’ is umbrella term used to describe medical care provided to pregnant women (Concise Oxford English Dictionary 2008:55). For the purpose of this research, antenatal services are viewed as health services provided to teenage pregnant girls from conception to the time of onset of labour.

1.7.2 Teenage girls

Teenage girls are people between 13 and 19 years of age (Concise Oxford English Dictionary 2008:1479). In this study, teenage girls are viewed as female clients who are single and pregnant between the age of 13 and 19 years.

1.7.3 Pregnancy

Pregnancy refers to the state of being pregnant, the period from conception to birth. This is the gestational process that lasts approximately forty weeks in humans, during which a fertilised egg develops into a distinct individual within the mother's uterus (Concise Oxford English Dictionary 2008:1131).

1.8 RESEARCH DESIGN

In this study, the research followed a qualitative, descriptive and contextual research design to describe the role of antenatal services in supporting teenage pregnant girls. The research design refers to the broader action plan that was employed in enabling this research study to achieve its aim and purpose (Mouton 2001:55). On the other hand, Henning (2005:142) consider the research design as the management plan that outlines and charts a course of action along which the processes and procedures of the study will finally come into completion. Furthermore, the research design is also viewed as the strategy that the researcher uses to obtain information on a research question.

The researcher utilised a qualitative approach to gain insight into and understanding of the respondents' experiences of attending antenatal services at Motebang Hospital in Leribe district of Lesotho. According to Burns and Grove (2009:45) qualitative research is a methodological non-objective approach used to describe how people experience phenomena or events, and what meaning they attribute to these experiences. Thus, the goal of qualitative research is to understand the meaning of a phenomenon from the perspectives of the people experiencing it. Holloway (2005:47-51) indicates that

qualitative approach involves the systematic collection and analysis of subjective narrative data in an organised and intuition fashion to identify characteristics and significance of human experience. Qualitative research is mostly associated with words, language and experiences rather than measurements, statistics and numbers.

According to Miles and Huberman (1994:4), the general reasons for conducting qualitative research are description and hypothesis generation. Description is done when little is known about the phenomenon under study. Little is known about the role of antenatal services in support of teenage pregnant girls. This study, therefore, focused on description rather than hypothesis generation. Researchers who use qualitative research adapt person-centred and holistic perspective to understand the human experience, without focusing on specific concepts. The original context of the experience is unique and rich knowledge and insight can be generated in depth to present a lively picture of the participants' reality and social context (Holloway 2005:4).

Some of the advantages of qualitative research are that; data collection methods are flexible, capture verbatim reports and yield data that usually do not take numerical form. Qualitative enquiry looks at the picture as a whole in order to understand all the components together, which is consistent with the philosophy of Nursing. Since human experiences are difficult to quantify (i.e. have a numerical value assigned to them), qualitative research resonates more naturally and is seen as a more effective method of investigating experiences than quantitative methodologies. Furthermore, qualitative research analyses data by extracting themes and uses words as the basis for analysing rather than numerical data. Qualitative research also develops insights and understanding from patterns of data. Abstract thinking processes are used to develop research findings from which meaning emerge (Brink & Wood 1998:246).

1.8.1 Qualitative research

The research paradigm for this study was qualitative. The reason why qualitative research design was chosen is because it takes place in the natural setting where

human behaviour and events take place. According to Joubert and Ehrlich (2007:319), qualitative research is often the only method used when the aim is to get an in-depth insight into what people think of a particular situation or event. In this study, qualitative research was utilised to obtain an in-depth holistic view of the role of antenatal services in supporting teenage pregnant girls in Leribe district of Lesotho.

1.8.2 Descriptive research

The researcher conducted a descriptive study with the aim of accurately portraying the role of antenatal services in supporting teenage pregnant girls. The purpose of descriptive research is to describe the phenomena under study in real-life situation. This approach is used to generate new knowledge about topics on which limited or no research has been conducted (Burns & Grove 2009:45). Data for this qualitative research is presented in descriptive terms, mainly in the words of the study participants.

1.8.3 Contextual research

This study is contextual in nature as it was conducted within the context of teenage pregnancy in Leribe district of Lesotho. The study focused on the role of antenatal services in support of teenage pregnant girls attending antenatal care clinic at Motebang Hospital in Leribe district of Lesotho. In contextual design, a phenomenon of interest is studied in terms of its immediate context (Mouton & Marais 1996:49).

1.9 RESEARCH METHODS

1.9.1 Research setting

The Kingdom of Lesotho is a land-locked country completely surrounded by the Republic of South Africa of which 59% is mountainous and only 10% is arable. Lesotho's status as an enclave means that it is largely dependent on South Africa. The

country is divided into ten administrative districts with Maseru being the capital town. The district of Leribe, where the study was executed, has a total population of 293 369 that is formed by 150 437 females and 142 932 males (Bureau of Statistics 2010:1-3). This district has two hospitals, namely, Motebang and Mamohau. The study was conducted in Motebang Hospital because it is a regional and referral hospital. Again, this hospital has a well-established teenage corner, also known as adolescent health corner, which serves the larger population of teenage pregnant girls in the district.

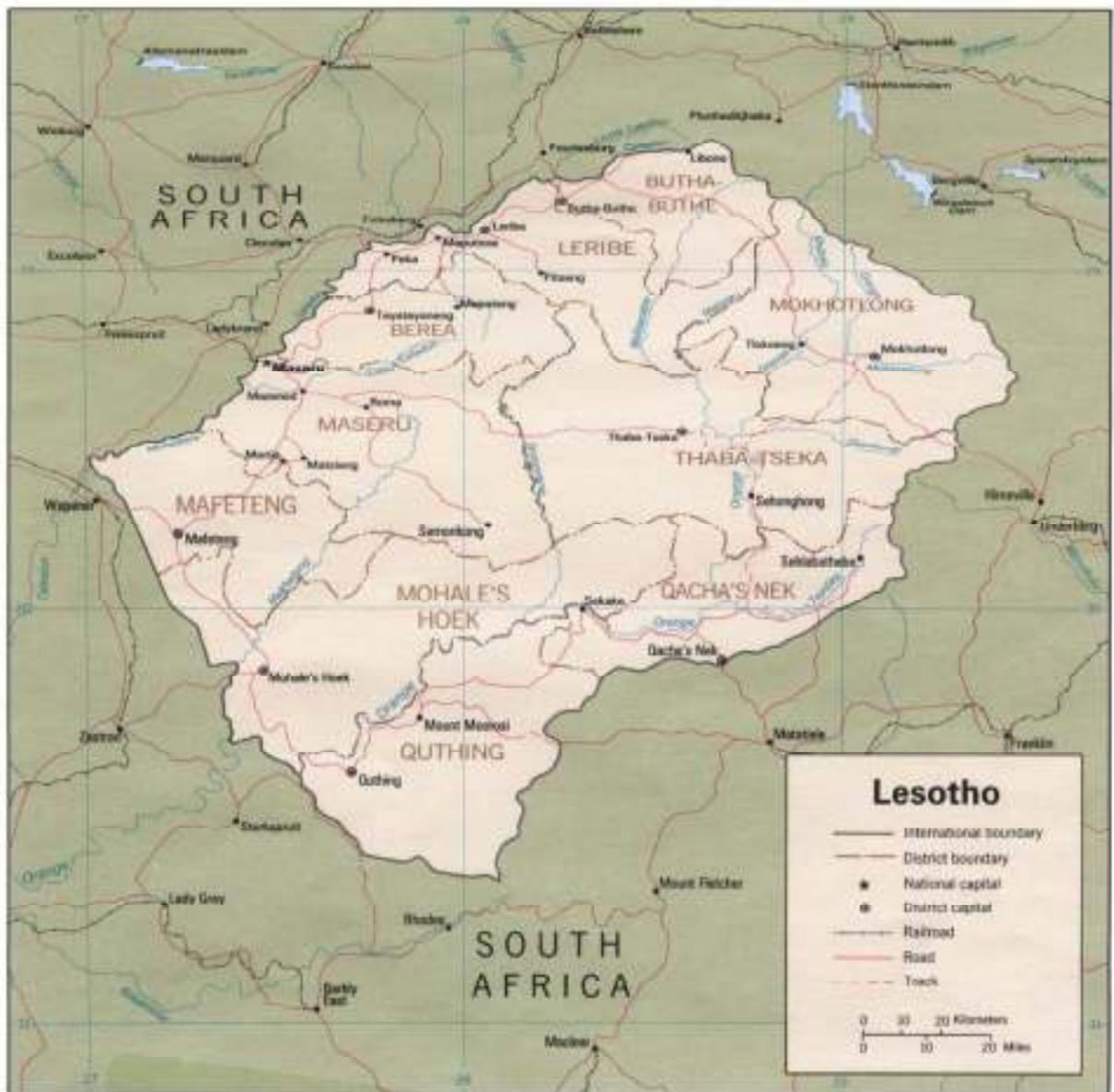


Figure 1.1 Map of Lesotho



Figure 1.2 Map of Leribe District of Lesotho

1.9.2 Research population

In this study, the research population was the entire number of teenage pregnant girls of the Leribe district of Lesotho found at Motebang Hospital antenatal clinic during the time of data collection. As it is not possible to study the entire population of teenage pregnant girls in Leribe district of Lesotho, a sample was drawn. The research population is the entire group of persons of interest to the researcher and includes individuals who meet the specified inclusion criteria. This is the group about which the researcher wants to gather information and draw conclusions (Joubert & Ehrlich 2007:94).

1.9.3 Sample and sampling technique

In this study the sample was made up of teenage pregnant girls aged between 13 and 19 years in Leribe district of Lesotho. According to Polit and Beck (2008:339), the research sample is a portion (subset) of the target population that represent the entire population so that inferences about the population can be made. Convenience sampling was seen as an appropriate sampling technique for this study because it enabled the researcher to gain deeper understanding of phenomenon under investigation using readily available study participants (Babbie 2010:192).

1.9.4 Sample size

According to Burns and Grove (2009:361), the focus in qualitative research is on the quality of information obtained from the person, situation, event, or documents sampled versus the size of the sample. The sample size used in qualitative research methods is often smaller than that used in quantitative research methods. This is because qualitative research methods are often concerned with getting or acquiring an in-depth understanding of the phenomenon under study. The concept of saturation is the most important factor to think about when mulling over sample size decisions in qualitative research (Dworkin 2012:1319). Saturation is the point at which the data collection process no longer offers any new or relevant information. Therefore, the sample size for this study was guided by the saturation of information.

1.9.5 Inclusion criteria

The selection criteria for inclusion in the study were that the participants had to be:

- Females between the ages of 13 and 19 years;
- Primigravida (pregnant for the first time);

- Single;
- Willing to take part in the study;
- Resident in Leribe district of Lesotho;
- Attending antenatal services at Motebang Hospital in Leribe district of Lesotho.

1.10 DATA COLLECTION

In-depth individual interviews were conducted in the language spoken by the respondents, that is, Sesotho, and their responses were recorded by a tape recorder, transcribed, and then translated into English. Each interview record was labelled with assigned code according to the date that the interview took place. The interview setting was made as free as possible from background noise and interruptions. In addition to the interviews, the Leribe district HIV/AIDS Officer assisted the researcher with the taking of field notes during in-depth individual interview sessions. Field notes relieve the researcher of having to remember all the events that took place during the interview (Wilson 1989: 435). In this study, field notes described the setting, respondents and actions, and captured the researcher's own ideas and concerns.

1.11 DATA ANALYSIS

All audio-recorded semi-structured interviews were transcribed verbatim. The Sesotho transcripts were translated into English. The analysis was done concurrently with data collection. Open coding data analysis was employed in this study. The transcribed verbatim data was translated before themes were formulated. Data analysis, organization and interpretation were done using Tesch's descriptive method (in Creswell 2009:186). This is discussed in greater detail in Chapters 3 and 4.

1.12 SCOPE AND LIMITATIONS OF THE STUDY

The study was conducted in Motebang Hospital in Leribe district of Lesotho. This hospital was conveniently selected because it is a regional and referral hospital, which has a well-established teenage corner that serves a larger population of teenage pregnant girls in Leribe. The researcher did not visit the villages falling under Motebang Hospital catchment area to find out the opinions of teenage pregnant girls who did not utilise antenatal services because of limited resources such as time and money. Therefore, the selected sample may not be representative and the findings cannot be generalised to the whole of Leribe district or Lesotho. Some questions that were asked during in-depth interviews were sensitive and so some teenage pregnant girls were reluctant to respond to them while others decided to give less detailed information.

1.13 CONCLUSION

This chapter outlines the study, including significance of the study, problem statement, research questions, purpose and objectives of the study, as well as the paradigmatic perspective on which the study was based. The research design and methodology were briefly discussed. The next chapter (chapter 2) presents the Literature Review.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In the previous chapter, an overview and introduction to the study was given. In this chapter, the literature related to the antenatal services for teenage pregnant girls is appraised. There is very little that has been published, except for literature and reports written by the World Health Organisation (WHO) on this issue and as such, the review here will also highlight gaps in the knowledge about antenatal care services for this client group. Burns and Grove (2007:33) consider a literature review as the systematic identification, location, scrutiny and summary of the related published work to gain information about a research topic. In addition, Brink (1996:76) describes the review of literature as the process that involves finding, reading, understanding and forming conclusions about the published research and theory on a particular topic.

The main purpose of literature review is to identify and compare earlier studies and this helps to save time, avoid duplication and unnecessary repetition (Mouton 2001:87). The rationale for review of literature relevant to this study is also to gain background understanding of information available on antenatal services for teenage pregnant girls. Therefore, it is evident that, through literature review, researchers can discover what is known about the topic and compare the findings of the present study. In general, the review of relevant literature, according to Burns and Grove (2009:90), provides a road map for the development and implementation of the research study. In this study, the literature review will discuss factors relate to teenage pregnancy, antenatal care services, programmes that support teenage pregnant girls, and the district health system.

2.2 TEENAGE PREGNANCY

The topic of teenage pregnancy (TAP) has been a focus of public concern, and has generated debate among academics, health professionals, and politicians because it is seen as a challenge that might contribute to a struggle to fulfil the objectives of the Millennium Development Goals (MDGs) directly related to the women's reproductive health and neonatal care (James, Rall & Strumper 2012:1). This challenge of pregnancy among teenage girls becomes worse as midwives and nurses sometimes find it difficult to fully supervise all these pregnancies, because teenagers may stay away or default from clinic attendance. Vlok (1996:318) concludes that TAP is a socio-economic problem. Health experts, therefore, agree that pregnant teenagers require special physical and psychological attention during pregnancy, childbirth, and the post-natal period for preserving their own health and the health of their babies (Braine 2009:410).

2.2.1 The extent of the problem. Global perspective

Dr Sapire (in Bezuidenhout 1998:29) mentions that 75% of the world population younger than 15 years have no access to information regarding sexuality and reproduction. Teenage pregnancies have reached epidemic proportions in Africa and in the United States. It is estimated that approximately one million teenagers fall pregnant each year, about 30,000 of them before they reach the age of 15 years. Research conducted by James et al (2012:1) indicates that teenage pregnancy holds many concerns for the pregnant teenager, her unborn baby, her immediate family and the society at large. These concerns emanate mainly from the fact that should complications occur during pregnancy or labour and delivery, two lives are at risk.

According to WHO (2011:ix), it is estimated that about 16 million teenage girls between 15-19 years of age give birth each year. Babies born to teenage mothers account for roughly 11% of all births worldwide, with 95% occurring in developing countries. For some of these young women, pregnancy and childbirth are planned and wanted, but for others they are not. In most cases, less than half of these teenage pregnant girls make four or more antenatal care visits or deliver at a health facility (UNFPA Factsheet

2012:2). However, globally midwives take their professional responsibility seriously and are encouraging women, especially teenagers, to attend antenatal care clinics as soon as they become aware of being pregnant, and to continue doing so until labour commences. Again, it's a challenge for midwives to fulfil this goal (James et al 2012:1).

In the United States (US), TAP and birth rates are substantially higher than those in other Western industrialised nations. For example, in 2009, a total of 409,840 infants were born to females aged 15-19 years. Nearly two-thirds of births to females younger than 18 years and more than half of those among females aged 18-19 are unintended. About 4% of all teenage girls give birth each year and teenage births represent 10% of the 4 million births each year in the US (CDC 2011:2). A study conducted long time ago in the US by Wallace, Gold, Goldstein and Oglesby (1973:5) found that the number of live births out of wedlock in girls under 20 years of age has increased from 42,600 in 1940 to 165,700 in 1968 and 2.1% of all out of wedlock pregnancies were in the under 15-year age group. Consequently, these young girls may be excluded from school.

On the other hand, a prevalent myth in Britain is that teenage girls believe there are economic and social advantages in having a baby. However, contrary to such speculation, several research studies report that the majority of teenage pregnancies are unplanned, and the outcomes for the mother and her child in terms of life chances are negative. The number of births to teenagers in Britain is considered unacceptable. Therefore, reducing teenage pregnancy is now a priority of health service in England, Scotland, Wales, and Northern Ireland (Irvine, Bradley, Cupples & Boohan 1997:323).

In Uganda, according to Atuyambe et al (2005:304), girls become sexually active earlier than boys. The median age of first sexual intercourse for men aged between 25-54 is 19.4 years compared with 16.7 years for women. This increases the risks of early pregnancies and marriages and consequently teenage motherhood. Teenagers in Uganda are often initiated into marriages and sex quite early when they are still growing, thus contributing to 31% ranking of TAPs, making this country one of those with high TAP rates in sub-Saharan Africa (State of Uganda Report 2005).

Saadhna, Makiwane, Rachod and Letsoalo (2009:22) reports that South Africans are currently faced with the challenge of increasing numbers of teenagers who get pregnant and some of them drop out of school before completing their studies. The increase is informally associated with the Child Support Grant offered by the Government as a social support to the children. However, the Human Sciences Research Council disputes this, further explaining that TAP in South Africa peaked from 1996, two years before the introduction of the grant. Statistics released by the Human Sciences Research Council on behalf of the National Department of Education show a teenage pregnancy rate of 58% amongst learners during the period 2004-2008, with the rate of pregnancy amongst those not at school averaging 35% (Saadhna et al 2009:23).

2.2.1.1 Teenage Pregnancy in Lesotho

According to the records of UNFPA (2010:2), teenage pregnancy in Lesotho is estimated at 52.1% and contributes to the risk of maternal deaths as pregnancy during this period carries very high risks such as pregnancy-induced hypertension, obstructed labour, prolonged labour, and unsafe abortion. Childbearing starts early at 13-19 years in Lesotho. It is estimated that 20% of teenagers (15-19 years) have had at least one birth or are pregnant with their first child. The 2006 Census results revealed that teenage childbearing is on the increase with Molepolole having the highest proportion of youth who have ever been pregnant (43.3%) while Leribe has the lowest (37%) (UNFPA 2010:2). Lesotho Planned Parenthood Association (2010:9-10) indicates that even though there is a high sexual activity among teenagers in Lesotho, contraceptive prevalence among teenagers of both sexes for any method is 16.3%. Condom use during first sexual encounter is 10% among teenage boys and 6% for teenage girls with only 11% of teenage girls reporting to be currently using condoms.

2.2.2 Themes that emerged during literature review

On reviewing the literature, three themes emerged, namely, the experiences of teenage pregnant girls with regard to support, their sexual behaviour and information.

2.2.2.1 Support

In many cases, according to Atuyambe et al (2005:304-305), the unmarried pregnant girls are rejected by their parents as they have added shame and an additional burden to the family. These teenage pregnant girls are sent away from home and at times are also beaten by their parents. In many cultures of Uganda, the unmarried teenage pregnant girl carries a feeling of shame, guilt and discrimination and this makes her to hide her condition from her family because of fear of rejection and lack of understanding. In addition, Bezuidenhout (1998:36) mentions that the reaction of the family of the teenage mother may range from understanding to ostracism of the teenager. Teenage pregnant girls should receive empathy and support from their parents, rather than being sent away from home and this will reduce chances of suicide.

Furthermore, teenage pregnant girls face a lot of stigma and male partners who impregnate them often deny responsibility. On the other hand, while the father of the unborn child may deny paternity and escape social stigmatisation, he may feel a deep sense of guilt and responsibility for the unborn child, which may result in despair and depression. If marriage takes place, usually, the relationship between a young mother and a young father is unstable. It must be acknowledged that not all relationships between young parents are healthy. However, a good relationship between a young father and his teenage partner is strongly associated with his involvement with his child in the early years and with lower stress for the teenage mother (DOH 2009:7).

In Lesotho, school systems do not offer social support to pregnant girls but rather they send them away. A poor educational qualification means poor employment and poor financial prospects. High repetition and dropout rates in both primary and secondary schools characterise the educational system of Lesotho (Motlomelo & Sebatane 1999:25). Morojele (in Mohai, Thaane, Mpotla, Mokutlulu & Luwanja 2002:6) reviewed court cases of abortion in Lesotho and found that the most common reason why teenagers resorted to unsafe abortions was fear of being expelled from school. While many girls who become mothers before completing schooling consider academic

qualifications to be very important, they may not be able to succeed academically if the support they need to complete their studies is insufficient (Chigona & Chetty 2008:261).

The attitudes of health workers are important as they determine whether antenatal care services are attractive to teenage pregnant girls or not. The study of Atuyambe et al (2005:308) indicated that health workers were not responding adequately to adolescent maternal needs. Some health workers were said to be harsh and abusive and they blamed and intimidated the girls. Therefore, there is a feeling that if health workers have negative attitudes, teenage pregnant girls will avoid health services and end up seeking help from unprofessional people. In Uganda, research by Mbonye (2003:105) demonstrated that implementation of adolescent friendly services improved access and use of services among adolescents leading to reduced unwanted pregnancies.

The support groups aim to ensure that the needs of vulnerable teenage pregnant girls are identified early and met by agencies working together in ways that are shaped by the views and experiences pregnant girls themselves. The support groups also ensure that teenage pregnant girls receive a personalised package of support, information, advice and guidance, and learning and development opportunities coordinated by a trusted health professional and delivered by agencies working in partnership (DOH 2008:18). There can be arrangement to refer teenage pregnant girls to agencies such as Targeted Youth Support, Connexions, A Children's Centre, and Teenage Parent Support Service where they exist for professionals in these agencies to assess support needs (DOH 2009:27).

Research done by Dlamini (2002:140) indicates that almost all teenage pregnant girls said they used to attend their churches regularly and took part in activities offered at the church before they got pregnant. All the participants mentioned that they did not feel free to go to church after they became pregnant, as the church did not condone sex before marriage. That is, the church does not accept pregnancy out of wedlock. In the US, on the other hand, in 2006-2010, the most common reason that sexually inexperienced teenagers gave for not having had sex was that it was against religion or morals (38% among females and 31% among males) (Guttmacher Institute 2012:1).

2.2.2.2 Sexual behaviour

A study done in Lesotho by Motlomelo and Sebatane (1999:7) shows that most teenagers become sexually active early in their lives and in most cases without prior information on sex and sexuality. Their parents do not teach much in relation to sex and sexuality. These teenagers start sexual intercourse at the age 14 years and most of them report that their first sexual episode was with other students (boyfriends). Most of them engaged in sexual relations out of their own choice. On the other hand, some girls are still cheated and coerced into sexual relations. However, in some rare cases, girls do it for money and sympathy for their sexual partners (Motlomelo & Sebatane 1999:7). In addition, UNFPA Factsheet (2012:1) states that for many teenage girls in developing countries, the mere onset of puberty that occurs during adolescence marks a time of heightened vulnerability to sexual exploitation, coercion and violence. The study done at a teenage clinic in Cape Town found that the earlier the age of menarche, the higher the prevalence of sexual intercourse at an early age. Young age at first sexual intercourse is associated with higher prevalence of multiple sex partners (promiscuity), smoking, alcohol and drug abuse, and a longer period of unprotected sexual intercourse (Vlok 1996:319). Thus, in most cases, earlier sexual maturity leads to earlier sexual activity.

The study conducted in the US by the Guttmacher Institute (2012:1) shows that although only 13% of the teenagers have had sex by age 15, most of them initiate sex in their later teenage years. By their 19th birthday, 7 in 10 female and male teenagers have had sexual intercourse. Among sexually experienced teenagers, 70% of females and 56% of males report that their first sexual experience was with a steady partner, while 16% of females and 28% of males report having first sexual intercourse with someone they had just met or who was just a friend. 7% of young women aged 18-24 who had sex before age 20 report that their first sexual experience was not voluntary.

Guttmacher Institute (2012:1) points out that a sexually active teenager who does not use contraception has a 90% chance of becoming pregnant within a year. Much disinformation exists about sex and the use of contraceptives. The result is that available contraceptives are not used or they are often used incorrectly. A study done

among teenage mothers in Poland by Zarzeczna-Baran and Balkowska (2002:1) revealed that contraceptive methods were used more frequently by more educated teenagers (College education, 40.9%) compared to less educated teenagers (5.88%) at primary level of education.

Moreover, an unknown percentage of teenagers intentionally fall pregnant. By falling pregnant they hope to find a solution to their problems. For example, the teenager may decide to be impregnated by a certain male, hoping that he will marry her. Other teenagers find it difficult to live in the same household with their stepparents and by falling pregnant they hope to achieve independence away from their homes. Some rebellious teenagers may intentionally fall pregnant because they are seeking release from their frustration and anger by indulging in sexual activity (Bezuidenhout 1998:30).

2.2.2.3 Information

Bezuidenhout (1998:30) states that sex is the topic that is least spoken about by members of the family. Teenagers who experience physical and physiological changes often find it difficult to discuss these experiences with their parents and siblings. In need of information, they turn to their peers for guidance or seek information from book, magazine articles and videos. Not all information obtained from these sources is correct or satisfies the curiosity of the teenager. This increases the chances of teenagers experimenting with sex, the outcome of which is sometimes an unwanted pregnancy.

According to Bezuidenhout (1998:31), the teenager, today, has a greater opportunity to view sexual activity on national television than before. Sexually arousing material, whether it is on film, in print or music, is freely available to the teenager. Often such information is presented out of the context of the prescribed sexual norms of that society. This influences the teenager to experiment with illicit sexual activity, with resultant pregnancy. Together with peer pressure, the influence of the mass media has a powerful triggering effect on the teenager to indulge in illicit sex.

On the other hand, when teenage girls move out of their parents' homes at a very early age due to schooling, direct parental control ceases and identification with the peer

group increases. The peer group is the most important socialisation agent next to the family and also the primary source of information about sex. Besides the fact that this information may be incorrect, peer pressure on the teenager to indulge in sex because “everyone does it” or not to “feel out”, may be the direct cause of an unwanted pregnancy. However, in South Africa, according to Vlok (1996:319), it is a criminal offence for any male to have sexual intercourse with a girl below the age of 16 years. That is, 16 years is considered as the legal age of consent for sexual intercourse.

2.2.3 Consequences of teenage pregnancy

There is a growing recognition that teenage pregnancy contributes to maternal mortality, to perinatal and infant mortality, and to the vicious cycle of ill health and poverty (WHO 2011: ix). Complications in pregnancy and childbirth are the leading causes of death among adolescent girls aged 15-19 years in low- and middle-income countries, resulting in thousands of deaths each year (WHO 2011:ix). The risk of maternal mortality is higher for teenage girls, especially those under 15, compared to older women. In fact, it is estimated that girls under the age of 15 years are up to five times more likely to die in childbirth than women in their 20s (UNFPA Factsheet 2012:2). In general, the younger the girl is when she becomes pregnant, whether she is married or not, the greater the risk to her health. Therefore, teenage pregnant girls are viewed as a high-risk maternity population requiring special health care services (Bezuidenhout 1998:33).

The CDC (2011:2) indicates that in the US, the social and economic costs of teenage pregnancy and childbearing are often high, and these costs can be both immediate and long-term for teenage parents and their children. For example, teenage pregnancy and childbirth contribute significantly to high dropout rates among high school girls. Only about 50% of teenage mothers receive a high school diploma by age 22, compared with nearly 90% of women who did not give birth during adolescence. Chigona and Chetty (2008:261) also confirm that in sub-Saharan Africa, teenage pregnancy is one of the major impediments to the educational success of girls and in many cases, the birth of a baby marks the end of schooling for the teenage mothers. Again, in the US, teenage pregnancy and childbirth cost US taxpayers an estimated \$9 billion per year because of

increased health care and foster care costs, increased incarceration rates among the children of teenage parents, and lost tax revenue from teenage mothers who earn less money because they have less education (CDC 2011:2).

According to WHO (2011: ix) the adverse effects of adolescent childbearing also extend to the health of their infants. Perinatal deaths are 50% higher among babies born to mothers under 20 years of age than among those born to mothers aged 20-29 years. Babies born to adolescent mothers are also more likely to be of low birth weight and some of these children are often malnourished due to economic difficulties. In other words, adolescent pregnancies put new-borns at risk. Deaths during the first month of life are 50 - 100 % more frequent if the mother is an adolescent than if she is older. The younger the mother is, the higher the risk for the baby (UNFPA Factsheet 2012:2).

WHO (2011: ix) states that unplanned and unwanted pregnancies among teenagers aged 15-19 years may end in abortions, which are often unsafe for this age group. UNFPA adds that 15% of all unsafe abortions in low- and middle-income countries are among adolescent girls aged 15-19 years. In 2008, there were an estimated 3.2 million unsafe abortions in developing countries among girls aged 15-19 years, and adolescents are more seriously affected by complications than older women. Unsafe abortion is responsible for about 13% of all maternal deaths (UNFPA Factsheet 2012:2).

Atuyambe et al (2005:305) mention that the most common medical complications among teenage girls are obstructed labour, pre-eclampsia and eclampsia, anaemia, STIs including HIV/AIDS, Vesico-vaginal fistula, high blood pressure, depression and anxiety. Braine (2009:411) agrees that teenage mothers face a higher risk of obstructed labour than women in their 20s. Without adequate emergency obstetric care, this can lead to uterine rupture and a high risk of death for both the mother and her infant. For those who survive, prolonged labour can cause obstetric fistula, which is a tear between the vagina and the bladder or the rectum, causing urine or faeces to leak. In Ethiopia and Nigeria, more than 25% of fistula patients had become pregnant before the age of 15 years and more than 50% before the age of 18 years (Braine 2009:411).

2.3 ANTENATAL CARE SERVICES

Antenatal care is the care of the pregnant woman until the birth of her child. It overlaps with perinatal care. In addition, antenatal care services are considered to be a critical intervention aimed at reducing maternal morbidity and mortality. This is a medical care given to expectant mothers whose major aim is to identify and treat problems and complications during pregnancy (Resty 2011:1). According to Anya, Hydera, and Jaiteh (2008:2) antenatal care provides a chance to interact with the pregnant woman so that the woman can make appropriate choices and decisions that will contribute to optimum pregnancy outcome and care of the new-born. Alemayehu et al (2010:121) found that timely antenatal care remains an opportunity to prevent the direct causes of maternal mortality and to reduce foetal and neonatal deaths related to obstetric complications. Thus, antenatal care is one of the recommended cares to be provided to pregnant women. Since this care provides an entry into the health system, for teenage pregnant girls, it may be one of the first comprehensive health assessments deemed necessary.

A study conducted by Bergsjö (1996:3) indicate that antenatal care is one of the “four pillars” of safe motherhood, as formulated by the Maternal Health and Safe Motherhood Programme, Division of Family Health, of WHO. The other three are family planning, safe delivery, and essential obstetric care. This package was devised to ensure that women should be able to go safely through pregnancy and childbirth and have healthy infants, in other words, to prevent dreaded outcomes of maternal, perinatal, and infant deaths. Antenatal care includes routine follow up provided to all pregnant women at primary care level from screening to intensive life support during pregnancy and up to delivery. Vlok (1996:377-378) summarises the aims of antenatal care as; to promote and maintain good physical and mental health during pregnancy, to ensure a live, mature, and healthy infant, to prepare the woman for labour, and to detect early and treat medical and obstetric conditions that would endanger the life or impair the health of the mother or the baby. Some researchers in the field of Maternal and Child Health, for example, Sellers (2006:166) also emphasise that antenatal care aims to provide the expectant mother with the overall supervision of maternal health and provision of education relevant to her confinement which may increase the survival rate of her child.

The research conducted in Nigeria by Dairo and Owoyokun (2010:4) indicates that antenatal care utilisation of 65% in developing countries is low when compared to that of the developed countries which is 97%. On the other hand, Lincetto, Mothebesoane-Anoh, Gomez, and Munjanja (2006:51) view antenatal care coverage as a success story in Africa since over two-thirds of pregnant women (69%) have at least one antenatal visit. However, to achieve the full life-saving potential that antenatal care (ANC) promises for women and babies, four visits providing essential evidence-based interventions, a package often called focused antenatal care, are required. Coverage for ANC is usually expressed as the proportion of women who have had at least one ANC visit. Lincetto et al (2006:56) is of the opinion that there are still inequalities in antenatal care. For example, in Africa, 80% of women in the richest quintile have access to three or more ANC visits, while only 48% of the poorest women have the same level of access. A similar disparity exists between urban and rural women. Thus, most barriers to the access and uptake of ANC are financial especially when ANC requires travel and long waiting hours. Generally, good care during pregnancy is, according to Lincetto et al (2006:52), important for the health of the mother and the development of an unborn baby. Good antenatal care links the woman and her family with the formal health system and increases her chances of using skilled attendant (doctor or nurse) at birth.

2.3.1 Approaches to ANC services

Antenatal care is practiced all over the world with programmes that have essentially similar schedules and content. While research has demonstrated the benefits of ANC through improved health of mothers and babies, the exact components of ANC and what to do are matters of debate. In recent years, there has been a shift in thinking from high-risk approach to focused antenatal care (Lincetto et al 2006:53). Therefore, this section discusses these two approaches (High-risk and Focused ANC -FANC) to ANC.

2.3.1.1 High-Risk Approach

Bergsjö (1996:4) reports that in 1978 the World Health Organisation developed the “risk approach” concept as a managerial tool for maternal and child health care, in particular,

for countries where access to medical care was limited. This risk approach was a strategy to identify risk factors for undesirable outcomes, with care to be delivered according to individual needs. However, because there are high levels of false positive and false negative results, the approach was not successful as a public health measure. Nevertheless, the risk approach spurred thoughts and was the basis for later attempts to induce changes. Obviously, in individual cases, clinicians should identify risk factors and give the advice or take action that they believe is necessary, but public health workers should regard every woman as being at risk and work towards a system which will result in emergency obstetric care accessible to all women. Lincetto et al (2006:53) confirms that the high-risk approach intended to classify pregnant women as “low risk” or “high risk” based on the predetermined criteria and involved many ANC visits. This approach was hard to be implemented effectively since many women had at least one risk factor and not all developed complications. At the same time, some low risk women did develop complications, particularly during childbirth, hence, the shift to FANC.

2.3.1.2 Focused Antenatal Care (FANC)

FANC has been developed and promoted by WHO in 2006 to provide specific evidence-based interventions for all pregnant women, carried out at certain critical times in the pregnancy. This package includes counselling, examinations, and tests that serve immediate purposes and provide proven health benefits (Stephenson 2005:1). Focused antenatal care is described by JHPIEGO (2003:4) as a maternal and neonatal care intervention that is evidence-based and built on global lessons learned about what works to save the lives of pregnant women and new-born babies. It is goal-oriented, has no adverse effects on the woman and the unborn baby, and includes four visits to antenatal clinic, where each visit is focused rather than routine (Viller, Carroli, Khan-Neelofur, Piaggio & Gulmezoglu 2001a:1). This new comprehensive approach to ANC emphasises the quality of care rather than the quantity of visits.

According to Lincetto et al (2006:53), the essential elements of a focused approach to ANC are as follows: identification and surveillance of the pregnant woman and her expected child, recognition and management of pregnancy-related complications,

particularly pre-eclampsia, recognition and treatment of underlying or concurrent illnesses, screening for conditions and diseases such as anaemia, STIs (particularly syphilis), HIV infection, mental health problems, and symptoms of stress or domestic violence, preventive measures including tetanus toxoid immunisation, de-worming, and iron and folic acid prophylaxis, advice and support to the woman and her family for developing healthy home behaviours and a birth and emergency preparedness plan. This involves provision of health advices on the care of the new-born, early exclusive breast feeding, optimal birth spacing through consistent use of family planning, and use of institutional delivery in order to improve maternal and foetal outcomes.

2.3.2 ANC in selected African Countries

Alemayehu et al (2010:121) points out that the recent recommendation by WHO requires the first ANC visit to be started as early as possible in pregnancy, preferably in the first trimester. If the pregnant woman has no serious health problems and does not need special attention, only four ANC visits suffice. The purpose of first assessment in ANC is to distinguish pregnant women who require standard care, such as the four-visit model, from those requiring special attention and more visits. James, Van Rooyeen and Strumpher (2010:5) state that attendance at ANC clinic is very important for pregnant teenagers as there is scientific evidence confirming that they are prone severe pregnancy and labour related complications. In this section, ANC in some African countries, namely, Tanzania, South Africa, Uganda and Lesotho has been discussed.

2.3.2.1 Tanzania

Although maternal and infant mortalities remain a major public health challenge in Tanzania, 94% of pregnant women make at least one antenatal care visit, and 62% of them make four or more visits. The reason for the low figure (62%) for subsequent visits is thought to be the drop in quality of antenatal services due to various factors such as shortage of skilled personnel, equipment, essential drugs, and unfriendliness of health care workers (Tanzania 2005:6). It is estimated that 14% of pregnant women start ANC during the first trimester in Tanzania. The indirect causes leading to poor maternal

health outcomes are malaria, anaemia, and HIV/AIDS. Therefore, the Ministry of Health developed a strategic plan to accelerate reduction of maternal and child deaths in line with the Millennium Development Goal (MDG) 4 – reduce child mortality and MDG 5 – improve maternal health. The target is increased ANC attendance for at least four visits from 62% to 90% by 2015 (Tanzania 2008:1).

Therefore, comprehensive ANC services are implemented as part of the strategies for improving maternal and child health services. In 2002, the Ministry of Health of Tanzania started promoting focused ANC. However, the most important study conducted in Southern Tanzania by Both, Fleba, Makuwani, Mpembeni and Jahn (2006:1) found that health workers spend an average of 46 minutes providing focused ANC to a first time client, and 36 minutes for a revisiting client. This was 30 minutes more on average than the current practice and poses challenges for service delivery.

2.3.2.2. South Africa

In South Africa, basic antenatal care aims to ensure that all pregnant women attend ANC clinic at least four times during their pregnancy, starting with the first follow up visit at 20 weeks of gestation. This allows pregnant women to be screened in order to make a thorough assessment of whether they are low- or high-risk patients during their pregnancy. Those who are diagnosed as high-risk mothers are appropriately referred to the tertiary healthcare facilities (Pattison 2005:9-14). On the other hand, the DOH (2006:7) indicates that the reports from the National Committee on Confidential Enquiries into Maternal Deaths revealed poor to non-attendance at antenatal clinics by pregnant teenagers, despite free ANC services offered at public institutions. Lack of knowledge on ANC and attitudes of teenagers, which ranged from a feeling of boredom to a non-conducive clinic environment are possible reasons that affected teenagers' attendance at ANC clinic (Tighe 2010: 295-298).

The findings of the study conducted in Kwazulu-Natal, South Africa by Chege, Askew, Ndube-Nxumalo, Kunene, Beksinska, Dalton, Snyman, Sturm and Moodley (2005:2) revealed that 94% of pregnant women receive antenatal care from a doctor or midwife, and the vast majority of these women (84%) have skilled attendance at birth. However,

maternal and infant morbidity and mortality rates remain high compared to other countries with a similar level of development. About 60% of maternal deaths are caused by factors that can be detected and addressed during the antenatal period, such as, hypertensive disorders of pregnancy, ante- and post-partum haemorrhage, abortion, ectopic pregnancy, and pregnancy-related sepsis. To improve the quality of ANC services, Department of Health resorted to focused ANC in 2001 (Chege et al 2005:2).

2.3.2.3 Uganda

In Uganda, as in many African countries, provision of universal ANC services face challenges because of inability of health care workers to recognise obstetric complications and shortage of skilled attendants at birth (Resty 2011:1). It is estimated that 31% of teenagers attending ANC services have fears of unknown, and as a result, they start ANC services late, thus, increasing the chances of complications. Atuyambe, Mirembe, Johansson, Kirumira and Faxelid (2005:304) mention that out of 94% of pregnant women who receive ANC in Uganda, only 37% of them deliver at health facilities. Low use of rural maternity services in Uganda impacts on women's well-being. Some of the reasons why pregnant teenagers under-utilise ANC services are long waiting hours, lack of support from their spouses, and inability to meet transport costs to ANC clinics. A study conducted by Tetui, Ekirara, Bua, Mutebi, Tweheyo and Waiswa (2012:2) in the eastern Uganda, maintains that ANC services in this country are characterised by poor attendance, poor counselling services, and poor client-provider relations, with the quality being worse in the rural areas. The quality of ANC is critical in enabling pregnant women and health workers to identify risks and danger signs during pregnancy, which should lead to appropriate action (Tetui et al 2012:2).

2.3.2.4 Lesotho

According to the LDHS (2010:103-105), more than 91.8% of pregnant women in Lesotho attend ANC clinic at least once. Attendance subsequently decreases, with only 60% of all women attending four times. Almost half of all pregnant women in Lesotho deliver outside health facilities. Only 33% of pregnant women receive ANC in the first

trimester. Phafoli et al (2007:17) confirms that there is a delay in deciding to seek ANC among pregnant teenagers in Lesotho. Early ANC, that is, during the first trimester, plays a major role in detecting and treating complications of pregnancy and forms a good basis for appropriate management during delivery and after childbirth. Pregnancy-related complications remain the primary cause of maternal and child morbidity and mortality in Lesotho. To address this problem, the Ministry of Health launched the Roadmap for Accelerating Reduction of Maternal and New-born Morbidity and Mortality in 2007. The roadmap was meant to define and monitor the problems associated with maternal and child morbidity and mortality and to find ways to rectify the problems (LDHS 2010:105). The Ministry of Health has adopted the WHO recommendation of scheduling at least four ANC visits for a woman with normal pregnancy, with the first visit made in the first trimester, and the subsequent visits at 24-28 weeks, 30-32 weeks, and 36-38 weeks of gestation (LDHS 2010:105).

2.3.3 The role of antenatal services in supporting teenage pregnant girls

Teenage pregnant girl friendly antenatal services, like adolescent friendly health services, need to be accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient. These characteristics are based on the WHO Global Consultation in 2001 (WHO 2002:27). In some studies pregnant teenagers have expressed their views about what they want from health services. However, because they have unique and complex needs, ANC services can engage more effectively with them by adopting the following characteristics adapted from WHO (2002:27) and DOH (2009:11-31):

2.3.3.1 A welcoming environment

Teenage pregnant girls want a welcoming health facility where they can 'drop in' and be attended to quickly. Teenage pregnant girls are self-conscious of using services where other service users are older than them. They are often sensitive to the possibility of encountering criticism when using antenatal services. A welcoming environment can be created by making working hours convenient to them, displaying positive images of

young mothers, providing appropriate information and educational material, offering privacy and avoiding stigma, and where possible by also allowing staff not wear uniform. Creating a welcoming environment in the reception and waiting area is also very important to reassure teenagers that the services are 'for them' (DOH 2009:12-13).

2.3.3.2 Easily accessible services

Teenage pregnant girls want antenatal services in a convenient place at a convenient time that is free or at least affordable. They may have difficulties in accessing antenatal services if their own transport or public transport is not affordable. Daytime ANC clinics may be problematic for teenage pregnant girls at school. Therefore, ANC services can be made accessible by; choosing clinic location accessible to pregnant teenagers by foot or public transport, taking account of teenage pregnant girls' circumstances when scheduling appointment (avoiding early mornings and school working hours appointments), ensuring that teenagers get transport re-imburement, where possible, encouraging pregnant teenagers to keep in touch with the health facility by phone (mobile and landline) and the health facility to keep in touch by the same means as teenagers may run out of credit due to the pay-as-go mobile phones (DOH 2009:13-14).

2.3.3.3 Treating young teenage pregnant girls with respect

Teenage pregnant girls want the health facility staff to treat them with respect, not to judge them. Some teenagers who become pregnant have low self-esteem and are likely to have experienced abusive relationships. They often have poor relationships with adults in positions of authority (such as teachers and social workers). Consequently, they may expect to be treated badly by old health workers, may appear defensive and reluctant to engage, and may be extremely sensitive to any words or body language that suggest disrespect. On the other hand, when these teenage pregnant girls encounter health workers who respect and value them, they respond positively and their self-confidence grows. Therefore, it is important that health workers approach teenage pregnant girls with an attitude that is warm, open, and non-judgemental (DOH 2009:17).

2.3.3.4 Empowering approach

Some teenage pregnant girls have little belief in their capacity to make choices about their lives. Therefore, the transition to parenthood is a major opportunity for developing their sense of capability. Health workers can support this process by, showing that they believe in them and that they are able to develop skills necessary to become effective parents. They can provide parenting education specific for teenage pregnant girls, explain choices clearly and show that they respect teenage pregnant girls' capacity to make right choices for themselves. Health workers can also support this process by treating each teenage pregnant girl as an individual, and not making stereotyped assumptions about the choices a pregnant teenager is likely to make, for example, that she will not want to breastfeed or attend antenatal education (DOH 2009:19-20).

2.3.3.5 Accessible information

Teenagers who become pregnant often have considerable unmet information needs, in part, because most of them do not attend antenatal classes. Some teenage pregnant girls feel too shy to ask questions, especially where the health worker appears to be very busy. Many pregnant teenagers have had educational problems and some low literacy skills, which make written information inaccessible to them. Therefore, health workers can make information more accessible by, ascertaining how comfortable each teenage pregnant girl is with reading, offering information in alternative formats, for example, dvds, using visual aids as much as possible, keeping information about birth and preparation for parenthood short, light, and fun and by making it clear from the beginning of the appointment that questions are welcome (DOH 2009:21-22).

2.3.3.6 Strong referral links with relevant agencies

Teenage pregnant girls often have significant additional needs that cannot be met by the antenatal services in isolation, and many of them need assistance with resolving crisis issues such as housing and financial support. The ANC services can act as a

gateway to other services for pregnant teenagers, especially those who are not receiving any support from agencies. Identifying the relevant agencies locally and creating strong referral links with them can also improve uptake of ANC services. There can be arrangement to refer teenage pregnant girls to agencies such as Targeted Youth Support, Connexions, A Children's Centre, and Teenage Parent Support Service where they exist for professionals in these agencies to assess support needs (DOH 2009:27).

2.3.3.7 Effective support to prevent second or subsequent unplanned pregnancies

Some teenage pregnancies are planned while others are not. Teenage pregnant girls are often unaware of how easy it is to become pregnant again after having a baby. They have limited understanding of the range of contraception available and are not actively supported to access contraception. Therefore, to offer effective support to prevent second or subsequent unplanned pregnancies, health workers can, display information in antenatal settings about the risks of becoming pregnant soon after birth, encourage teenage pregnant girls to make a contraceptive choice before delivery or very shortly afterwards, make access to the chosen method of contraception as straightforward as possible, and integrate family planning into antenatal care (DOH 2009:29-30).

2.3.3.8 Staff who are trained to work with teenage pregnant girls

The Ministry of Health, as a form of overcoming negative attitudes and misunderstandings between health workers and teenage pregnant girls, can give all staff who are likely to come in contact with pregnant teenagers a basic training on communication skills and promotion of attitudes and values that are young people friendly. Pregnant teenagers prefer health workers who are motivated, non-judgemental and considerate, easy to relate to and trustworthy, who treat all clients with equal care and respect and provide appropriate information and support to them (WHO 2002:27).

2.4 SOME PROGRAMMES THAT SUPPORT TEENAGE PREGNANT GIRLS

Teenage girls are less likely than older women to access sexual and reproductive health care, including modern contraception and skilled attendance during pregnancy and childbirth. Many are poor, have little control over household income, have limited knowledge about sexual and reproductive health issues, and lack the ability to make independent decisions about their health (UNFPA Factsheet 2012:1). Moreover, they often do not have access to health care that meets their specific needs.

In the US, a number of programs are available to help teenage pregnant girls. They include residential programs, usually private organisations that help these pregnant girls to learn parenting skills and to complete their education. Support groups are typically free and not for profit. National programs are also available, such as Planned Parenthood, where pregnant teenagers can get help to cope with their situations.

Planned Parenthood is a national organization with a wealth of resources for pregnant teenagers. It offers counselling services for pregnant teens, giving advice on abortion, adoption and parenting. Planned Parenthood is the nation's number one sexual and reproductive health care provider, with over 850 health centres in the US. 23% of Planned Parenthood clients in the US are aged below 20 years (Fitzpatrick online [s.a]).

School Systems: Schools across the United States have implemented programs to assist pregnant teenagers during and after their pregnancies. The Martha Nielsen School in New York City is specifically for pregnant teens and young mothers. It provides childcare, parenting courses and a high school curriculum to make it as easy as possible for the students to attend school (Fitzpatrick online. [s.a]).

Health Care: The Generations Program is one of a few programs in the US designed to give teenage parents and their children access to health care. It serves parents 18 and younger, or 19 and younger with special-needs children. The program links with community-based services for teenaged parents and provides much-needed immunizations, parenting education and physical check-ups for teens and their children.

Media: Websites, forums and online communities are available on the Internet. These sites are places where pregnant teens can go to learn more about their condition and to talk to others in a similar situation. YoungMommies.com is one such site, designed to offer support and to provide information to pregnant teens. MTV also airs a series called "16 and Pregnant," which follows several months in the lives of pregnant teenagers.

2.5 DISTRICT HEALTH SYSTEM

According to the Health Systems Trust (1999:1) the District Health System (DHS) is the 'means' to achieve the 'end' of an equitable, efficient and effective health system based on the principles of the Primary Health Care (PHC) approach. This means that the DHS is more than just a structure or form of organisation. It is the manifestation of a set of activities that includes community involvement, integrated and comprehensive health care delivery, intersectoral collaboration and a strong 'bottom-up approach to planning, policy development, and management. DHS therefore, includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private, or traditional (WHO 1988:9). It is a system, which WHO Global Programme Committee adopted in 1986 in order to provide primary health care services that will reach all communities, whether rich or poor. Management in the DHS is more effective because services are decentralised, problems are solved where they occur and services are nearer to the people. This also makes it easy to coordinate various programmes and services at different levels of the DHS (Gorgen, Kirsch-Woik & Schmidt-Ehry 2004:28). The active involvement of communities, providers, and policy makers in the process of decentralisation may bring positive changes in health services.

2.6 CONCLUSION

The literature review has revealed that pregnancy among teenage girls is a major public health concern, because of its high prevalence, in developing countries, especially sub-

Saharan countries, more than it is in developed countries. Such pregnancies represent a serious health, social, psychological, and educational problem. Often the pregnancy may be unwanted. The girl may be afraid to tell her family because of the fear of rejection. Because of lack of community understanding and services, the pregnant girl may be excluded from school. Steps to seek antenatal care may be poor or delayed due to poor experiences with the health system. Most teenage girls believe that health providers have judgemental attitudes towards them, especially when seeking antenatal services. The literature review has also confirmed that the teenage pregnant girl is a unique human being, who experiences some difficulties and who has unique needs as an individual in coping with pregnancy and childbirth. Pregnant girls also face relational problems with families, partners, and health workers. Therefore, it is important to sensitise health workers about the role of antenatal services in supporting these girls.

The next chapter (chapter 3) discusses the research design and method.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

This chapter covers the research design and method that was used to describe the role of antenatal services in supporting teenage pregnant girls in Leribe district of Lesotho. The discussion is structured around the research design, population sampling, data collection, and data analysis. Ethical considerations and measures to ensure trustworthiness of the study are also discussed.

3.2 PURPOSE OF THE STUDY

The purpose of this study was to describe the role of antenatal services in supporting teenage pregnant girls in Leribe district of Lesotho.

3.2.1 Research Objectives

1. To describe the role of antenatal services in supporting teenage pregnant girls.
2. To identify programmes that can improve antenatal services for teenage pregnant girls.

3.2.2 Research Questions

1. What is the role of antenatal services in supporting teenage pregnant girls?
2. What are the programmes that can improve antenatal services for teenage pregnant girls?

3.3 RESEARCH DESIGN

The research design is a plan for scientific inquiry where a strategy is developed on how the process should be undertaken in addressing the research problem. The underlying principle of a research design is that the researcher must be able to outline what needs to be investigated and explain the way that the investigation has to be carried out (Babbie & Mouton 2009:72). In this study, a qualitative, descriptive and contextual research design was used to describe the role of antenatal services in supporting teenage pregnant girls.

3.3.1 Qualitative research

Qualitative research is mostly associated with words, language and experiences rather than measurements, statistics and numerical figures (Burns & Grove 2009:507). The goal of qualitative research inquiry is to understand the meaning of the phenomenon from the perspective of the people experiencing it because they are presumed to have the required information (Hofstee 2006:132). The reason why qualitative research method was used for this study is because it takes place in the natural setting where human behaviour and events take place. Researchers who use this paradigm are usually interested in understanding a particular social situation, event, role or interaction, as in this case, the role of antenatal services in supporting teenage pregnant girls in Leribe district of Lesotho. This paradigm enabled teenage pregnant girls to provide detailed information without restriction or preconceived ideas of the researcher.

3.3.2 Descriptive research

The researcher conducted a descriptive study with the aim of accurately portraying the role of antenatal services in supporting teenage pregnant girls. The purpose of descriptive research is to describe the phenomena under study in real-life situation. This

approach is used to generate new knowledge about topics on which limited or no research has been conducted (Burns & Grove 2009:45). Therefore, the descriptive part of this study was used to provide the participants with an opportunity to give in-depth descriptions in order to discover facts about the role of antenatal services in supporting teenage pregnant girls. The researcher also attempted in this discussion to give a full picture of teenage pregnant girls' experiences with regard to recent antenatal services.

3.3.3 Contextual research

The aim of qualitative research is to describe and understand events within the concrete, natural contexts in which they occur (Babbie & Mouton 2004:272). Research findings need to be contextualised within the parameters of the phenomenon being studied. Therefore, this study is contextual in nature as it was conducted within the context of teenage pregnancy in Leribe district of Lesotho. The study focused on the role of antenatal services in support of teenage pregnant girls attending antenatal clinic at Motebang Hospital in Leribe district of Lesotho. In contextual design, a phenomenon of interest is studied in terms of its immediate context (Mouton & Marais 1996:49).

3.4 RESEARCH METHOD

In this section, the research method that was used is discussed under the following headings: Research setting, Research population, Sample and Sampling technique, Inclusion criteria, Sample size, Data collection, and Data analysis.

3.4.1 Research setting

The Kingdom of Lesotho is a land-locked country completely surrounded by the Republic of South Africa of which 59% is mountainous and only 10% is arable.

Lesotho's status as an enclave means that it is largely dependent on South Africa. The country is divided into ten administrative districts with Maseru being the capital town. The Northern region of Lesotho has four districts, namely, Berea, Leribe, Botha-Bothe, and Mokhotlong. The target population for this study lived in Leribe. Furthermore, the district of Leribe, where the study was executed, has a total population of 293 369 that is formed by 150 437 females and 142 932 males (Bureau of Statistics 2010:1-3). This district has two hospitals, namely, Motebang and Mamohau. The study was conducted in Motebang Hospital because it is a regional and referral hospital. Again, this hospital has a well-established teenage corner, also known as adolescent health corner, which serves the larger population of teenage pregnant girls in the district.

3.4.2 Research population

The research population is the entire group of persons that is of interest to the researcher and meets the criteria for inclusion as study participants. This is the group about which the researcher wants to gather information and draw conclusions (Joubert & Ehrlich 2007:94). For the purpose of this research, the target population consisted of all teenage pregnant girls who attended antenatal services at Motebang Hospital during the time of data collection. As it was not possible to study the entire population of teenage pregnant girls in Leribe district of Lesotho, a sample was drawn.

3.4.3 Sample and Sampling technique

A non-probability convenience sampling technique was used in this study because it enables the researcher to gain deeper understanding of phenomenon under investigation using readily available study participants (Babbie 2010:192). Again, this technique was used because it provides easy access to the respondents. A non-probability sample is used by researchers to target a particular group that does not necessarily represent the wider population, but has specific characteristics that are of interest to the researcher (Cohen, Manion & Morrison 2007:113). In this study, the

sample was made up of teenage pregnant girls between 13 and 19 years of age who attended antenatal services at Motebang Hospital in Leribe district of Lesotho.

The participants were selected when teenage pregnant girls presented themselves for antenatal services on the days on which the researcher visited Motebang Hospital to collect data. The researcher approached teenage pregnant girls individually as they arrived to discuss the purpose of the research with them. Those who did not want to spend time at the antenatal clinic were not included in the sample even if they were willing to take part as the researcher did not want to cause any inconvenience for them. When the researcher had a minimum of 15 participants who fitted into the selection criteria, the participants were taken to the private room allocated to him by clinic staff for the research project. The researcher again explained the purpose of the research and their ethical rights (outlined later in this chapter). Then, individual interviews started.

3.4.4 Inclusion Criteria

The selection criteria for inclusion in the study was that the participants had to be:

- Females between the ages of 13 and 19 years;
- Primigravida (pregnant for the first time);
- Single
- Willing to take part in the study;
- Resident in Leribe district of Lesotho.
- Attending antenatal services at Motebang Hospital in Leribe district of Lesotho.

3.4.5 Sample Size

The sample for this study consisted of teenage pregnant girls at Motebang Hospital who met the inclusion criteria. According to Polit and Beck (2008:357), a guiding principle

for sample size in qualitative studies is determined by data-saturation, which means sampling of participants is controlled by the point at which no new information is obtained and redundancy is achieved. A sample is used in a research study as it is often not practical or possible to study the entire population of interest to the researcher. The sample size for this study was determined by data saturation. The researcher had initially thought of interviewing a minimum of 15 teenage pregnant girls from the teenage corner of Motebang Hospital who met the eligibility criteria set for the study. The researcher, however, stopped the analysis of data on the 12th transcript that showed clearly that saturation of data had been reached and that data collected during additional in-depth individual interviews would not reveal any new information.

A small convenient sample of 12 teenage pregnant girls is ideally suited to qualitative inquiry. For researcher, it is crucial to describe, justify and explain small sample selection so that other researchers can judge its strengths and weaknesses (Patton 1990:186 in Ulin, Robinson & Tolley 2005:55).

3.4.6 Data Collection

Data collection in qualitative studies is much more flexible than in quantitative studies. According to Burns and Grove (2009:510), data in qualitative research is collected by means of verbal responses from individuals and organized into categories that describe the phenomenon being studied by means of data analysis. In this study, in-depth interviews were used for data collection because they provide much more detailed information than what is available through other data collection methods, such as surveys (Boyce & Neale 2006:3). In-depth interviews also provide a more relaxed atmosphere in which to collect data and participants feel more comfortable having a conversation with the researcher about the phenomenon under study as opposed to filling out a survey. George (2010:1) argues that in a typical focus group, participants have average of ten minutes each to talk, but with in-depth interviews, each participant has more time and opportunity to share feelings, perspectives and attitudes. The researcher has plenty of time to probe and obtain in-depth responses from participants.

3.4.6.1 Data collection approach and method

The researcher used the semi-structured data collection approach to ensure that all required information was collected. This semi-structured method of questioning allows for deeper and more thoughtful responses from the participants (Polit & Beck 2008:372). For this study, the interview guide was drawn up using research objectives as guidelines and was used as a tool for data collection. In this way it was ensured that data was collected in a systematic way and that important data was not forgotten. The interview guide consisted of open-ended questions that yielded more information because participants had the opportunity to fully describe their experiences with regard to antenatal services. In general, this method of data collection was chosen to allow teenage pregnant girls to share their own views in their own words rather than being forced by pre-established lines of thinking developed by the researcher. With semi-structured interviews the researcher had a set of predetermined questions on an interview guide, but the interviews were guided rather than dictated by the guide. Participants shared more closely in the direction the interview took and they could introduce an issue the researcher had not thought of. In this relationship, participants were perceived as the experts on the subject and were therefore given the maximum opportunity to tell their story (Smith, Harre & Van Langenhoven 1995:9-26) in (de Vos 2011:352). Questions are nearly always open-ended. The researcher physically went to the teenage pregnant girls at the antenatal clinic of Motebang hospital in Leribe district of Lesotho to conduct interviews with them in a face-to-face encounter.

The in-depth individual interviews were conducted in the language spoken by the respondents, that is, Sesotho, and their responses were recorded by a tape recorder, transcribed, and then translated into English. The researcher requested assistance from an expert in both the English and Sesotho languages to do the translations. Each interview record was labelled with an assigned code according to the date that the interview took place. After the interviews, the researcher listened to the recordings and transcribed audio recordings into “verbatim” reports. The researcher made sure that recording equipment was functioning well and that spare batteries and tapes were available. The interview setting was made free from background noise and interruptions.

3.4.6.2 Development and testing of the data collection instrument

The researcher developed the interview guide that was reviewed by the supervisor and the University of South Africa Health Studies Higher Degrees Committee. It was also reviewed by the doctors and nurses involved in the provision of antenatal services at Motebang Hospital in Leribe district of Lesotho. Final review and approval of this interview guide was done by Lesotho Ministry of Health Research Ethics Committee.

A pilot study of the interview guide was conducted at the same hospital and the very same respondents were not included in the real study. Their feelings and thoughts about the interview questions were captured. It is important for the researcher to consider all the implications of undertaking a pilot study in a qualitative project, and act accordingly (de Vos et al 2011:75). The feedback was integrated into the final version of the data collection instrument. Joubert and Ehrlich (2007:50) indicate that a pilot study is a mini-study which tests part of the study before the main study to check the methods, obtain data to assist in sample size estimation and test the adequacy of field training. Pilot data was not used in the main study. The researcher was of the opinion that the most effective way to find out how good and clear the interview guide was; was to pre-test it with a group of respondents with the same characteristics as those that would be involved in the study.

3.4.6.3 Characteristics of the data collection instrument

The interview guide had four sections and the first section obtained information related to participant's biographical data (e.g. Area of residence, home language, age, marital status, religion, and educational level). The second section reflected interview identification (e.g. Interview number, date and time of interview). The third section had a central question (e.g. Tell me about your experience of attending the antenatal clinic services in Motebang Hospital). The last section had probing questions (e.g. what services are there for you in Motebang Hospital as a teenage pregnant girl? What is

your experience with the care that you receive at the antenatal clinic? What information do you need about the antenatal clinic services?).

According to Polit and Beck (2008:429), probing is a technique used by researchers to elicit more useful and detailed information from participants than is volunteered in the initial reply. It assists in the collection of interview data provided the researcher has necessary skills. In this study, the researcher probed by encouraging teenage pregnant girls to talk openly about their experiences of attending antenatal clinic services in Motebang Hospital. Open-ended questions were used in the interview guide and they did not restrict participant's answers to the pre-established alternatives.

3.4.6.4 Data collection process

The permission to conduct this research project was granted by the University of South Africa (UNISA) Health Studies Higher Degrees Committee in December 2012 and the Lesotho Ministry of Health Research Ethics Committee in February 2013. Data was collected by the researcher over one month (in June 2013). The researcher was introduced to the antenatal clinic staff by the Motebang Hospital Management and all necessary protocol was observed. The Leribe district HIV/AIDS Officer assisted the researcher with the taking of field notes during in-depth individual interview sessions.

The antenatal clinic was visited in the mornings of the stipulated ANC clinic days. The nurse in-charge of the clinic facilitated the process by informing all pregnant teenagers attending antenatal care about the study and the researcher. More information was given to those who were eligible and the questions were answered appropriately. In-depth individual interviews were conducted early in the morning while the participants were waiting on the queue to be consulted or seen by the nurse. This was done to avoid keeping them longer at the clinic. Interview sessions took place in the private room to ensure privacy. The room was prepared to allow for face-to-face contact with the research participants. Data collection continued until saturation was reached. The aim of preparing the data collection field was to ensure that the venue was quiet so that the

researcher could talk freely with the participants without distractions such as telephone calls and visitors (Watson, Mckenna, Cowman & Keady 2008:284).

3.4.6.5 Ethical issues related to sampling

Ethics refers to a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants (Polit & Beck 2008:753). As this research involved human participants, the researcher considered it very important to establish trust between himself and the participants. He respected them as autonomous beings, thus enabling them to make sound decisions (Burns & Grove 2009:189-190).

The recruitment took place in Motebang Hospital during antenatal clinic attendance of eligible participants. Information about the study was given by the researcher after the nurse in-charge had facilitated the introduction process. The teenage pregnant girls were informed that the study was not part of their routine antenatal care and that their participation was voluntary. They were also informed that they could withdraw at any time from the study if they did not want to continue and that their withdrawal would not affect their antenatal care in any way. Informed consent and assent were obtained from the participants. The teenage pregnant girls were further informed that the study might be used for scientific purposes and may be published. However, information was kept confidential and the researcher would not expose it to people who should not see it.

3.4.6.6 Ethical considerations related to data collection

To protect the rights of the institution; ethical clearance was obtained from the UNISA Health Studies Higher Degrees Committee and the Lesotho MOH Research Ethics Committee. A letter was written to the MOH in Lesotho with an attachment of the research proposal to request the Ministry to authorize the researcher to carry out the study. Other people that were notified include the District Medical Officer (DMO), Manager Hospital Nursing Services, Matron, Hospital Administrator and Nurses in the hospital where the study is conducted. This was done in order to get their full support and cooperation during the period of study.

The researcher emphasised on voluntary participation into the study. The participants were again informed of their right to withdraw from the study at any point without penalty (Streubert, Speziale & Carpenter 2007:62). Informed consent and assent were obtained to protect the rights of the participants. Consent means participating in the study out of own free will, that is, voluntarily without any undue pressure, after receiving all sufficient information related to the research project including possible risks involved (Babbie 2010:66). Data was collected in a secure, private room and no names were used on the interview guide to assure anonymity, privacy and confidentiality. Each interview record was labelled with an assigned code according to the date that the interview took place. The participants were thanked for their time and contribution to the research project. The data records such as audiotapes and interview guides were kept safely and locked in a cabinet in which only the researcher had access. The researcher decided to use a secretive password as a means to ensure protection of research data.

3.4.7 Data analysis

All audio-recorded semi-structured interviews were transcribed verbatim. The researcher requested assistance from an expert in both the English and Sesotho languages to do the translations. The Sesotho transcripts were then translated into English. The analysis was done concurrently with data collection. Open coding data analysis was employed in this study. The transcribed verbatim data was translated before the themes were formulated. Data analysis, organization and interpretation were done using Tesch's descriptive method (in Creswell 2009:186). The eight steps that were followed in data analysis were as follows:

- The researcher read all the transcripts carefully so as to get a sense of what was contained in them.
- The researcher picked one transcript randomly and read it again. As the researcher was reading the transcript he was asking himself what it was all about. The researcher's ideas and thoughts were written in the margin.

- This process was repeated with all the transcripts jotting down all the thoughts. Topics and themes that emerged were then clustered into 'Themes' and 'Sub-themes'.
- Codes were allocated to similar topics. This exercise was repeated with all the transcripts coding all the topics.
- As themes and sub-themes were developed, the researcher found the most descriptive wording for the topics.
- Appropriate abbreviations for each of the above were finalized. The data in each theme were grouped together. The data was also checked to see if re-coding was necessary and the process of analysis was then finalized (Creswell, 2009:186).
- The researcher, together with the independent coder, analysed data independently from each other and had consensus discussion about the findings.

Literature control was conducted in order to present results of similar studies, to relate the present study to the on-going dialogue in the literature, and to provide framework for comparing results of a study with other studies (Creswell, 2003:46).

3.5 MEASURES TO ENSURE TRUSTWORTHINESS

In this study, Lincoln and Guba's model was used to ensure trustworthiness of the research findings (Polit & Beck 2008:539). Criteria for trustworthiness that were applied throughout the study are credibility, dependability, confirmability and transferability.

•3.5.1 Credibility

The truth-value of this qualitative research will be the discovery of the role of antenatal services in support of teenage pregnant girls in Leribe district of Lesotho as experienced by the participants themselves. The qualitative study is credible when it presents confidence in the truth of the findings (Polit & Beck 2008:539). The researcher enhanced credibility of the study by conducting repeated in-depth interviews until data

saturation was reached. That is, until no new information was raised. All participants were taken through the same main or central question. The participants were given enough time to share their experiences and their responses were recorded adequately. The interviews were tape-recorded and transcriptions were made of each interview (referral adequacy). An independent coder was used to verify the credibility of the study.

•3.5.2 Dependability

The researcher believes that the same findings would be found if the study was to be replicated with the same respondents in a similar context. The concept of dependability is related to the consistency of the research findings in a qualitative study. Dependability refers to the stability of the findings over time and confirmability to the internal coherence of the data in relation to findings, interpretations, and recommendations (Bowen 2005:216). The key to qualitative research is to learn from the participants rather than to control them. The researcher enhanced dependability of this study by keeping copies of the research methods, tape recorders, transcribed data, and reports containing coded data. The researcher provided a dense description of the methodology used to conduct the study. Research data was organized into themes and sub-themes.

•3.5.3 Confirmability

Confirmability refers to the objectivity or neutrality of the data and for this criterion to be achieved, the findings must reflect the participants' voices and the conditions of the inquiry, and not the biases, motivations, or perspectives of the researcher (Polit & Beck 2008:539). The researcher took the following steps to enhance confirmability of the study and increased worth of the research findings; a relaxed atmosphere was created for the participants to feel free and share their experiences with the researcher; enough time was spent with each participant when the in-depth interviews were conducted. The participants were not rushed to answer and were allowed to give their honest opinions; in-depth interviews were used to obtain data for the study; the findings were evaluated by the participants and experts in the field of research. The researcher established an audit trail by keeping personal notes in the diary during the interviews. The researcher then met with an independent coder to discuss and reach consensus on the findings.

•3.5.4 Transferability

The transferability of this research was enhanced by conducting data collection until data saturation occurred and by providing dense description of the research data, including verbatim quotations. The findings of this study will not necessarily be applicable to other communities and settings. Therefore, the results cannot be generalized to the broader teenage pregnant girl community of Lesotho. However, the same results may be found when a similar study is done in the same setting (Polit & Beck 2008:539). Detailed data was collected in the natural setting of the participants.

3.6 CONCLUSION

This chapter 3 discussed qualitative, descriptive, contextual research design that was to be used in order to describe the role of antenatal services in supporting teenage pregnant girls. Semi-structured in-depth individual interviews with conveniently sampled participants will be held to collect data. Tesch's open coding data analysis method will be used (cited in Creswell 2009:186). Measures to ensure trustworthiness (i.e. credibility, dependability, confirmability and transferability) were described. Ethical considerations were discussed.

The next chapter 4 analyses, presents, and describes the research findings.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

In this chapter four, the research findings are presented with the literature support from relevant sources and previous research studies in order to contextualise them. The objectives of this research were as follows:

- To describe the role of antenatal services in supporting teenage pregnant girls.
- To identify programmes that can improve antenatal services for teenage pregnant girls.

The researcher pre-tested the interview guide with two respondents who had the same characteristics with those that were involved in the study. Therefore, these pilot interviews enabled the researcher to do a practice run before conducting the main study and they were very crucial as they sharpened the researcher's interviewing skills.

Data was collected by means of using in-depth individual, semi-structured interviews, probing and field notes over a period of one month. The sample comprised of all teenage pregnant girls who agreed to participate in the study and be interviewed on their experiences of antenatal clinic services at Motebang hospital teenage corner. Data saturation occurred on the 12th interview and the researcher decided to stop the process of data collection.

Data analysis, organization and interpretation, was done according to Tesch's method of data analysis for qualitative research in order to understand the meaning of the data and identify themes and sub-themes from the collected data (in Creswell 2009:186).

Four (4) main themes emerged from the data analysis. Each theme is discussed with relevant quotations from the participants and the relevant literature is also cited as the control to the findings of this research. The collected data is presented verbatim and coded under appropriate themes and sub-themes as diagrammatically presented in Figure 4.1 below:

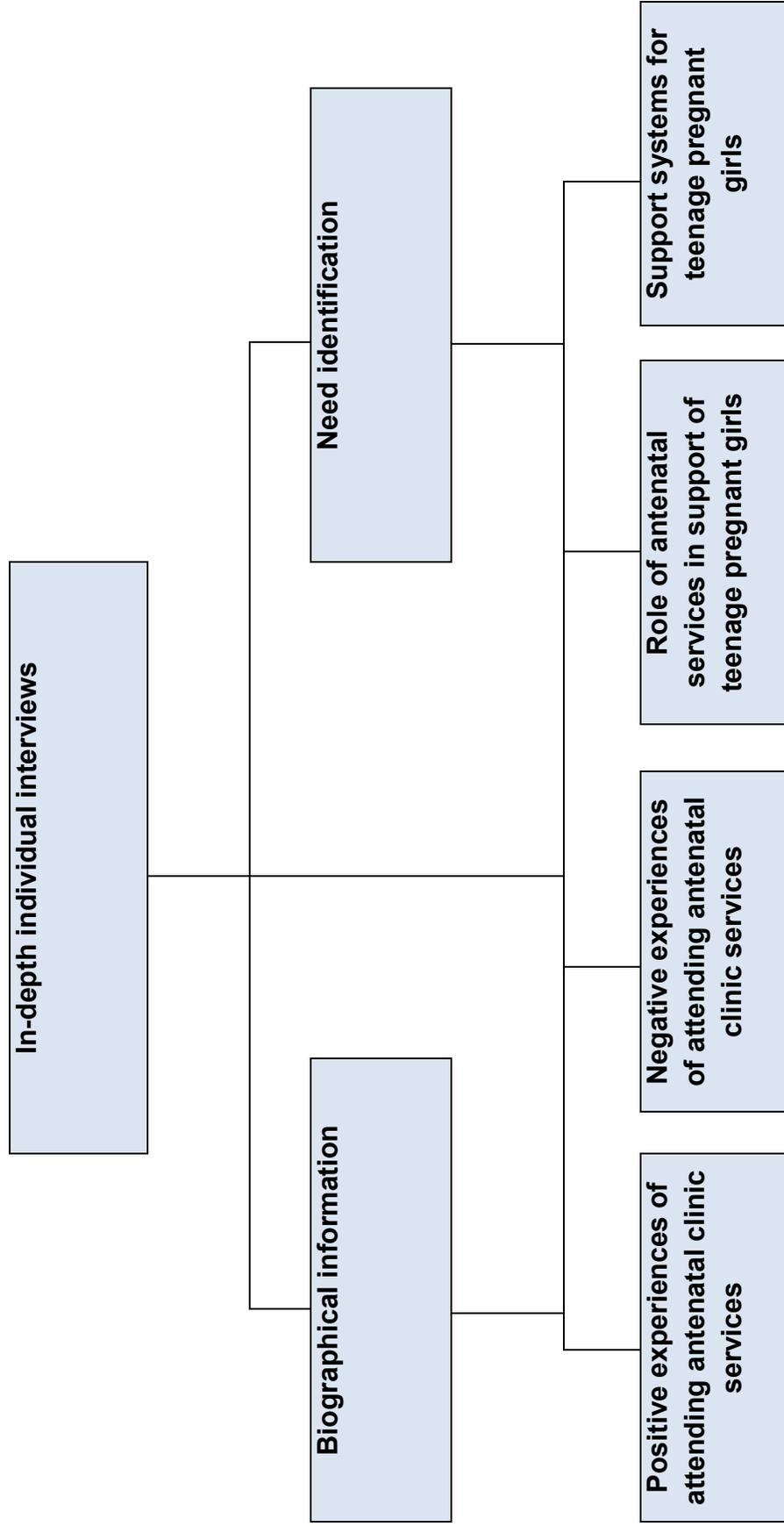


Figure 4.1 Visual presentation of thematic groupings of data from in-depth individual interviews

4.2 BIOGRAPHICAL INFORMATION

A total of 12 participants (n=12) who had attended antenatal care clinic services at Motebang Hospital teenage corner in Leribe district of Lesotho were interviewed. Table 4.1 provides a description of the respondents according to their age, area of residence, home language, marital status, educational level, religion and employment status. This is also referred to as participants' biographical information.

Table 4.1 Biographical data of participants interviewed at Motebang Hospital teenage corner.

Respondent No.	Area of residence	Home language	Age	Marital status	Education level	Religion	Employment status
1	Lisemeng	Sesotho	17yrs	Single	High School	RCC	Schooling
2	Mankoaneng	Sesotho	15yrs	Single	Primary School	Baptist	Not employed
3	Tsikoane	Sesotho	18yrs	Single	High School	RCC	Self-employed
4	Sebothoane	Sesotho	17yrs	Single	High School	ACL	Not employed
5	Matukeng	Sesotho	19yrs	Single	Tertiary	LEC	Schooling
6	Lisemeng	Sesotho	14yrs	Single	Primary School	ACL	Not employed
7	Ha Leshoele	Sesotho	16yrs	Single	Never attended school	RCC	Not employed
8	Leqhutsung	Sesotho	15yrs	Single	High School	SDA	Not employed
9	Khanyane	Sesotho	18yrs	Single	Tertiary	LEC	Schooling
10	Sebothoane	Sesotho	19yrs	Single	High School	Faith Mission	Self-employed
11	Likhakeng	Sesotho	17yrs	Single	Primary School	LEC	Not employed
12	Khanyane	Sesotho	18yrs	Single	High School	RCC	Not employed

Table 4.1 above shows that all 12 participants (100%) for this study were single because it was one of the criteria for inclusion in the study. For eligibility, the participants had to be single and pregnant for the first time. The home language for all participants (100%) was Sesotho because they were all Basotho who resided in Leribe district of Lesotho who happened to be at the ANC clinic during the time of data collection. Hence, the interviews were conducted in Sesotho, that is, in their original language. Furthermore, Sesotho and English are only two official languages in Lesotho.

Three villages (Lisemeng, Sebothoane and Khanyane) had the highest number of participants, that is, two (16.7%) per village, while the rest of the villages had one participant (8.3%) each. The numbers of participants interviewed according to age were: 14yrs=1(8.3%), 15yrs=2(16.7%), 16yrs=1(8.3%), 17yrs=3(25%), 18yrs=3(25%) and 19yrs=2(16.7%). The biographical data of participants interviewed at Motebang Hospital according to their level of education were as follows: Never attended school = 1 (8.3%), Primary School = 3 (25%), High School = 6 (50%) and Tertiary = 2 (16.7%). The biographical data of participants interviewed with regard to their religious affiliations were: RCC = 4 (33.3%), LEC = 3 (25%), Others = 3 (25%) and ACL = 2 (16.7%). The biographical data of participants with regard to their status of employment were as follows: Not employed = 7 (58.3%), self-employed = 2 (16.7%) and schooling = 3 (25%).

4.3 QUALITATIVE DATA ANALYSIS

Data analysis is a process of bringing order, structure and meaning to the mass of data collected. Burns and Grove (2009:695) emphasise that data analysis is conducted to reduce, organise and give meaning to data. Data analysis may also be considered as the separation of data into parts for the purpose of answering research questions and objectives. The process involves sharing and communicating these answers to other researchers in a meaningful manner (Polit & Beck 2008:68). Data analysis was ongoing during data collection and throughout the study. In this study, data was analysed using Tesch's method of data analysis for qualitative research (in Creswell 2009:186).

Tesch's steps that were followed and their application to this study are indicated in Table 4.2 below to allow the reader to understand how the results were obtained.

Table 4.2 Tesch's steps and their application to this study

Tesch's Steps	Application to this study
<p>•Reading through all transcripts carefully so as to get a sense of what was contained in them.</p>	<p>Each interview conducted was recorded by an audiotape. The researcher listened to the audiotapes to check the sense of the whole, to internalise the content and then transcribed the contents verbatim. The researcher also read and re-read all the verbatim transcripts carefully to get an understanding of the interviews and to familiarise himself with the data and some ideas were jotted down as they emerged. Field notes were used as additional data to support that contained in the transcripts.</p>
<p>•Picking one transcript randomly. Going through it and asking oneself "what is it about". Thinking about the underlying meaning of the interview and jotting down thoughts in the margin.</p>	<p>The researcher picked up the first verbatim transcript randomly and re-read it again. The researcher's ideas and thoughts were written in the margin. Topics which represented positive experiences were written in green colour, those that represented negative experiences were written in red colour, those that represented role of antenatal services were written in blue colour and those that represented support systems were written in yellow. This was an initial segmentation</p>

	of data and open coding.
<ul style="list-style-type: none"> •Repeating this process with all the transcripts and making a list of all topics. Clustering similar topics together into columns, which consisted of themes and sub-themes. 	<p>This process was repeated with all the transcripts jotting down all the thoughts. A list of topics that emerged was made and these topics were clustered together into themes and sub-themes, which are presented in Table 4.3 of this chapter.</p>
<ul style="list-style-type: none"> •Taking this list of topics and going back to the transcripts. Abbreviating the topics as codes next to the appropriate segments of the text and observing the organisation of data to check if new codes emerge. 	<p>Codes were allocated to similar topics. These codes were written next to the appropriate segments of the text. These codes were also colour-coded (i.e. green for positive experiences, red for negative experiences, blue for the role of antenatal services and yellow for support systems. This exercise was repeated with all the transcripts coding all the topics.</p>
<ul style="list-style-type: none"> •Finding the most descriptive wording for the topics and turning them into categories. Finding ways of grouping the topics that relate to each other and drawing lines between the themes to show their relationships. 	<p>The most descriptive wordings to the topics were identified and used as themes. Topics that were related to each other were grouped together in order to reduce the list of themes. Identified themes were used to refine probing questions in further interviews and this allowed for the saturation of themes to occur.</p>
<ul style="list-style-type: none"> •Making a final decision on the specific abbreviation for each category and arranging the codes alphabetically. 	<p>Appropriate abbreviations for each of the above were finalized. The data in each category were grouped together. The data was also checked to see if re-coding was necessary and the process of analysis was then finalized (Creswell, 2009:186).</p>

<p>•Assembling all the data material belonging to each category in one place and performing a preliminary analysis.</p>	<p>The researcher, together with the independent coder who is an experienced researcher and supervisor in qualitative data analysis, analysed data independently from each other, had a discussion and came to an agreement on the themes and sub-themes identified.</p>
<p>•Discussing the themes and sub-themes</p>	<p>The themes and sub-themes that emerged during data collection and analysis are discussed in the following section.</p>

In reporting the research findings, some participants' verbatim responses have been included. Literature control was conducted in order to present results of similar studies, to relate the present study to the on-going dialogue in the literature, and to provide framework for comparing results of a study with other studies (Creswell, 2003:46).

4.4 RESEARCH FINDINGS AND LITERATURE CONTROL

Themes represent a way of describing large quantities of data in a condensed format (Lo-Biondo-Wood & Haber 2010:128). A theme is a label. Polit & Beck (2008:767) consider a theme as a recurring regularity that emerges from an analysis of qualitative data. During data collection and analysis, four themes associated with the role of antenatal services in support of teenage pregnant girls emerged as follows:

- Positive experiences of attending antenatal clinic services
- Negative experiences of attending antenatal clinic services
- The role of antenatal services in support of teenage pregnant girls
- Support systems for teenage pregnant girls

These themes and sub-themes are discussed with accompanying quotations from the data and supported by literature control. The exact translated quotations from in-depth individual interviews are aimed at giving additional clarification. The researcher will discuss each theme and its sub-themes in the sequence reflected in table 4.3 below.

Table 4.3 Themes and sub-themes that emerged from the data analysis

THEMES	SUB-THEMES
4.4.1 Positive experiences of attending antenatal clinic services	4.4.1.1 Free health services 4.4.1.2 Availability of the teenage corner 4.4.1.3 Comprehensive antenatal services
4.4.2 Negative experiences of attending antenatal clinic services	4.4.2.1 Attitudes of ANC clinic staff 4.4.2.2 Accessibility of ANC services 4.4.2.3 Communication problems
4.4.3 The role of antenatal services in support of teenage pregnant girls	4.4.3.1 Characteristics of teenage pregnant girl-friendly antenatal services
4.4.4 Support systems for teenage pregnant girls	4.4.4.1 Support from the family 4.4.4.2 Support from school 4.4.4.3 Support from the community 4.4.4.4 Involvement of the male partner 4.4.4.5 Programmes for teenage pregnant girls

4.4.1 Positive experiences of attending antenatal clinic services

Table 4.4 below presents the first theme, namely, teenage pregnant girls' positive experiences of attending antenatal clinic services. Each sub-theme under this theme will be discussed individually and direct quotations from participants' responses will also be presented. The relevant literature will be cited as a control for research findings.

Table 4.4 Positive experiences of attending antenatal clinic services

THEME	SUB-THEMES
4.4.1 Positive experiences of attending antenatal clinic services	4.4.1.1 Free health services 4.4.1.2 Availability of the teenage corner 4.4.1.3 Comprehensive antenatal services

4.4.1.1 Free health services

The participants indicated that they received antenatal services free of charge from Motebang Hospital. It is clear that they appreciated this initiative (of free health services) that was introduced in 2007 by the Ministry of Health in Lesotho. The purpose of this initiative is to make health services accessible to all Basotho regardless of age, gender, religion or social class. These services are more appropriate for pregnant girls because most of the time they lack financial support. The following are some of the comments from teenage pregnant girls:

“I was very happy to see that I do not have to pay anything for antenatal services. I’m not working and I’m also in need of financial assistance for my child”. (Participant 2, Primary School).

“The majority of pregnant girls will attend antenatal services because there is no fee attached. I think we should thank the Ministry of Health for this effort”. (Participant 12, High School).

“I come from a disadvantaged family background, and therefore, it would be a hard blow for me to pay for health services”. (Participant 4, High School).

“Both of us (myself and my boyfriend) are not working and we already have stress to buy clothes for the child. Paying for health services would be a disaster”. (Participant 5, Tertiary).

4.4.1.2 Availability of the teenage corner

The National Adolescent and Development Programme was started in 1998 by the Ministry of Health to address the needs of teenagers in Lesotho. This led to the establishment of antenatal clinics, also referred to as teenage corners, which focus specifically on pregnant teenagers in three districts of Lesotho, namely, Leribe, Mafeteng and Maseru. These districts were referred to as pilot districts as the teenage corner concept was first implemented there. The districts were selected on the basis that they were the largest urban areas (Phafoli et al 2007:17a). The participants expressed their happiness with regard to the teenage corner as follows:

“I’m happy with the antenatal services here in Motebang Hospital because we are not combined with older mothers. I would be shy to ask questions where I do not understand if older mothers were present”. (Participant 11, Primary School).

“It’s a good thing to put us together as teenage pregnant girls. This allows us to become friends and to feel free to discuss issues that affect us”. (Participant 1, High School).

“I felt it was less embarrassing for me to attend a special clinic with only teenage pregnant girls. Thus, I enjoyed being separated from adult women”. Participant 10, High School).

Pregnant girls are aware of the fact that the society frowns on young people participating in unsafe sex, resulting in teenage pregnancies (James et al 2010:4). Therefore, these girls may become uncomfortable in the presence of adult women, who they think will not understand their situation.

4.4.1.3 Comprehensive antenatal services

Antenatal care is the medical care received during pregnancy from skilled health personnel, such as the goal-oriented model, recommended by the WHO, which includes four visits for pregnant women who are not having medical problems. The goal of

antenatal care is to prepare for birth and parenthood as well as to prevent, detect, alleviate, or manage the health problems (for example, complications of pregnancy, pre-existing conditions that worsen during pregnancy and effects of unhealthy lifestyles) that affect mothers and their babies (Lincetto et al 2006:52). Antenatal care also provides women and their families with appropriate information and advice for a healthy pregnancy, safe childbirth, and postnatal recovery, including care of new-born, promotion of early, exclusive breastfeeding, and assistance with deciding on future pregnancies in order to improve pregnancy outcomes. The participants reported to have received the following antenatal services that they described as comprehensive: Health education, HIV counselling and testing (HCT), tetanus toxoid immunisation, prophylaxis and treatment of anaemia, treatment of STIs, PMTCT, family planning and nutrition counselling, physical examination and laboratory investigations. According to the participants:

“I’m satisfied with the antenatal services in this hospital because health workers give us counselling and testing for HIV and injection against tetanus. They also screen and treat us for sexually transmitted infections”. (Participant 7, never attended School).

“As a new person, I’m happy to have been taught about danger signs in pregnancy, exclusive breastfeeding, how I should eat, and family planning methods so that I can decide which one I would like to use after delivery”. (Participant 3, High School).

“The good news about antenatal services here is that nurses draw blood so that we can know our blood groups, rhesus and haemoglobin level. They also give us medications (ferrous and folic acid) as prophylaxis against anaemia”. (Participant 9, Tertiary School).

“When I started antenatal care clinic, I came with my boyfriend and the nurses were very happy. He was welcomed in a special manner and we listened to the health talk which opened our eyes on what to expect during labour. Both of us tested for HIV”. (Participant 5, Tertiary School).

The priority of the Ministry of Health in Lesotho is to provide medical care and counselling services to women during pregnancy and delivery because these services will improve their health and probability of survival. Information on maternal health care

can be used to identify teenage pregnant girls whose babies are at risk and to plan interventions to improve their maternal services. According to the LDHS (2010:103), coverage for ANC by medical professionals (doctor, nurse, or midwife) in 2009 is slightly higher than that recorded in the 2004 LDHS (92% compared with 90%).

4.4.2 Negative experiences of attending antenatal clinic services

According to Kotze (2008:200), a therapeutic milieu is an environment that allows accompaniment and provision of support to those in need of such assistance. This author also emphasises a trusting relationship in order to enhance a therapeutic environment. The aim of therapeutic milieu is to provide patients with a stable environment that assists with facilitation and implementation of individualised treatment plans and provide a structure that entails proper organisation of the service that involves set patient-nursing activities (Stuart & Laraia 2005:700). Therefore, the positive nurse-patient relationship facilitates learning in the ANC clinic setting, which in the context of this study would benefit participants with the necessary insight into the pregnancy.

This study has revealed that some of the participants considered the antenatal clinic as an uncomfortable place that evoked feelings of stress and sadness. They were of the opinion that they have wasted their time by coming early to the ANC clinic as there is only one nurse assisting them. Judging from the responses of the participants, it is clear that the relationship between the nurse and some participants was poor. Table 4.5 below presents the second theme, namely, the teenage pregnant girls' negative experiences of attending antenatal clinic services.

Table 4.5 Negative experiences of attending antenatal clinic services

THEME	SUB-THEMES
4.4.2 Negative experiences of attending antenatal clinic services	4.4.2.1 Attitudes of ANC clinic staff 4.4.2.2 Accessibility of ANC services 4.4.2.3 Communication problems

4.4.2.1 Attitudes of ANC clinic staff

Most health care workers assume that the health problems of female teenagers can be addressed by general improvements of women's health services. However, the level of care required teenagers, especially those who are pregnant for the first time, is considerably greater than that required by adult women. Moreover, many women's health services are hostile to young teenagers who become pregnant out-of-wedlock.

The attitudes of health workers are important as they determine whether antenatal care services are attractive to teenage pregnant girls or not. Whereas most participants were satisfied with the way they were handled at the ANC clinic of Motebang Hospital, only one participant reported that health workers had negative attitudes towards her. That is, they were rude, abusive, and threatening, as indicated by the following response:

“My first experience was terrible because the nurses shouted at me and blamed me for getting pregnant at a young age. Yes, sometimes you will even regret for coming to the antenatal clinic when you receive unfriendly treatment from the health workers”.
(Participant 8, High School).

This is consistent with the study of Atuyambe et al (2005:308) which indicated that health workers were not responding well to adolescent maternal needs. Some health workers were said to be harsh and abusive and they blamed and intimidated the girls. Therefore, there is a feeling that if health workers have negative attitudes, pregnant girls will avoid health services and end up seeking help from unprofessional people. It is important to emphasise that the judgmental nature of some ANC clinic staff towards teenage pregnant girls may negatively influence these girls' efforts to attend ANC. Therefore, health care workers who provide antenatal services for teenage pregnant girls should be committed, friendly, and have a non-judgemental approach.

4.4.2.2 Accessibility of ANC services

The participants indicated that the reasons why they do not like to attend antenatal services are long waiting hours and inconvenient service hours at the ANC clinic.

Participants identified shortage of nurses at the clinic to be contributing to the waste of time, making the clinic environment stressful and unattractive to them. In fact, some of the participants felt that coming early to the clinic was waste of time, as one could spend as many as seven hours at the clinic. This practice may not be tolerated by many teenage pregnant girls because they can be very impatient. Some teenage pregnant girls remarked:

“I thought coming early in the morning will do me any favour, but I still finished my ANC at 15.00 because there is staff shortage at this clinic. I wish the Ministry of Health can employ more nurses to help us (pregnant girls) because we don't know many things”.
(Participant 9, Tertiary).

“Because I'm very busy at school during the day, it will be very helpful if antenatal services could be provided after hours as well. I have observed that my class teacher is no longer happy with the excuses I make every month of going to the ANC clinic”.
(Participant 1, High School).

“Most of us (teenagers) are free on weekends and so we could attend antenatal services instead of loitering if they (ANC services) were provided on weekends”.
(Participant 5, Tertiary).

According to Phafoli et al (2007:17b), adolescent health services should be financially, functionally, and geographically accessible and should be adolescent-friendly and confidential. The environment in which antenatal services are provided for teenage pregnant girls must be appealing to them, probably by avoiding the clinical atmosphere often associated with hospitals or hospital-based care. At the moment, antenatal services provided for teenage pregnant girls in Leribe are still located at the hospital, and offered between 08.00 and 17.00 on weekdays only. Some participants mentioned that it would be better if ANC services were also provided after hours and on weekends when there is less congestion of people in the hospital. This strategy will enable those who are still schooling or committed with other things to attend ANC services effectively.

4.4.2.3 Communication problems

The participants felt that it would be better if there was a telephone at the teenage corner of Motebang Hospital so that they can communicate with the nurses directly all the time when they experience pregnancy-related problems at home. Currently, their concerns are only addressed when they come for ANC. According to one respondent:

“Since pregnancy has a lot of complicated issues, we can appreciate if we get an opportunity to discuss some of these issues telephonically with the nurses without having to come here at the clinic. This will also reduce transport costs”. (Participant 6, Primary School).

The responses from the interviews also confirm that the participants would like to be assisted by young nurses or at least nurses of their age so that they can feel free to talk about sexual and reproductive health issues with them. WHO (2002:27) points out that pregnant teenagers prefer health workers who are motivated, non-judgemental and considerate, easy to relate to and trustworthy, who treat all clients with equal care and respect and provide appropriate information and support to them.

4.4.3 The role of antenatal services in support of teenage pregnant girls

The teenage pregnant girls represent a high-risk group contributing to many of the population problems in Lesotho such as illegitimacy, complications of pregnancy and increased perinatal and infant mortality. Therefore, attendance at the ANC clinic plays an important part in enabling the screening of pregnant teenagers for health problems and limiting the possibility of complications. However, it is surprising to note that the role of antenatal services in supporting teenage pregnant girls is described as being so minimal. The suggestion is that some consideration should be given in order to enlarge the antenatal services' role in providing comprehensive support to teenage pregnant girls. This support can be supplemented by other relevant disciplines such as education, social work, nutrition and special medical care. Table 4.6 below presents the third theme, namely, the role of antenatal services in support of teenage pregnant girls.

Table 4.6 the role of antenatal services in support of teenage pregnant girls

THEME	SUB-THEME
4.4.3 The role of antenatal services in support of teenage pregnant girls	4.4.3.1 Characteristics of teenage pregnant girl-friendly antenatal services

4.4.3.1 Characteristics of teenage pregnant girl-friendly antenatal services

Because teenage pregnant girls have complex needs, the antenatal services should offer comprehensive support through dedicated clinics. This will also improve attendance and clinical outcomes. In this study, teenage pregnant girls have expressed their views with regard to the type of antenatal services they want from the ANC clinic:

“I wish we could attend ANC services where we can see the nurses at any time without having to make an appointment because I’m highly committed at work”. (Participant 4, High School).

“It’s nice to be taken care of by the health workers who respect and provide high quality antenatal services regardless of age, religion and social class”. (Participant 12, High School).

“The ANC clinic should provide us with information and education materials so that we can know more about pregnancy and childbirth in the early stages”. (Participant 9, Tertiary School).

The antenatal care services. The participants indicated that they prefer antenatal services which are free, where consultation is made with or without appointment, where there is easy and confidential registration of clients, where there are short waiting times and swift referral of clients to other relevant services when necessary. These ANC services should address each teenage pregnant girl’s physical, social and psychological

health and development needs. They should take into account the special needs of different sectors of the population including vulnerable and under-served groups.

The health care providers. The participants highlighted that they would like to be assisted by health workers who are technically competent in teenager specific areas, who have interpersonal and communication skills, where health workers are motivated, non-judgemental and considerate, easy to relate to and trustworthy. These health workers should devote adequate time to clients and act in the best interests of their clients, treat all clients with equal care and respect. The health workers should also provide appropriate information and support to enable each pregnant teenager to make the right free choices from her unique needs.

The health care facility. The teenage pregnant girls seemed to prefer the health facility that provides a safe environment at a convenient location with an appealing ambience. The health facility must have convenient working hours and encourage parental and community support to teenage pregnant girls. It must also guarantee privacy and confidentiality and promote autonomy so that pregnant teenagers can consent to their own care and treatment. There should be no stigma so that they can utilise the services.

4.4.4 Support systems for teenage pregnant girls

According to Hawkins (1988:822), support systems are a set of connecting parts (such as individuals and institutions) which work together to provide a holistic support for teenage pregnant girls. Sufficient support during pregnancy is associated with positive pregnancy outcomes. In fact, teenage pregnant girls who have enough coping resources, a supportive family, a stable, sympathetic partner and access to well-designed intervention programmes that teach parenting skills and help solve their problems adjust better and provide higher quality parenting skills (Phafoli et al 2007:17). However, from the review of the interviews, it was clear that the support teenage pregnant girls got from the family, school, community and the male partner was not

enough to facilitate their coping. As such, they experienced many challenges. Table 4.7 below presents the fourth theme, namely, support systems for teenage pregnant girls.

Table 4.7 Support systems for teenage pregnant girls

THEME	SUB-THEMES
4.4.4 Support systems for teenage pregnant girls	4.4.4.1 Support from the family 4.4.4.2 Support from school 4.4.4.3 Support from the community 4.4.4.4 Involvement of the male partner 4.4.4.5 Programmes for teenage pregnant girls

4.4.4.1 Support from the family

The participants indicated that they experienced lack of support from their families after they fell pregnant. Their parents had negative attitudes due to stigma attached to teenage pregnancy and some parents actually distanced themselves from these pregnant girls. This is because the parents felt ashamed that the community would look down upon the family because of their child's behaviour. The following are some of the comments from teenage pregnant girls:

“The biggest challenge we face as teenagers is being chased away from home when parents learn that you are pregnant. You start loitering like a person who does not have a home and this happens because our parents do not understand what we are going through as their daughters. When you try to go back home, parents do not bother to help you deal with the situation. In my own opinion, this is exactly what most pregnant girls go through”. (Participant 3, High School).

“When I got pregnant, the first thing my parents told me is that they will not provide me with any financial support because they did not decide for me to have a child. They further mentioned that it is my responsibility and I should know what to do”. (Participant 1, High School).

“Some of us have very harsh parents. For example, I have a very harsh father and I’m fearful that if I tell him about my pregnancy, he might think of beating me up. So I have decided to hide it and at the moment, it’s only my mother who is aware”. (Participant 7, Never Attended School).

“When my parents discovered that I’m pregnant, they were very angry and could not talk to me for roughly three weeks because they believed I’m still very young. I feel they did not give me emotional support when I needed it most”. (Participant 9, Tertiary School).

Atuyambe et al (2005:304) indicates that girls who become pregnant out of wedlock are rejected by their parents because they have added shame and an additional burden to the family. However, Pillow (2004:11) argues that all these pregnant girls need help and support that any mother parenting as a single parent with limited income needs.

4.4.4.2 Support from school

The study revealed that the teenage pregnant girls did not receive enough support from the school. For teenagers who were still schooling when they got pregnant, teachers did not consider them as learners with special needs and they were not interested to go through the lessons the pregnant girls had missed when they attended ANC clinic. In fact, it is surprising to note that some teachers did not empathise with these pregnant girls and they expected them to perform and behave just like any other learner, as some teenage pregnant girls remarked:

“Our teachers put us under a lot of pressure without really understanding what we are going through as young girls. Sometimes, they ridicule us in front of classmates when we have not satisfied the class requirements. I had sleepless nights early in my pregnancy because I was sick, when I took nap in class, the teachers embarrassed me”. (Participant 2, Primary School).

“I was not happy and felt I could not go to school anymore while still pregnant because some teachers and students intimidated me. I believe most girls discontinue schooling because of the same situation”. (Participant 1, High School).

Another pregnant girl stated:

“I was expelled from school the same day the principal learned that I’m pregnant. It was painful because I wanted to continue with my studies, but the principal claimed that other students will copy this bad behaviour and the school says I should be released”. (Participant 4, High School).

This concurs with Motlomelo and Sebatane (1999:25) who indicate that high repetition and dropout rates in both primary and secondary schools characterise the educational system of Lesotho. Morojele (in Mohai, Thaane, Mpota, Mokutlulu & Luwanja 2002:6) reviewed court cases of abortion in Lesotho and found that the most common reason why teenagers resorted to unsafe abortions was fear of being expelled from school. According to Pillow (2004:111-116), teenage girls who are schooling are often described as and assumed to be poor or incapable students. Again, some media have portrayed them as bad girls who behaved uncontrollably, irresponsibly and immorally. Phafoli et al (2007:17e) argues that if teenage pregnant girls are expelled from school, this will further perpetuate poverty among this group of people.

4.4.4.3 Support from the community

The communities in which pregnant girls lived had a big impact on their lives. The participants indicated that becoming pregnant as a teenager was a stigmatising experience and that it brought shame to the society. Some community members were said to be negative, forcing pregnant girls to hide. The results of this study also show that, the community, instead of supporting pregnant girls, treated them as people who have low morals. The following are some of the verbatim responses from participants:

“When young girls fall pregnant, the people around point fingers at them and this causes them to stay in the house, especially during the day, as a form of hiding. Some girls are taken away from their homes to other places where they are not known”. (Participant 8, High School).

“Some community members tell their children to stop talking to us due to the fear that we will contaminate them. As a result, I lost my best friend and I’m now feeling lonely”. (Participant 12, High School).

One teenage pregnant girl emphasised:

“Community members who feel pregnant girls should be expelled from school may find ways and means, like intimidating them on their way to and from school, in order to prevent them from attending school with their children”. (Participant 9, Tertiary School).

“I decided to hide my pregnancy because the society does not want to see teenage girls with their big tummies going to school with peers”. (Participant 11, Primary School).

The findings of this study highlight the need to sensitise the communities on the girls’ rights to health and education and also to stress to the communities that health and education of teenage girls will not only benefit the girls but also their babies and the community as a whole. Pillow (2004:134) states that by keeping the pregnancies invisible until birth when the pregnant body stops fitting into the school, the girls support school practices of ‘pregnancy as a cold’. On the other hand, it may be argued that although keeping pregnancy invisible might be a hard thing to do, the idea may be empowering and learning process of the pregnant girls not socially affected.

4.4.4.4 Involvement of the male partner

Many young fathers feel that health workers either ignore them or treat them as irresponsible and incapable people. These fathers are often insecure and defensive about their role and may appear reluctant to engage with health professionals. Therefore, specific efforts are needed to reach out to young male partners and to give them the sense that they are respected and valued in their role, because they may easily disengage from the pregnancy and from parenting if they feel judged or excluded. Having a highly involved father, independently of whether the father and mother remain a couple, is associated with better emotional, behavioural and educational outcomes.

According to the results of this study, most participants indicated that their boyfriends had a job of some kind, on a part-time or full-time basis. The majority of these boyfriends did not finish school and they were known to the parents of the pregnant girls. Some participants complained that their male partners refused to take the responsibility of pregnancy:

“Even though my boyfriend always visited me in my home, when I got pregnant, he ran away and I heard that he is now working in the mines in South Africa”. (Participant 8, High School).

“My boyfriend is working as an Office Assistant because he did not finish school, he left when he was doing Form B. I’m sad because he is denying me”. (Participant 6, Primary School).

Some participants felt supported by their male partners:

“The person who impregnated me is much older than me and he has his own family. He is providing me with financial assistance because I’m not working”. (Participant 3, High School).

“Since I informed my boyfriend about this pregnancy, he has always been there for me. At times we go to the clinic together and this makes me feel good”. (Participant 9, Tertiary School).

DOH (2009:7) emphasised that a good relationship between a young father and his teenage partner is strongly associated with his involvement with his child in the early years and with lower stress for the teenage mother. For a male who accompanies his female partner to ANC, health workers can show that they value and welcome his involvement by: ensuring he has a place to sit next to his partner, making it clear that he is invited to all antenatal educations offered, taking down all his details with interest and asking him if he has any questions, ensuring that he knows what to expect during labour and showing him how he can support his partner during breastfeeding.

4.4.4.5 Programmes for teenage pregnant girls

The results of this study have revealed that teenage pregnant girls lack basic needs such as food, shelter and security. They frequently face relational problems with their families, partners and the community. Therefore, financial assistance and psychological support may be some of the priorities for this group of people. The study also found that unlike in the US, there are no media, school systems, health care, and Planned Parenthood programmes for teenage pregnant girls in Leribe. In the US, a number of programs are available to help teenage pregnant girls. They include residential programs, usually private organisations that help these pregnant girls to learn parenting skills and to complete their education. Support groups are typically free and not for profit. National programs are also available, such as Planned Parenthood, where pregnant teenagers can get help to cope with their situations. The participants stated that they were not aware of any special programmes for teenage pregnant girls. They also, could not mention any special program of medical care for pregnant girls. This is surprising because of the fact that teenage pregnant girls are a high-risk population.

“I don’t know of any special program for teenage pregnant girls in this district (Leribe), people do not understand services and needs of young pregnant girls”. (Participant 11, Primary School).

“Most of us come from the disadvantaged families so we have nothing to eat at home. I wish we can get food packages and financial support as pregnant girls”. (Participant 3, High School).

“I wish to go back to school after the child is born, but I don’t know who will take care of my child since we don’t have free day care centres in Leribe”. (Participant 8, High School).

The research done in the United States by Wallace et al (1973:7) highlights that the most frequent services provided to teenage pregnant girls in the special program are counselling, social service, special education, special health class, and instruction in family life education. The least frequent services provided are abortions, day care for

infants, and special services for fathers, maternity home care and pregnancy testing. This latter list begins to point up some unmet needs for teenage pregnant girls. Contraception and sex education should have high priority in services provided to sexually active teenagers. Other services that should be provided to teenage pregnant girls in the special program are home visiting, nutrition program, special medical care, vocational assistance, psychiatric service and legal advice. There is a need to coordinate and involve most if not all of the community agencies, such as Lesotho Planned Parenthood Association, Thakaneng Youth Project, Social Development, Help-Lesotho Youth Project, Baylor Teens' Club, School Health, and Maternity and Infant Care Project, in order to develop a comprehensive program for teenage pregnant girls.

4.5 NEED IDENTIFICATION

Needs are distinguished from wants because a deficiency can cause a clear negative outcome such as a dysfunction or death. According to Garver & Scheier (1996:94) needs can be objective and physical such as food or they can be subjective and psychological, such as the need for self-esteem. In psychology, a need is considered to be an internal state that is less than satisfactory. This is a circumstance that requires some course of action. On the other hand, the idea of need refers to a relationship between problems and the responses available. A need may be regarded as a claim for service. There is no doubt that there are certain basic needs that are common to all human beings, and that these needs must be fulfilled if an individual is to attain his optimal level of well-being. This research study has revealed that teenage pregnant girls are a high-risk population group with special and unique needs.

Bradshaw (1972) identifies four different types of need, namely, normative needs, felt needs, expressed needs and comparative needs. This section discusses three (3) types of need encountered during in-depth individual interviews with teenage pregnant girls:

Normative needs. A normative need is a need which is identified according to a norm or a set standard and such norms are generally set by experts. This need is distinguished by professionals and refers to what expert opinion based on research

defines as need, for example, need for vaccination or a decision by a surgeon that a patient needs an operation. However, normative needs are not absolute and there may be different standards laid down by different experts. This study has revealed the following normative needs of teenage pregnant girls; there is a need for education services such as special classes, instruction in sex education and education about childcare. Again, there is a need for nutrition services which consist of improving nutrition in general, nutrition education and food supplements. There is also a need for general and administrative services, which include transportation, housing, the need to reach more pregnant girls, and the need for coordination of services for teenage pregnant girls.

Felt needs. A felt need is a need which people feel, that is, a need from the perspective of the people who have it. These are wants, wishes and desires of teenage pregnant girls. Felt needs are limited by individual perceptions and knowledge of services. In this study, felt needs refer to what teenage pregnant girls attending antenatal services at Motebang hospital said they want or felt they need and these are; basic needs such as food, shelter and security. They raised a need for financial assistance, which involves the need for procurement of the baby's clothes and funds for hospital care and delivery. The other need found by this study is the need for vocational assistance which includes the need for jobs, training and placement of teenage mothers when the child is old.

Expressed needs. An expressed need is the need, which teenage pregnant girls say they have. These are vocalised needs or how people use services. Expressed needs may be referred to as felt needs turned into action. This is also help seeking, for example, when teenage pregnant girls go to Motebang hospital to seek antenatal care services. The results of this study have confirmed that teenage pregnant girls went to the antenatal care clinic of Motebang hospital because of the need for comprehensive health services which consist of special medical care, family planning and quality prenatal care. These pregnant girls needed social services which include the need to work with fathers of the babies and parents of the pregnant girl. They also indicated their need for counselling services and psychological support and the need for follow-up services after the mother and the baby have been discharged from the hospital.

4.6 CONCLUSION

This chapter discussed the composition of the study sample as well as the findings gathered from the twelve semi-structured interviews. The findings of the study were correlated with the role of antenatal services in support of teenage pregnant girls identified in the literature. Support for this high-risk maternity population has been associated with positive pregnancy outcomes. The health system should provide comprehensive support to these pregnant teenagers by offering teenage pregnant girl-friendly antenatal services, where well trained health workers care for these girls. Some characteristics of antenatal services specific for teenage pregnant girls are; the ANC clinic environment must be welcoming, services have to be accessible, teenage pregnant girls should be treated with respect and referral links with relevant agencies must be strong. There is a need to empower pregnant girls through education and counselling and the need for the Ministry of Education and Training in Leribe to review the policy regarding the expulsion of pregnant teenagers from school. Community awareness campaigns must be held to sensitise the public about the services and needs of teenage pregnant girls. Some of the important needs revealed by this study are financial assistance, psychological support and quality prenatal care.

Chapter 5 concludes the study, discusses its limitations and makes recommendations for practice and future research.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents a summary of the research findings, conclusions and limitations of the study, and makes recommendations for practice and further research. The researcher investigated the role of antenatal services in support of teenage pregnant girls. The study was conducted in Leribe district of Lesotho. The participants were teenage pregnant girls attending antenatal services at the teenage corner of Motebang Hospital, which is a regional hospital serving a larger population of teenagers in Leribe.

Antenatal services are considered to be a critical intervention aimed at reducing maternal morbidity and mortality. According to Anya et al (2008:2) antenatal care provides a chance to interact with the pregnant woman so that the woman can make appropriate choices that will contribute to optimum pregnancy outcome and care of the child. Thus, antenatal care is one of the recommended cares to be provided to pregnant girls. Since this care provides an entry into the health system, it may be one of the first comprehensive health assessments deemed necessary for teenage pregnant girls.

The main purpose of the study was to describe the role of antenatal services in supporting teenage pregnant girls so as to strengthen the body of knowledge for health workers in this important area of public health. It is anticipated that this study will also be valuable for planning unique antenatal and support services for teenage pregnant girls.

5.2 RESEARCH DESIGN AND METHOD

A qualitative, descriptive and contextual research design was used in this study to investigate and describe the role of antenatal services in supporting teenage pregnant

girls. The researcher opted for qualitative approach because it takes place in the natural setting where human behaviour and events take place. Data was collected by means of using in-depth individual, semi-structured interviews. The central question asked to all participants was as follows:

- Tell me about your experience of attending the antenatal clinic services in Motebang Hospital.

The participants were offered an opportunity to share their experiences with regard to the antenatal services for teenage pregnant girls. The researcher gained an insight and an understanding of the phenomenon studied by asking probing questions during the interview sessions and this also allowed participants to provide detailed descriptions of their experiences. The target population consisted of all teenage pregnant girls attending antenatal services at Motebang Hospital teenage corner. Data analysis was conducted using Tesch's descriptive method (in Creswell 2009:186). Four themes associated with the role of antenatal services in support of teenage pregnant girls emerged. In this study, Lincoln and Guba's model was used to ensure trustworthiness of the research findings (Polit & Beck 2008:539). The criteria for trustworthiness applied throughout this study were credibility, dependability, confirmability and transferability.

5.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

5.3.1 Biographical data

The results of this study have revealed that all teenage pregnant girls (100%) were single and comfortable when interviews were conducted in Sesotho, which is their mother-tongue language. The prevalence of teenage pregnancy is high at 16.7% in three villages, namely, Lisemeng, Sebothoane and Khanyane as compared to the rest of the villages which had 8.3%. Half of teenagers (50%) were at High School when they fell pregnant. More than half (58.3%) of teenage pregnant girls were unemployed. The above figures strongly highlight the need for relevant stakeholders to establish antenatal care services that are unique, special and supportive to teenage pregnant girls.

5.3.2 Positive experiences of attending ANC clinic services

This research confirmed that some of the participants had positive experiences of attending ANC clinic services as they reported to be feeling happy for various reasons. The fact that ANC services in Lesotho are provided free of charge impressed and motivated some teenage pregnant girls to utilise them. The majority of the participants seemed to be appreciative of ANC services they have received, which they also described as comprehensive because they included; Health education, HIV counselling and testing (HCT), tetanus toxoid immunisation, prophylaxis and treatment of anaemia, treatment of STIs, PMTCT, family planning and nutrition counselling, physical examination and laboratory investigations. Also, these pregnant girls loved the idea of being separated from older women by attending their services at the teenage corner.

It is important to note that many hospitals in Lesotho offer ANC services without regard to the age of the pregnant woman. While this might be convenient for health workers, it is really a drawback for teenage pregnant girls to find themselves in the company of older women who are probably married, while they might be pregnant out of wedlock.

5.3.3 Negative experiences of attending ANC clinic services

The findings of this study have shown that one participant felt that she received unfriendly treatment from the health workers. The fact is, if health workers are harsh and abusive, blame and intimidate pregnant girls, they (pregnant girls) will avoid health services and end up seeking help from unprofessional people. This is consistent with the study of Reeve (2005:121), who emphasises that pregnant girls are usually attracted to a person whom they feel they can trust to take care of their well being. They will try to avoid a person whom they do not trust. . It must be acknowledged that health workers dealing with teenagers should receive special training in health services, including, communication skills specific for teenage pregnant girls. Currently, health services provided to pregnant teenagers in Lesotho are still located at the hospitals and

are offered between 08.00 and 17.00 on weekdays only. Therefore, this makes it difficult for teenage pregnant girls to utilise them effectively as they are busy at this time.

5.3.4 The role of antenatal services in support of teenage pregnant girls

Antenatal care services are considered to be a critical intervention aimed at reducing maternal morbidity and mortality. Therefore, attendance at the ANC clinic plays an important part in enabling the screening of pregnant teenagers for health problems and limiting the possibility of complications. The participants indicated that they prefer antenatal services which are free, where consultation is made with or without appointment, where there is easy and confidential registration of clients, where there are short waiting times and swift referral of clients to other relevant services when necessary. The participants highlighted that they would like to be assisted by health workers who are technically competent in teenager specific areas and are motivated, non-judgemental and considerate, easy to relate to and trustworthy. The health facility must have convenient working hours and encourage parental and community support to teenage pregnant girls. There should be no stigma so that they can utilise the services.

5.3.5 Support systems for teenage pregnant girls

The findings of the interviews indicated that the biggest challenge the teenage pregnant girls of Leribe district of Lesotho experienced is lack of support from the family, school, male partners, health workers and other members of the community. Most of these pregnant girls suffered rejection and this impacted emotionally on them as it left them feeling guilty, lonely and unhappy. Apart from social stigma brought by teenage pregnancy, another reason that made the parents to be very angry with their daughters is because they had to carry the financial burden of caring her. These pregnant girls believed that financial support would make their life much easier by being less dependent on their parents and the father of the baby. Some teenage pregnant girls did

not express much love for the school but they realised the importance of education for their futures. Other pregnant girls felt they were not empowered with knowledge on how to prevent unwanted pregnancies. None of the teenage pregnant girls reported to be receiving any formal support from community programmes or agencies in the district.

According to Phafoli et al (2007:17b), social support has been reported to affect attitudes and behaviours, including satisfaction with pregnancy and parenting. Pregnant girls who have high stress and low social support networks have been found to have more neonatal and obstetric complications than those who have high stress and high social support networks. Therefore, attending ANC clinic will assist in the identification of such stress, resulting in appropriate management of the identified problems.

5.3.6 Need identification

Needs are distinguished from wants because a deficiency can cause a clear negative outcome such as a dysfunction or death. There is no doubt that there are certain basic needs that are common to all human beings, and that these needs must be fulfilled if an individual is to attain his optimal level of well-being. The findings from the in-depth individual interviews revealed various needs of teenage pregnant girls such as basic needs, need for educational services, need for nutrition services, need for administrative services, need for comprehensive health services, need for social services, need for counselling services and need for financial assistance. These needs have been classified as normative, felt and expressed as highlighted in Chapter 4 of this study.

5.4 RECOMMENDATIONS FOR PRACTICE

Based on the findings of this study, the following recommendations are made which could be implemented to improve health services for teenage pregnant girls:

- The findings of this study have revealed that some community members were very negative and forced pregnant girls to hide, while teachers intimidated them. The Ministry of Health should, therefore, establish and strengthen the national policies to protect the rights of teenage pregnant girls regardless of their socioeconomic status, place of residence, religion or ethnic group.
- Most participants indicated that shortage of nurses led to long waiting hours making ANC clinic environment a very uncomfortable place. One participant was not happy with the unfriendly treatment she received from the ANC clinic staff. Therefore, the Ministry of Health should improve the staffing pattern at teenage corners and health workers should be well-trained in issues related teenagers, they should be motivated and interested in working with teenagers and they should have a non-judgemental attitude towards those who are pregnant.
- The study has revealed that most schools in Lesotho do not offer any special support to teenage pregnant girls, but rather they (pregnant girls) are expelled from school immediately when teachers learn that they are pregnant. To address this challenge, the Ministry of Education and Training in Lesotho should review its policy regarding expulsion of teenage pregnant girls from school. Rather, strategies to support teenage pregnant girls should be developed and scaled-up because academic qualifications determine future employment prospects.
- The findings of the study have shown that antenatal services for teenage pregnant girls are, at the moment, provided at the Hospital setting only. There may be teenage pregnant girls who do not like Hospital environment. So, there is a need to integrate antenatal services with other programmes. To maximise the opportunities for teenage pregnant girls, antenatal services should take advantage of existing programmes such as Expanded Programme on Immunisation, HIV/AIDS and Nutrition because these programmes usually have outreach services and therefore more teenage pregnant girls could be reached.

- The participants emphasised that they would prefer to see antenatal services provided after hours and on weekends because they are tight during the week days. In response to this, the Ministry of Health should be committed to reducing barriers to accessing care and in reaching out to teenagers without access. Utilisation of ANC services should be encouraged by reducing barriers to access such as limited opening hours, long travel distances, and long waiting times.
- The participants mentioned that being pregnant as a teenager was a stigmatising experience and that it brought shame to the society. Therefore, there should be quarterly community awareness campaigns to sensitise the public about the increasing rates of teenage pregnancies and their consequences thereof. The community should be made aware of the role they can play to prevent teenage pregnancies and to support teenagers who become pregnant despite this effort.
- According to the results of this study, some participants complained that their male partners denied them and refused to take the responsibility of pregnancy. There is a need to develop and implement supportive programmes for young fathers. When sensitised and shown that they are valuable people, young fathers are more likely to support their female partners during pregnancy and thereafter.

5.5 RECOMMENDATIONS FOR FURTHER RESEARCH

Further research can be conducted on the following aspects:

- A study to investigate the extent of knowledge of teenage pregnant girls on sexual and reproductive health matters including prevention of HIV/AIDS.
- Follow-up research can be conducted on this group of teenagers to determine how they coped with pregnancy and what strengths they developed over time.

- A study to explore utilisation of health services by teenagers in Leribe district and the role the attitudes of health workers play in their health-seeking behaviour.
- There is a need to duplicate this study in other districts of Lesotho prior to generalisation of research findings.
- Explore how male partners could best be involved in maternal and child health programmes despite negative and harsh treatment they sometimes receive.
- Research to explore social behaviour issues that contribute to high pregnancy rates among teenagers in Leribe district of Lesotho.
- A survey can be carried out to determine what special support systems are available in the community for teenage pregnant girls.
- Research is needed for the development of strategies to involve parents, teachers and the community in sexual and reproductive health for teenagers.

5.6 CONTRIBUTIONS OF THE STUDY

There is no recorded research found that had been conducted in Leribe district of Lesotho on the role of antenatal services in support of teenage pregnant girls. Therefore, the findings of this study may assist the District Health Management Team (DHMT) of Leribe to strengthen the body of knowledge for health workers in this important area of public health. Also, data collected from this research study can be valuable for planning unique antenatal and support services for teenage pregnant girls.

5.7 LIMITATIONS OF THE STUDY

There were certain limitations in this study. First, the study focused only on teenage pregnant girls attending ANC services in Motebang Hospital teenage corner, therefore, the findings cannot be generalised to all other health facilities within Leribe district of Lesotho. Secondly, the study was limited to only teenage pregnant girls utilising ANC services, thus depriving the researcher of insight into the experiences of those who remained in their villages. They may have had different experiences. Lastly, the respondents were pregnant girls and the discussion related to sexual relationships is the sensitive one. Hence, the participants could have provided less detailed information.

5.8 CONCLUSION

This research study assisted the researcher in understanding the views of teenage pregnant girls with regard to antenatal services and the role they play in supporting them. The use of a qualitative, descriptive and contextual research design with semi-structured interviews during data collection has enabled the researcher to obtain rich descriptions of teenage pregnant girls' experiences. Probing questions were asked by the researcher in order to pursue in-depth understanding of the phenomenon studied. Tech's descriptive method of data analysis was used and an independent coder was involved in the data analysis. The limitations of the study have been highlighted and the recommendations based on the research findings have been outlined.

The findings of this study have confirmed that teenage pregnant girls are a high-risk maternity population and that they have unique needs. Therefore, Knowledge obtained from this research can be implemented to improve health services specific for teenage pregnant girls. Creating teenager-friendly ANC services should be a priority for the Ministry of Health in Lesotho as this can also reduce maternal morbidity and mortality.

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**UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE**

HS HDC/127/2012

Date: 12 December 2012 Student No: 4591-092-8

Project Title: The role of antenatal services in supporting teenage pregnant girls in
Leribe District of Lesotho.

Researcher: Scema Elliot Ntjabane

Degree: Masters in Public Health Code: DLMPH95

Supervisor: Ms DSK Habedi
Qualification: MA in Public Health
Joint Supervisor: -

DECISION OF COMMITTEE

Approved



Conditionally Approved



for

Prof L Roets

CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACTING ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

for

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE B

LENYAKOANE

P. O. BOX 223

MAPUTSOE 350

LESOTHO

22nd January 2013

The Chairperson

RESEARCH AND ETHICS COMMITTEE

MINISTRY OF HEALTH

P. O. BOX 514

MASERU 100

Dear Sir/Madam

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I hereby request permission to conduct research on the title: **The role of antenatal services in supporting teenage pregnant girls in Leribe District of Lesotho**. I intend to do in-depth individual, semi-structured interviews with teenage pregnant girls attending antenatal clinic services at Motebang Government Hospital Teenage Corner.

I therefore request permission to collect data for this study in partial fulfilment of the degree of Master of Public Health (MPH) with the University of South Africa (UNISA).

The information collected will only be used for research. The clients, health workers, and flow of health services will not be compromised during the study process.

Yours Faithfully



Mr S E NTJABANE

ANNEXURE C

ID 20/2013



Ministry of Health
PO Box 514
Maseru 100

5 February 2013

Secma Elliot Ntjabane (Mr.)
MPH candidate
University of South Africa
District Clinical Coordinator
EGPAF, Lesotho

Dear. Mr. Ntjabane

Re: The role of antenatal services in supporting teenage pregnant girls in Leribe district of Lesotho

Thank you for resubmitting the above mentioned modified proposal. The Ministry of Health Research and Ethics Committee having reviewed your protocol hereby authorizes you to conduct this study among the specified population. The study is authorized with the understanding that the protocol will be followed as stated. Departure from the stipulated protocol will constitute a breach of the permission.

We are looking forward to have a progress report and final report at the end of your study.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. M. Moteetee', written over a horizontal line.

Dr. M. M. Moteetee
Chairperson Research and Ethics Committee
Director General of Health Services

ANNEXURE D

CONSENT FORM FOR TEENAGE PREGNANT GIRLS (English)

I _____ (Participant) understand that I am being asked to participate in the research study carried out at Motebang Hospital in Leribe district of Lesotho. The study is aimed at describing the role of antenatal services in supporting teenage pregnant girls. I agree to respond to the questions during the interview. I realise that knowledge gained from this study will help me or other teenage pregnant girls in future. I also realise that my participation in this study is voluntary and I may withdraw from the study at any time and that such withdrawal will not jeopardise health services directed to me.

I further understand that all research data from this study will be kept confidential. However, this information may be used in professional decision making. The study has been explained to me by Seema Ntjabane (The Researcher). I have read and understand this consent form, all my questions have been answered, and therefore, I agree to participate.

Participant's Signature _____

Date _____

Researcher's Signature _____

Date _____

ANNEXURE E

CONSENT FORM (Sesotho)

(Foromo ea ho lumela ho nka karolo liphuputsong (Research) bakeng sa batho ba lilemo tse Leshome le metso e robeli (18) hoesa holimo)

'Na _____ (Lebitso la Mokhachane) ke utloisisa hore ke kopuo ho nka karolo liphuputsong tse etsoang Sepetlele Motebang seterekeng as Leribe - Lesotho. Boithuto bona bo reretsoe ho manolla karolo e bapaloang ke lits'ebeletso tsa bokhachane ho ts'ehetsa bakhachane ba tlaase lilemong. Kea lumela hore ke tla araba lipotso nakong ea lipuisano. Ke hlokomela hore tsebo e fumanoeng boitotong bona e tla thusa 'na kapa bakhachane ba bang ba tlaase lilemong ka moso. Ke boela ke hlokomela hore ho nka karolo hoaka boithutong bona ke boithaopo le hore nka ikhula neng kapa neng 'me' boikhulo boo bo keke ba ama lits'ebeletso tse ke li fuoang.

Ke boela ke utloisisa hore litaba tsa boithuto bona li tla bolokoa e le lekunutu empa li ka sebelisoa ha ho etsoa liqeto tsa mosebetsi oa bophelo. Boithuto bona ke bo hlalositsoe ke Seema Ntjabane (Mofuputsi). Ke balile ke bile ke utloisisa foromo ena, lipotso tsaka kaofela li arabiloe 'me ke lumela ho nka karolo boithutong bona.

Boitekeno ba Mokhachane _____

Letsatsi _____

Boitekeno ba Mofuputsi _____

Letsatsi _____

ANNEXURE F

ASSENT FORM (English)

My name is Seema Ntjabane. I am a student at the University of South Africa (UNISA).

I am asking you _____ (Name of Participant) to take part in a research study because I am trying to learn more about the role of antenatal services in supporting teenage pregnant girls. As part of this study, I also want to learn more about programmes that can improve antenatal services for teenage pregnant girls and teenage pregnant girls' experiences on recent antenatal services.

If you agree, you will be engaged in an interview. You will be asked to explain the role of antenatal services in supporting you as a teenage pregnant girl and the programmes that can improve antenatal services for teenage pregnant girls. You will also be asked to indicate your experiences with regard to recent antenatal services. You do not have to say who you are (your name) during an interview.

You do not have to be in this study. No one will feel bad if you decide not to do this study. Even if you start, you can stop later if you want. You may ask questions about the study.

If you decide to be in the study I will not tell anyone else what you said in the study. Even if your parents or guardians ask, I will not tell them about what you said.

Signing here means that you have read this form and that you are willing to take part in this study.

Participant's Signature _____

Date _____

Researcher's Signature _____

Date _____

ANNEXURE G

ASSENT FORM (Sesotho)

**(Foromo ea ho lumela ho nka karolo liphuputsong (Research) bakeng sa batho ba
ka tlaase ho lilemo tse Leshome le metso e robeli – 18)**

Lebitso laka ke Seema Ntjabane. Ke moithuti sekolong se seholo sa South Africa-unisa.

Ke u kopa _____ (Lebitso la Mokhachane) ho nka karolo liphuputsong hobane ke leka ho ithuta ka botebo karolo e bapaloang ke lits'ebeletso tsa bokhachane ho ts'ehetsa bakhachane ba tlaase lilemong. Liphuputso tsena li tla boela li nthute ka mananeo a ka ntlafatsang lits'ebeletso tsa bokhachane bakeng sa bakhachane ba tlaase lilemong le ho fumana maiphihlelo a bona ka ts'ebeletso tse teng ha joale.

Haeba u lumela utla ba lipuisanong 'me' u tla kopuo hore u hlalose karolo e bapaloang ke lits'ebeletso tsa bokhachane ho ts'ehetsa bakhachane ba tlaase lilemong le mananeo a ka li ntlafatsang. U tla boela u kopuo hore u bolela maiphihlelo a hau ka lits'ebeletso tse fanoang ha joale. Ha ua tlameha ho bolela lebitso la hua nakong ea lipuisano.

Ha se setlamo hore u nke karolo boithutong bona. Ha ho motho ea tla u koatela ha usa nke karolo. Le haeba u se u qalile, u ka emisa ka boikhethelo ba hau. U ka botsa lipotso mabapi le boithuto bona.

Haeba u etsa qeto ea ho nka karolo boithutong bona, nke kebe ka joetsa mang kapa mang se u se buile nakong ea lipuisano. Le haeba batsoali kapa bahlokomeli ba hau ba botsa nkekebe ka ba joetsa letho.

Ho tekena mona ho bolela hore u balile foromo ena ebile u rata ho nka karolo liphuputsong tsena.

Boitekeno ba Mokhachane _____
Letsatsi _____

Boitekeno ba Mofuputsi _____
Letsatsi _____

ANNEXURE H

PARENTAL CONSENT (English)

Dear Parent/Guardian

My name is Seema Ntjabane (a student from the University of South Africa). I would like to include your child in a research study on the role of antenatal services in supporting teenage pregnant girls. The study will be carried out at Motebang hospital in Leribe district of Lesotho.

Your child's participation in this study is completely voluntary. In addition to your permission, your child will also be asked if she would like to take part in this study. You are free to withdraw your permission for your child's participation at any time and for any reason without penalty. Information obtained during this study will be kept confidential.

If you have any questions or concerns, please feel free to contact me at Motebang hospital or by emailing me at 45910928@mylife.unisa.ac.za or by calling me at +266 62005252.

As the parent or guardian of _____ (Name of your child),

I grant my permission for Mr Ntjabane to include my child in his research study. I fully understand that data will be kept confidential and used only for research purposes.

I do NOT grant my permission for Mr Ntjabane to include my child in his research study on the role of antenatal services in supporting teenage pregnant girls.

Parent/Guardian's name: _____

Parent/Guardian's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

ANNEXURE I

PARENTAL CONSENT (Tumello ea Motsoali/Mohlokomeli) (Sesotho)

Motsoali/Mohlokomeli ea ratehang!

Lebitso laka ke Seema Ntjabane. Ke moithuti sekolong se seholo sa South Africa-unisa. Ke kopa ho kenyeletsa ngoana hau boithutong ba karolo e papaloang ke lits'ebeletso tsa bokhachane ho ts'ehetsa bakhachane ba tlaase lilemong. Boithuto bona botla etsetsoa sepetlele Motebang seterekeng sa Leribe, Lesotho.

Ho nka karolo hoa ngoana hau boithutong bona ke boithaopo. Ele ho tlatsetsa tumello ea hau, ngoana hau le ena u tla botsoa na aka rata ho nka karolo. U lokolohile ho ka hula tumello ea hau neng kapa neng ka lebaka lefe kapa lefe, ha hona na ba le kameho ea lits'ebeletso. Litaba tse fumanoeng boithutong bona li tla bolokoa e le lekunutu.

Haeba u na le lipotso u ka mphumana sepetlele Motebang kapa oa ntetsetsa linomorong tsena +266 62005252.

Ke le Motsoali/Mohlokomeli oa _____ (Lebitso la Ngoana),

[] Ke fana ka tumello ea hore Mr Ntjabane a kenyeletse ngoanaka boithutong ba hae. Ke utloisisa hore litaba tsa boithuto bona li tla bolokoa e le lekunutu 'me li tla sebelisoa feela bakeng sa liphuputso kapa boithuto.

[] Ha ke fane ka tumello ea hore Mr Ntjabane a kenyeletse ngoanaka boithutong ba hae ba mosebetsi oa lits'ebeletso tsa bokhachane ho ts'ehetsa bakhachane ba tlaase lilemong.

Lebitso la Motsoali/Mohlokomeli _____

Boitekeno ba Motsoali/Mohlokomeli _____ Letsatsi _____

Boitekeno ba Mofuputsi _____ Letsatsi _____

ANNEXURE J

INTERVIEW GUIDE FOR TEENAGE PREGNANT GIRLS (English)

Interview guide for the study of the role of antenatal services in supporting teenage pregnant girls in Leribe district of Lesotho.

1. Interview

Interview No : _____

Date of interview : _____

Time of interview : _____ Start _____ Finish

2. Central Question

1. Tell me about your experience of attending the antenatal clinic services in Motebang Hospital.

(The conversation may lead to the following):

3. Probing Questions

- What services are there for you in Motebang Hospital as a teenage pregnant girl?
- What is your experience with the care that you receive at the antenatal clinic?
- What is your experience about the services rendered at the antenatal clinic?
- What information do you need about the antenatal clinic services in Motebang Hospital?
- How can nurses/doctors at the antenatal clinic services in Motebang Hospital assist you as a teenage pregnant girl?
- What are the programmes that can improve antenatal services for you as a teenage pregnant girl?
- What are your experiences as a teenage pregnant girl with regard to recent antenatal services?

THANK YOU FOR YOUR TIME

ANNEXURE K

INTERVIEW GUIDE (TATAISO EA LIPUISANO) (Sesotho)

Tataiso ea lipuisano boithutong ba karolo e bapaloang ke lits'ebeletso tsa bokhachane ho ts'ehetsa bakhachane ba tlaase lilemong.

1. Puisano

Nomoro ea puisano: _____

Letsatsi la puisano: _____

Nako ea puisano: _____ Qalo _____ Qetello

2. Potso ea sehloho

1. Ako ntjoetse ka maiphihlelo a hau mabapi le ho tsamaea lits'ebeletso tsa bokhachane sepetlele Motebang.

(Lipuisano li ka tlisa tse latelang):

3. Lipotso tse fatisisang

- Ke lits'ebeletso life tse teng bakeng sa hau sepetlele Motebang u le mokhachane ea tlaase lilemong?
- Maiphihlelo a hau ke afe mabapi le tlhokomelo e u e fumanang klinikeng ea bokhachane?
- Maiphihlelo a hau ke afe mabapi le lits'ebeletso tse fanoang klinikeng ea bokhachane?
- Ke tlhahiso-leseling efe eo u e hlokanang mabapi le lits'ebeletso tsa bokhachane sepetlele Motebang?
- E be baoki le lingaka ba sebetsang klinikeng ea bokhachane sepetlele Motebang ba ka u thusa joang u le mokhachane ea tlaase lilemong?
- Ke mananeo afe a ka ntlafatsang lits'ebeletso tsa bokhachane bakeng sa hau u le mokhachane ea tlaase lilemong?
- Maiphihlelo a hau ke afe u le mokhachane ea tlaase lilemong mabapi le lits'ebeletso tsa bokhachane tse fanoang hona joale?

KEA LEBOHA KA NAKO EA HAU

ANNEXURE L

Academic and manuscript Editing Services.



Annexure L

To Whom It May Concern:

Date: 13/09/2013

Re: Masters Dissertation : Title: - **THE ROLE OF ANTENATAL SERVICES IN SUPPORTING TEENAGE PREGNANT GIRLS IN LERIBE DISTRICT OF LESOTHO.**

Client name: **SEEMA ELLIOT NTJABANE**

This serves to confirm that the above identified dissertation was edited and finalised by feraPHASE Academic and manuscript Editing services for language and format adherence in line with the Harvard (version 2.1) manuscript formatting requirements.

This was in preparation for submission to the University of South Africa for a dissertation of limited scope in partial fulfillment of the requirements for a Masters in Public Health.

Dr Sunil Sagoo

Director "feraPhase Academic and manuscript editing services.

94 Condere Estate , Bergrivier Drive , 1619 - sunil.sagoo5@gmail.com

Director(s): Dr S Sagoo and Dr Vyas